Providing Culturally Appropriate Services to Immigrant Children and Families Involved with the Allegheny County Department of Human Services

Turan Jafarova

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PROVIDING CULTURALLY APPROPRIATE SERVICES TO IMMIGRANT CHILDREN AND FAMILIES INVOLVED WITH THE ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES

A Thesis
Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Master of Arts

By
Turan Jafarova

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PROVIDING CULTURALLY APPROPRIATE SERVICES TO IMMIGRANT CHILDREN AND FAMILIES INVOLVED WITH THE ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES

By

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ABSTRACT

PROVIDING CULTURALLY APPROPRIATE SERVICES FOR IMMIGRANT CHILDREN AND FAMILIES INVOLVED WITH THE ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES

By

Turan Jafarova

May 2011

Thesis supervised by Dr. Linda Morrison and Dr. Evan Stoddard

In the last decade, the immigrant population in Allegheny County has doubled and currently accounts for approximately seven percent of the general population. This number, despite being low, especially compared to other counties and states, is very diverse from an ethnic point view and includes immigrant and refugees from Iraq, Bhutan, Burma, Burundi, Nepal, Somalia, numerous Latin American and other countries. Such an ethnically diverse population presents new opportunities for Allegheny County, the population of which has been declining and aging, at the same time posing various challenges to local human service organizations.

This research studies the experience of human service organizations in Allegheny County with immigrant children and families and focuses specifically on prevention, family support and foster care programs. The research identified the language barrier as
the major obstacle preventing immigrant children and families from receiving culturally and linguistically appropriate services.
DEDICATION

To all families who found their new homes in the United States and try their best to make it work and all those who support these families in their efforts.
ACKNOWLEDGEMENT

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I thank all those who agreed to participate in this research and share their experience and insight on this important issue.

Finally, I am very grateful for the love and support of my husband and family.
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LIST OF ABBREVIATIONS

ACS – American Community Survey
CLAS – Culturally and Linguistically Appropriate Standards
CYF – Office of Children, Youth and Families
DARE – Office of Data Analysis, Research and Evaluation
DHS – Department of Human Services
U.S. DHHS – U.S. Department of Health and Human Services
DOJ – Department of Justice
IRB – Institutional Review Board
LEP – Limited English Proficiency
OMB – Federal Office of Management and Budget
OMH – Office of Minority Health
PRWORA – Personal Responsibility and Work Reconciliation Act
UNHCR – United Nations High Commissioner for Refugees
CHAPTER ONE
INTRODUCTION

Chapter Overview

This chapter is an introduction to the research – a study about the experience of human service organizations in Allegheny County serving immigrant children and families with a particular focus on prevention, family support and foster care programs. The chapter includes research questions, the purpose and significance of the study, and describes the structure of this thesis.

1.1 Problem Statement

The immigrant population in Allegheny County is growing. According to the Pennsylvania Refugee Resettlement Program (2010), the refugee population in Allegheny County has doubled within last ten years and currently constitutes seven percent of the general population. This number, despite being considerably low, especially compared to other counties and states, is very diverse from an ethnic point view. These seven percent include immigrant and refugees from Iraq, Bhutan, Burma, Burundi, Nepal, Somalia, numerous Latin American and other countries. Such an ethnically diverse population presents new opportunities for Allegheny County, the population of which has been declining and aging (US Census 2009) and at the same time posing various challenges to local human service organizations.

1.2 Research Questions
The questions addressed by the research covered but were not limited to the following:

What is the current experience of organizations providing family support, prevention and foster care services to immigrant children and families? What are the main challenges/barriers to serving this population? How are these challenges addressed? How can these organizations make their work more culturally competent?

1.3 Purpose and Significance of the Study

The purpose of this research is to study the experience of organizations providing family support, prevention and foster care services to immigrant children and families involved with the Allegheny County Department of Human Services (DHS).

This research will provide the Allegheny County DHS with information on how organizations contracted by them are serving the growing immigrant population of Allegheny County. The findings as well as the recommendations based on the findings will help organizations make service provision more accessible and culturally competent; achieve the best possible outcomes for immigrant children and families; introduce changes in the policies regarding the immigrant and international population in Allegheny County.

1.4 Thesis Structure

This thesis consists of seven chapters. This chapter is an introduction to the research. Chapter two reviews the literature on the researched topic as reflected in books, journal articles, and electronic publications. Chapter three describes the Allegheny
County Department of Human Services and its approach to providing culturally competent services to its immigrant population. It also provides statistical information on immigrant population residing in Allegheny County. Chapter four is dedicated to the research design and methodology. Chapters five, six, and seven address research findings and discussion, conclusions and recommendations and research limitations respectively.
CHAPTER TWO
LITERATURE REVIEW

Chapter Overview

This chapter reviews existing literature on cultural competence, its importance in health and human service provision, and connection to immigration in the U.S. While reviewing the literature immigrant children and families were the focus: particularly the growing number of children in immigrant families, common characteristics of such families, major challenges they face while accessing various social services, and how they affect their well-being, as well as their involvement with the child welfare system.

Reviewed literature includes books and articles from scholarly journals, information provided on the websites of key federal and other related agencies (U.S. Department of Health and Human Services, National Center on Cultural Competence, U.S. Department of Justice, etc.), publications, reports, and issue briefs of various research institutes and centers (Migration Policy Institute, Urban Institute, etc.).

2.1 Culturally Appropriate Services: Definition and Requirements

The concepts of cultural appropriateness and cultural competency are synonymous and are used interchangeably throughout this study.

2.1.1 Cultural Competency

Cultural competency has been promoted in the U.S. for many years as a way to understand and address the complex needs of its diverse population (Cohen 2003; Child Welfare League of America 2001; Cross, Bazron, Dennis, and Isaacs 1989; Lum 2003;
Martinez, Green, and Sanudo 2004; McPhatter 1997; McPhatter and Ganaway 2003; Mederos 2003; Woodroffe and Spencer 2003).

Cultural competency is a complex concept that has numerous interpretations and definitions (Child Welfare League of America 2009; Cross et al. 1989; Goode 2004; Lum 2003; National Center for Cultural Competence 2010; National Standards 2001; Martinez et al. 2004; Suleiman 2003). Included here are some of the most widely used definitions of cultural competence.

According to the Child Welfare League of America (2009:1) cultural competency is “the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths or religions in a manner that recognizes, affirms, and values the worth of individuals, families, tribes, and communities, and protects and preserves the dignity of each.”

The National Center for Cultural Competence (2010) suggests that for an organization to become culturally competent it needs to have the following:

- a defined set of values and principles and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally;
- the capacity to value diversity, conduct self assessment, manage the dynamics of differences, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities they serve; and
- the willingness to incorporate the above in all aspects of policy-making, administration, practice, and service delivery, and systematically involve consumers, key stakeholders, and communities.
According to Lum (2003), cultural competence contains four major components: cultural awareness, knowledge acquisition, skill development, and inductive learning.

1. **Cultural awareness** is awareness of a person’s own life experience with regard to culture and contact with other cultures, allowing for a conscious assessment of the influence of those on the formation of personal prejudices;

2. **Knowledge acquisition** includes acquiring knowledge about various cultural groups, their history, strengths, etc., and also critical evaluation of such knowledge;

3. **Skill development** involves development of skills required to serve diverse populations;

4. **Inductive learning** is based on one’s knowledge of and experience with diverse populations, as well as on one’s ability to educate others in becoming culturally competent.

At an individual level cultural competency is believed to include the following most commonly mentioned elements (Pine 2005):

- The culture of the individual’s country of origin and the immigration experience are important to identify what made the individuals leave their homelands and the resources they brought;

- Regardless of why the individuals left their homelands they all have left behind very important and familiar things, like culture, environment, language, climate, family, friends, norms of behavior, etc.;

- Much of what the U.S. has to offer the newcomers is unfamiliar, strange and bewildering.
Cross et al. (1989) suggested that cultural competence is not a static, one-time achievement but rather a developmental process evolving over time. He has defined cultural and linguistic competence as a “set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations” (Cross et al. 1989:8). Culture in this definition refers to “integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups” (Cross et al. 1989:28). Competence “implies having the capacity to function effectively” as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (Cross et al. 1989:28).

Cross (1989) described the process of becoming culturally competent as a continuum that includes six stages: in particular, cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence and cultural proficiency. Individuals and organizations may be at various stages of awareness, knowledge and skills along this continuum. Following are the characteristics of each of these stages (Cross et al 1989:29-33):

- **Cultural destructiveness** shows itself in attitudes, policies, structures, and practices within an organization that are destructive to a cultural group;

- **Cultural incapacity** is lack of capacity of systems and organizations to understand and effectively respond to the needs of culturally and linguistically diverse groups. Incapacity displays an institutional or systemic bias; practices that may result in discrimination in hiring and promotion; disproportionate allocation of resources benefiting one cultural group over another; unequal treatment of various
cultural groups like subtle messages that some of them are neither valued nor welcomed; as well as lower expectations for some cultural, ethnic, or racial groups;

- **Cultural blindness** is reflected in the philosophy of some organizations to view and treat all people as the same without recognizing their differences. This may include: policies and approaches in the service delivery that ignore cultural differences; the practice of blaming consumers for their problems and circumstances they are in; little value placed on training and resource development that facilitates cultural and linguistic competence; lack of diversity in race, ethnicity, language, gender, age, etc. in the workplace, and few structures and resources for gaining cultural knowledge;

- **Cultural pre-competence** as a stage of the continuum includes the following: the organization values the delivery of high-quality services to culturally and linguistically diverse populations; commitment to human and civil rights; diverse workplace; representation of diverse populations on boards, etc. Despite these positive characteristics, organizations at the cultural pre-competence stage do not usually have a clear plan for achieving cultural competence;

- **Cultural competence** is the stage of achievement at which organizations accept and respect cultural differences. Such organizations are characterized by: existence of a mission statement reflecting the value of cultural and linguistic competence in all aspects of the organization; use of culturally and linguistically competent practices, strategies for involvement of consumers and community in the planning, delivery and evaluation of the organization; implementation of
policies and procedures to recruit and maintain a diverse and culturally and
linguistically competent workforce; support and development for the
improvement of cultural and linguistic competence at the board, program, and
staff levels; collection and analysis of data that have impact on culturally and
linguistically diverse populations;

- **Cultural proficiency** is the characteristic of an organization that continually adds
to the knowledge base of cultural and linguistic competence by conducting
research and developing new approaches for working with diverse populations;
employs staff, consultants and consumers with expertise in cultural and linguistic
competence in various areas of service provision; publishes and disseminates
promising practices, interventions, training, education models, etc.; supports other
organizations in their progress along the continuum; continually enhances and
expands the organization’s capacities in cultural and linguistic competence;
advocates with as well as on behalf of unserved and underserved populations, and
so on.

The definition by Cross (1989), presented in detail above, is one of the most
widely utilized especially with regard to the heath care industry, which employs the
concept of cultural competency more than any industry or area of service provision
(Frates and Saint-Germain 2004; Martinez et al. 2004; National Center for Cultural
Competence 2010; National Standards 2001). The existence of the national standards of
providing appropriate services with regard to one’s culture and language proves this
point.
The Culturally and Linguistically Appropriate Standards (National Standards 2001) were designed based on Cross’s comprehensive definition of cultural competency. Developed by the Office of Minority Health of the U.S. Department of Health and Human Services (U.S. DHHS) in 2001, CLAS standards are intended to serve as the national standards for providing culturally and linguistically appropriate services in health care. DHHS is the principal agency of the U.S. government in charge of protecting health and providing essential human services for all Americans, especially to those “who are least able to help themselves” (U.S. DHHS 2011). In 1986 U.S. DHHS created the Office of Minority Health to improve the health of the racial and ethnic minorities by developing health policies and programs aimed at eliminating health disparities (U.S. DHHS OMH). Development of the CLAS standards was one of such steps.

CLAS standards were proposed as a means of correcting the inequalities in health care provision and making health services more inclusive and responsive to the needs of all cultures. These standards were specifically designed to address the needs of racial, ethnic, and linguistic populations who experience unequal access to health care (Martinez et al 2004; National Immigration Law Center 2003; National Standards 2001).

CLAS standards (National Standards 2001:1-2) are organized by the three themes which represent recommended, mandated, and suggested standards of culturally and linguistically appropriate health care services (Appendix 1). Standards 1-3 are recommended standards of culturally competent care; standards 4-7 are mandated standards of language access services based on Title VI of the Civil Rights Act of 1964 (discussed later); standards 8-14 are recommended standards for organizational support of cultural competency.
CLAS standards are not mandatory and so they lack the power of law. Despite that, human services agencies can use the CLAS standards, as they include the basic important aspects of culturally and linguistically appropriate service provision and can significantly assist providers of various services in addressing the cultural and linguistic needs of their patients and clients (Grantmakers in Health 2005; Martinez et al 2004; Morse 2003; National Immigration Law center 2003; National Standards 2001).

2.1.2 Language Access: Practical and Legal Sides of the Issue

Practical Side

Absence of language access has been identified as a major barrier for both immigrants who, in the majority of cases, have limited proficiency in English, and for providers of various services (Bachurski, Bennet, and De Chellis 2011; Dobrzycka 2008; Earner 2007; Earner and Rivera 2007; Frates 2004; Fortuny 2008; Fortuny et al. 2009; Good, Warren, and Dalton 2010; Grubbs, Chen, Bindman, Vittinghoff, and Fernandez 2006; Hernandez 2004; Kugler 2009; Lessard 2004; Martinez et al 2004; Mather 2009; Morse 2003; Shields 2004; Skinner 2010). The Federal Office of Civil Rights defines Limited English Proficient or LEP individuals as people “who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English” (Limited English Proficiency 2010).

The 2007 American Community Survey (ACS) reports showed that the vast majority of the population five years old and older in the U.S. spoke only English (80 percent) (Shin and Kominski 2010). At the time the survey showed that the population
speaking a language other than English at home has dramatically increased in the last thirty years. Twenty percent of 281.0 million people aged five and over, or 55.4 million people, spoke a language other than English at home. According to the Census Bureau (2007), the language “other than English” may be one of 381 distinct languages which are usually divided into four major groups: Spanish; Other Indo-European languages; Asian and Pacific Island languages; and All Other languages (Shin and Kominski 2010). Of the 55.4 million people who spoke a language other than English at home, 62 percent, or 34.5 million speakers, spoke Spanish; 19 percent, or 10.3 million speakers, spoke another Indo-European language; 15 percent, or 8.3 million speakers, spoke an Asian and Pacific Island language; and finally 4 percent, or 2.3 million speakers, spoke an Other language (Shin and Kominski 2010).

The majority of the people (31 million) who identified a language other than English as the one they used at home reported that they spoke English “very well.” Eleven million speakers spoke English “well”, nine million “not well,” and four and a half million described their ability to speak English as “not at all.” Shin and Kominski, the authors of the ACS Reports (2010), suggested that people who speak English at a level below the “very well” category are those who need assistance in various social situations.

Many adults arriving in the United States from other countries have difficulties learning English; their children, on the contrary, grow up learning English as their primary language (Dinan 2006; Grantmakers in Health 2005; Mather 2009; Wang 2009). The American Community Survey conducted in 2007 revealed that almost half of all
children in immigrant families spoke English well (Shin and Kominski 2010). However, despite children speaking English well, they usually reside in the so-called “linguistically isolated” families in which parents had difficulties speaking English, in other words, have limited English proficiency (LEP) (Dinan 2006; Fortuny, Capps, Simms, and Chaudry 2009; Hernandez 1998; Hernandez 2004; Lincroft 2006; Mather 2009; Shields and Behrman 2004; Wang 2009). Children in such families are often used as translators for their parents or older siblings (Childhood in Translation 2008; Dinan 2006; Grantmakers in Health 2005; Lincroft 2006). Using children as interpreters raises a whole array of issues related to confidentiality and appropriateness and is absolutely rejected by child welfare specialists (Childhood in Translation 2008; Grantmakers in Health 2005; Lincroft 2006). This problem and its consequences are explored in the famous “Childhood in Translation” documentary project by the Migration Policy Institute (2008), which is based on true stories of those who as children served as interpreters for their LEP family members. The survey of people who watched the film showed that it was very helpful in educating mainstream audiences about language access problems by exposing the “tremendous need” for linguistically accessible services in an increasingly diverse America (Wang 2009:7).

As shown by studies, parents’ ability to speak English is very closely connected to their success in the labor force and their children’s success at school (Hernandez 2004; Mather 2009). Limited English proficiency of parents reduces job opportunities, earnings, and access to social and other services. It also has a negative impact on their children’s academic performance because LEP parents have a limited ability to help their children
with homework and to interact with the school system (Dinan 2006; Hernandez 2004; Mather 2009).

Controversy and lack of knowledge around the questions of who is responsible for providing interpretation services for non-English speaking or LEP individuals still persists. This may have various consequences ranging from a delay or a denial in delivering services to immigrant children and families due to the unavailability of an interpreter to tragic consequences which may occur as the result of a wrong medical prescription, for example (Bachurski et al 2011; Childhood in Translation 2008; Dinan 2006; Morse 2003; Smedley, Stith, and Nelson 2003).

**Legal Side**

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin in programs and activities receiving Federal financial assistance. In particular, Title VI provides that "no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance" (US DOJ Title VI 2010). If an agency is found to be violating the provisions of Title VI, its federal assistance can be withdrawn. Title VI also requires that all the documents needed to be signed by immigrants are presented to them in a language they can read and understand. Title VI does not specifically mention discrimination on the basis of one’s language. The Supreme Court determined that language was a proxy for national origin in 1974 in the Lau v. Nichols, 414 U.S. 563 case.
initiated by Chinese American students against the school they were attending in San Francisco, California (U.S. Supreme Court Center 2011).

Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency,” signed by President Clinton on August 11, 2000, extended the language access requirements of Title VI (Martinez et al. 2004; Morse 2003; National Immigration Law Center 2003; U.S. DOJ Executive Order 13166 2000). Particularly, it required federal agencies to examine their approach to LEP clients and develop practical ways of improving their accessibility to this population (U.S. DOJ Executive Order 13166 2000). The Executive Order did not prescribe specific approaches to language access services but it did require that federal agencies prepare the so-called LEP plans, describing the process to ensure that LEP individuals are eligible for their programs and have access to them. Also, federal agencies which provide financial assistance to state, local, or regional programs and services are required to develop guidance for the recipients of the funding to clarify their obligations under Title VI (U.S. DOJ Executive Order 13166 2000).

The Department of Justice (U.S. DOJ 2002), which oversees this process, suggested that agencies use the following four factors while assessing their programs, activities, and services and their accessibility to LEP individuals: (1) the number or proportion of LEP persons eligible to be served or likely to be encountered by the program; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance to people’s lives of the program, activity, or service receiving federal funding; (4) the resources available to the recipient of federal funding and the cost of language access services. These instructions intend to create a
balance between ensuring access to critical services by LEP individuals and avoiding a burden to agencies and organizations which receive federal funding (U.S. DOJ 2002).

The Bush administration reaffirmed Executive Order 13166 after a cost-benefit analysis of the order conducted by the Federal Office of Management and Budget (OMB 2002) revealed that improved access to a wide variety of services can substantially improve the health and quality of life of many LEP individuals and their families. The OMB analysis concluded that “language-assistance services can increase the efficiency of distribution of government services to LEP individuals and may measurably increase the effectiveness of public health and safety programs” (OMB 2002:4). Another landmark report released the same year by the Institute of Medicine stated that “bias, stereotyping, prejudice, and clinical uncertainty on the part of the healthcare providers may contribute to racial and ethnic disparities in healthcare” (Smedley, Stith, and Nelson 2003:178).

The issuance of the Executive Order stimulated numerous agencies to engage in various activities aimed at eliminating negative effects of the language barrier (Frates and Saint-Germain 2004; Morse 2003; Wang 2009). However, not all the agencies receiving federal funding have been very responsive to the language law. There are still many language barriers in various services and programs, especially in the states which have not been traditional destinations for immigrant populations (Dinan 2006; Fortuny and Chaudry 2009; Fortuny 2010). As shown in the next chapter, this problem exists in Allegheny County, which experiences a growing diversity of its population.

Studies also showed that the majority of immigrants are unaware of their rights and of the responsibility of a federally funded agency to provide necessary services in a language they can understand (Grubbs 2006; Hernandez 2004). However, the first
multilingual study in the U.S. to focus on the awareness of language laws and its association with language access conducted in San Francisco, California (Grubbs et al. 2003) showed that these two factors have little connection. A telephone survey carried out with 1200 Californians (1000, or 83%, of whom had limited English proficiency) in 11 non-English languages revealed that awareness of LEP clients about the language laws was not sufficient to resolve language barriers for such individuals. The language barrier problem, researchers suggested, should be approached at various levels to ensure accessibility to LEP clients.

The Office of Minority Health acknowledges that Executive Order 13166, the report of the Institute of Medicine on racial and ethnic disparities in health care and CLAS standards (mentioned earlier) are the “three key federal documents that have made it clear that system-wide changes in the areas of culturally and linguistically appropriate services are both timely and necessary” (National Standards 2001:41) Language access and accurate communication are receiving increased attention as critical and inevitable conditions that lead to improved public health and safety, resulting in greater integration of newcomers and increasing economic well-being of the broader community (Fong 2007; Grantmakers in Health 2005; Hernandez and Charney 1998; Ontai and Mastergoeroge 2006; Wang 2009; Woodroffe and Spencer 2003).

2.2 Immigrants in the United States: Numbers, Destinations, Legal Status and Welfare Reform of 1996

Numbers and Destinations
The United States has always been and continues to be a “continent of hope” for people from other countries (Fenelly 2007; Gingrich 2005). People from all over the world come to the United States for a variety of reasons and for various time periods: temporarily to study, to do research, to gain experience to apply it in their home countries on their return; and permanently due to increased opportunities, availability of jobs, to pursue their own “American dream” as well as to escape war and persecution in their home countries. Throughout much of the history of the United States immigration has been a major source of population growth and cultural change (Fennelly 2007; Hernandez and Charney 1998; Hernandez 2004; Mather 2009).

According to the Migration Information Source, the foreign-born population of the U.S. quadrupled from 9.6 million in 1970 to approximately 38.1 million in 2007. In 2009 the number of immigrants was about 37.1 million (Papademetriou and Terrazas 2009). Such a dramatic change was observed not only in numbers, but in immigration trends. Particularly, a shift happened in immigrants’ background and their destinations in the U.S. The shift in immigrants’ background was that the majority of them were Latinos and Asians as compared to Europeans in earlier years (Fenelly 2007; Papademetriou and Terrazas 2009). The destinations of the immigrants have been changing from the so-called “traditional gateway” states to new areas (Dinan 2006; Fortuny and Chaudry 2009; Fortuny et al. 2010; Grantmakers in Health 2005; Hernandez 2004; Mather 2009; National Center for Children in Poverty 2002). Still, today the majority of immigrant families are concentrated in the six states that have long served as the traditional destinations for the foreign-born population, particularly California, Florida, Illinois, New
Literature shows that settling of immigrants in states which have not been exposed to many immigrants before can lead to fear and even hostility among local residents. Immigrants in such communities are mostly the so-called recent immigrants, who are usually younger, less educated, usually poorer and more often undocumented than immigrants in traditional destinations (Dinan 2006; Fortuny et al. 2009; Mather 2009).

**Legal Status**

In general, immigrants are usually classified into four categories, depending on their status: legal permanent residents, naturalized citizens, refugees, and undocumented immigrants (Pine and Drachman 2005; Torrico 2010).

A *legal permanent resident* is a person who has been legally admitted to the United States after a successful application process. His or her coming to the US is usually sponsored by a family member living in the U.S. or, in some cases, by an employer. Legal permanent residents receive a “green card” which allows them to work in the US and also makes them eligible to becoming naturalized citizens three to five years after receiving a green card.

*Naturalized citizens* are those who have acquired the citizenship or nationality of the USA.

*Refugees* are admitted to the United States because of a “well-founded fear of persecution” in their own country. The USA uses the UNHCR definition of a refugee, which is as follows: a refugee is “someone who, owing to a well-founded fear of being
persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country, or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it” (UNHCR 2010). Refugees can apply for legal permanent residence after a year of their staying in the U.S. For a graphic explanation of how the resettlement process works please see Appendix 2. A category of immigrants close to the refugee is the asylee. Both refugees and asylees fall under the same legal definition of having a fear of persecution due to race, nationality, religion, political opinion, or affiliation with a certain social group. The difference between these two categories is the time when individuals receive legal permission to resettle in the United States: refugees receive the permission before they arrive, whereas asylees receive permission only after their arrival (BRYCS 2010).

Undocumented immigrants or illegal immigrants are those who do not have valid immigration documents. They can be people who did not leave the country after their temporary visas expired or those who entered the country without the knowledge of immigration authorities.

Along with those categories some newcomers can be granted a special immigration status that is given to some minor immigrants under Special Immigrant Juvenile Status (Child Protection Best Practice Bulletin 2010).

Also, pertinent to the child welfare system is the so-called mixed-status family, in which members fall under different legal immigration categories (Child Protection Best Practice Bulletin 2010; Dinan 2006; Lincroft 2006; Mather 2009). Such a family may
have children who are born in the United States and are automatically citizens, undocumented children, an undocumented parent, a parent who is a legal permanent resident, etc.

Each of the above-mentioned statuses is associated with specific entitlements to benefits, services and legal rights, which changed after the welfare reform of 1996 can facilitate or impede integration and, in general, the life of newcomers in the U.S. Immigrant children and families usually face various barriers and hardships due to their varying statuses, which are described below (Mather 2009; Grantmakers in Health 2005; Pine and Drachman 2005; Torrico 2010; Velazquez, McPhatter, and Yang 2003).

**Welfare Reform of 1996**

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) signed by President Clinton in 1996 aimed to “end welfare as we know it.” It restricted legal immigrants’ access to many benefit programs (welfare, food stamps, health insurance, etc.) (National Association of Social Workers 1996). This was the first law to comprehensively codify the eligibility of refugees, legal and unauthorized immigrants for state and federal public benefits. The restrictions introduced by this law reflected a popular belief that welfare is the major magnet attracting immigrants to the U.S. This law intended to promote the self-sufficiency of the general population of the U.S. as well as that of the immigrants and increase the quality of life for both. This law also had three immigrant-specific goals:
- altering immigrant flows to the U.S. by reducing the effects of the “welfare magnet” and thus “increasing the quality of new immigrants” (National Association of Social Workers 1996:6);
- shifting responsibility for the immigrants’ support from the states onto the sponsors of immigrants;
- saving money.

In reality, studies say, this law just created new challenges for immigrants and refugees by narrowing their access to public benefits. The changes introduced by PRWORA reduced benefit participation even among immigrants who were eligible for assistance (Dinan 2005; Van Hook, Brown, and Bean 2004). Explanations of such an outcome include confusion over the new eligibility criteria and fear of interacting with government officials. This fear is explained by a belief popular among immigrants that any contact with government officials can risk their immigration status or result in discovery and deportation of undocumented family members. This negative effect on the use of benefits by eligible immigrants is called a “chilling effect” (Dinan 2005:7; Earner 2007:68)

Despite some stringent restrictions, welfare reform granted a greater power to the states in determining immigrants’ eligibility for such public benefits as food stamps, Temporary Assistance for Needy Families, Supplementary Security Income, and public health insurance for children and parents. Immigrants’ integration and general well-being vary depending on how states use the power granted to them (Dinan 2005, Federal Policies; Dinan 2005, State Policies).
The effect of the 1996 welfare reform act on immigrants was thoroughly investigated by Michael Fix in “Immigrants and Welfare: The Impact of Welfare Reform on America’s Newcomers,” a book published in 2009. His research revealed that restrictions created by the reform complicate immigrants’ integration into American society. Fix also claims that the exclusion of non-citizen children from benefits will unavoidably have serious future consequences for the American economy because these children will constitute a considerable share of the future workforce in the U.S. The U.S., the author proposes, should support the integration of newcomers by extending and ensuring full benefit access to legal immigrants at the time of their arrival, thus encouraging them to eventually become citizens. Fix concluded that “we would make them better citizens by treating them like citizens sooner” (2009:30).

2.3 Immigrant Children and Families

Interesting research on coverage of immigration-related issues in newspaper articles and scientific publications undertaken by the Population Reference Bureau has discovered that, since 1980, most articles about immigration covered primarily legal status or criminal activities of immigrants, government debates about immigration policy, and the issues of national security (Mather 2009). Only five percent of all researched stories covered issues concerning immigrant children and families. Yet the children of immigrants are at the center of numerous social and public policy issues in the United States and represent the fastest growing population group (Dettlaff, Haymes, Velazquez, Mindell, and Bruce 2009; Fix, Capps, and Kausbal 2009; Fortuny 2009; Hernandez 2004; Mather 2009; Pine and Drachman 2005; Shields and Behrman 2004).
According to a study by the Urban Institute, the number of children of immigrants doubled from 8 million in 1990 to 16.4 million in 2007 (Fortuny 2009). This increase has been nationally recognized as an issue requiring special attention because it has important implications at the federal, state and local levels for health, housing, education, family and other policies (Fortuny 2009; Kugler 2009; Mather 2009). Moreover, children of immigrants will most likely constitute the majority of the future U.S. labor force (Fix et al 2009; Fortuny 2009; Hernandez 2004; Mather 2009). Special attention is also required as immigrant children and their families face many universal risk factors of well-being, such as low family income and also risks unique to the immigrant population (Borelli, Earner, and Lincroft 2007; Dettlaff et al. 2009; Fong 2007; Fortuny 2009; Lincroft 2006; McPhatter and Ganaway 2003; Pine and Drachman 2005; Torrico 2010).

Families coming to the United States seek a better life for themselves and their children, but they do not always find it here. Most of the immigrants have limited resources and support, which together with cultural differences and limited English proficiency bring them to the attention of child welfare systems. These challenges also create barriers for the service providers (Borelli et al. 2007; Fortuny 2010; Segal and Mayadas 2005; Shields and Behrman 2004).

Provided below are the most common findings on the characteristics of immigrant children and families and the problems they face.

The majority of immigrant children live in a low-income household, which can be below 200 percent of the official poverty level (Hernandez 2004; Lincroft and Dettlaff 2010; Lincroft 2006; Shields and Behrman 2004; National Center for Children in Poverty...
Studies revealed that two-thirds of children in immigrant families, or 65 percent (2.1 million), are low-income.

Children in immigrant families usually have both parents (Dinan 2006; Lincroft 2006; Mather 2009; Fortuny et al. 2010). Data from December 2004 showed that 71 percent of low-income immigrant families had both parents. For native-born children this number was 42 percent.

Children in immigrant families are usually linguistically isolated (Dinan 2006; Fortuny et al. 2009; Hernandez 1998; Hernandez 2004; Lincroft 2006; Mather 2009; Shields and Behrman 2004; Wang 2009). Census 2000 indicated that 26 percent lived in linguistically-isolated households, i.e. were LEP.

Children in immigrant families have less-educated parents. The research of the National Center for Children in Poverty (2004) revealed that 45 percent of children from immigrant families have parents who do not possess a high school degree. Among native-born children this number is only 18 per cent. The low level of parents’ educational attainment usually negatively affects their children’s development, as they usually face difficulties while helping their children with homework. In general, issues connected to schooling of the children from immigrant families are among the most important ones as these children are really changing the “face of American classrooms” (Kugler 2010:1-2). The Center for Immigration Studies (2007) has estimated that there were 10.8 million school-age children from immigrant families in the United States in 2007 and that immigration accounted for almost all the national increase in U.S. public school enrollment over the last twenty years (Camarota 2007). The demographers of the Center are predicting that by 2015 children from immigrant and refugee families may constitute
30 percent of all American students (Camarota 2007). They present serious challenges for local, state and federal policymakers who are constantly trying to increase educational attainment among America’s youth.

Despite the great emphasis immigrant parents place on education and the enthusiasm of their children about going to school, they face numerous problems, barriers and challenges. And so do their American teachers and educators. One of the major concerns of American educators is that the families do not pay sufficient attention to their children’s education (Kugler 2010). Research shows that this can be explained by the low educational attainment of immigrant parents, who do not feel knowledgeable enough to engage in communications with the school system, which, coupled with the language barrier, can result in a complete avoidance of such engagements. Another explanation suggests that immigrants show their respect for schools “by keeping their distance from them” (Kugler 2010; Mather 2009). Relationships between a family and a school in many countries can be based on a belief that teaching a student is the teacher’s job and parents’ intervention into the educational process is disrespectful towards the teachers. Parents may give the full authority and responsibility over their children to the teachers and don’t get involved unless there is a serious problem (Kugler 2009:3-5; Mather 2009:7-9).

The academic success of immigrant and refugee children depends on various factors. Oftentimes the focus, while supporting immigrant and refugee children to improve their academic performance, is on improving their English language skills (Kugler 2009). Yet the main factor creating challenges can be overlooked. This factor is the experience of moving to the United States, which can be associated with various problems, depending on the status of children and families (Earner 2007; Grantmakers for
Many children come from families which escaped war or persecution in their own countries. The majority of such families experience repeated violence which results in depression, behavioral problems and post-traumatic stress disorder. Research has found a link between these symptoms and both lower academic achievement and high dropout rates among immigrant and refugee children (Kugler 2009; Mather 2009).

Refugee children in many cases have even more emotional problems preventing them from achieving success in school. Some of them have lived in refugee camps for many years, with little or no opportunity for formal education. Some may come from countries with no established education system. Also, if children did attend school in their countries, their education had been interrupted when the family left its native country (Pine and Drachman 2005).

2.4 Immigrant Children and Families and the Child Welfare System in the U.S.

Studies have shown that immigrant and refugee children are at greater risk of being involved with the child welfare system (Lincroft 2009; Mather 2009; Torrico 2010). Experience related to migration, socioeconomic and psychosocial hardship makes families more vulnerable to various problems in their new country and thus increases the risk of getting involved with child welfare (Borelli et al. 2007; Cohen 2003; Earner 2007; Earner and Rivera 2007; Fong 2007; Hernandez 2004).

Currently, very limited data exist about the number of immigrant children and families in the child welfare system. This information is not collected uniformly on a local, state, or national level (Lincroft 2006; Mather 2009). Interviews with child welfare
workers and researchers conducted by the Annie E. Casey Foundation in 2005 suggested that this lack of data integrity, misclassification, and under-reporting, or even misreporting, are the result of problems with the child welfare intake system and database (Lincroft 2006). Intake forms and electronic databases in general lack fields with such information as country of origin, primary language, immigration status, etc. Such information is difficult to obtain for the following reasons: confusion about immigration status, fear of jeopardizing the immigration status of the family, and also because information can be different for each family member (the so-called mixed-status families in which there are children who were born in the U.S. and thus citizens, undocumented children, as well as parents and other family members who have permanent legal residency or some other status, etc.) (Lincroft and Dettlaff 2010).

One of the major reasons an immigrant or refugee family comes to the attention of the child welfare system is the case of alleged abuse or neglect (Earner 2007). It is a well known fact that there is not a universal standard of child rearing, nor is there such a standard for child abuse and neglect (Cohen 2003; Lincroft 2006). Nevertheless, some traditional practices of immigrant families may represent abusive and neglectful practices if they are judged based on American standards. Particularly, corporal punishment can be widely practiced in some countries refugees and immigrants are coming from, whereas in the United States it is considered child abuse. At the same time, some Western parenting styles might appear “too permissive” for some immigrant and refugee families (Serving Foreign-Born Foster Children 2004:4). It has been widely recognized that child welfare workers should approach immigrant families with sensitivity and understanding of their unique experience and culture. (Borelli et al. 2007; Cohen 2003; Dinan 2005; Earner
In almost every culture, community members have a responsibility to intervene when a child is being hurt, abused or neglected. The problem is that the definition of what constitutes abuse and neglect varies considerably across cultures (Cohen 2003; Serving Foreign-Born Children 2004). Understanding of abuse and neglect in a certain culture is closely connected to the intervention methods and identification of their causes, as well as the ways to help overcome the problem. All of these factors in turn are closely connected to the understanding of a particular culture. For example, some traditional initiation rites practiced by different cultures can be perceived as abusive in the United Stated. At the same time, some American child rearing practices could be viewed as no less abusive or neglectful by other cultures. Evaluating various parental practices and methods outside of their cultural context can result in false conclusions, which could ultimately lead to a family breakdown and children’s removal from their biological families (Borelli et al. 2007; Cohen 2003; Earner 2007; Earner and Rivera 2007; Fong 2007; Hernandez 2004; Serving Foreign-Born Foster Children 2004).

According to the latest comprehensive research on immigrant and refugee children in the child welfare system conducted by the Annie E. Casey Foundation (2005), immigrant families often enter the public child welfare system for the same reasons as the general population, with poverty, domestic violence, substance abuse, mental and physical health being among major reasons (Lincroft 2006). However, there are also unique factors bringing immigrant children and families to the attention of child welfare
which are associated with their experiences of immigration and acculturation. Due to the changing cultural context, loss of their community, and loss of social support systems, immigrant families are more vulnerable to stress, depression and marginalization as well as various physical and mental health complications (Child Protection 2010; Dettlaff et al. 2009; Earner 2007; Fong 2007; Lincroft and Dettlaff 2010).
CHAPTER THREE
CULTURALLY APPROPRIATE SERVICES IN ALLEGHENY COUNTY

Chapter Overview

This chapter provides background information about the Allegheny County Department of Human Services and its approach to providing culturally appropriate services to county residents through the efforts of its Immigrants and Internationals Initiative project and the Immigrants and Internationals Advisory Council. It also describes the provision of child welfare services in Allegheny County. The chapter concludes with statistical information on the number of immigrants and refugees in Allegheny County. This chapter reviews information and publications posted on the official website of Allegheny County DHS and documents of the Immigrants and Internationals Initiative Project of the Allegheny County DHS, particularly meeting minutes and reports of the Immigrants and Internationals Advisory Council’s Committees.

3.1 Allegheny County Department of Human Services: “...all services will be culturally competent”

The Allegheny County Department of Human Services (DHS) was created in 1997 to unify the provision of various social services across Allegheny County. Currently, the Allegheny County DHS has five program offices: the Area Agency on Aging, Office of Behavioral Health, Office of Children, Youth and Families (CYF), Office of Community Services, and Office of Intellectual Disability (About DHS 2010).
Three supportive offices of DHS are the Office of Administration and Information Management Services, Office of Community Relations, and Office of Data Analysis, Research and Evaluation (DARE) (About DHS 2010).

The vision of the DHS is to meet the human service needs of county residents, particularly the vulnerable populations and ensure that all services are:

- High quality – based on best practices in case management, counseling, and treatment
- Readily accessible – in natural, community-based settings
- Strength-based – focusing on strength and capabilities of clients, not their deficits
- Culturally competent – treating individuals, their goals and preferences with dignity and respect
- Individually tailored and empowering – building confidence and independence of the clients
- Holistic – serving the comprehensive needs of families and individuals through a full continuum of services (DHS Guiding Principles and Vision Statement 2010).

As seen from the above-mentioned guiding principles, DHS is committed to provide high-quality services and achieve the best possible outcomes for the clients they serve, especially the vulnerable population. Such an approach is especially important as the number of immigrants and internationals in Allegheny County is growing. As a response to the growing diversity of the region DHS established the Immigrants and Internationals Initiative project (DHS Newsletter 2010)

The Immigrants and Internationals Initiative project was created in 2007 as a response to the growing number of immigrants in Allegheny County and thus a growing
need to provide them with culturally competent, accessible, and individually tailored services in accordance with the guiding principles of the department ((DHS Newsletter 2010).

In order to solicit ideas on how to better serve immigrants, DHS reached out to members of the immigrant and international community to come together and exchange ideas. This resulted in formation of the Immigrant and International Advisory Council in October 2008, with the main goal of advising the director and executive staff of the DHS regarding the human service needs of immigrant and international county residents (DHS Advisory Bodies 2010). The Advisory Council has developed five committees to address several human-service needs of the immigrant and international residents (Description of Immigrants and Internationals Advisory Council 2010):

1. *The Translation and Interpretation Committee* works to improve the capacity of DHS to serve individuals with limited English proficiency;
2. *The Cultural Competency Committee* develops training for DHS staff and contracted providers;
3. *The COMPASS AmeriCorps* project works on on-going social service needs of immigrants and refugees through volunteers;
4. *The Refugee Career Mentoring Committee* is working to develop a mentor-supported workforce development program to assist refugees with higher education and skills in finding work opportunities with career paths and recertification so that they can contribute their skills to the regional workforce;
5. The Foster Care, Prevention and Family Support Committee is working to improve culturally appropriate foster care, prevention and support services for children and families.

The Advisory Council has been active in advocating for the immigrant population by starting several initiatives. One such initiative was a request to identify the needs and capacities for providing services to individuals with limited English proficiency (LEP) in Allegheny County. To do so, the Advisory Council initiated a survey which was carried out by the Data Analysis, Research and Evaluation Office (DARE) of DHS in 2009 (DHS Newsletter 2010). DARE, on behalf of the Advisory Council, surveyed DHS Senior Staff (internal survey) and contracted providers (external survey) to find out about the requests for services in languages other than English, learn which languages and cultures were represented in the area served by the Allegheny County DHS, as well as identify challenges and capabilities in providing services to LEP individuals (Good et al. 2010).

Major findings of the internal survey included the following: language demands and capacities were not clearly understood within DHS; there was a need to document the language needs of consumers as well as language capacities of DHS staff; the outreach to the LEP community was minimal. The external survey showed that there were requests for twenty-nine different languages. Based on these surveys the Advisory Council made recommendations to DHS on how its services could be made more culturally competent and accessible (DHS DARE Publications, Good et al., 2010).

Based on the findings of this survey and on the challenges in service provision to the foreign-born population reported by provider agencies, the Translation and Interpretation Committee of the Advisory Council proposed the creation of a community
language bank that will serve DHS and the broader community. After more than two years of research, meetings and negotiations, the language bank is almost ready to be launched by the end of 2011 (DHS Newsletter 2010).

Along with that, the Advisory Council’s recommendations resulted in compiling a comprehensive resource guide (“Immigration and Public Benefit Eligibility”) for many of the publicly-funded benefits (DHS 2010). This resource guide is being distributed and widely used by those serving LEP population. Also, as a part of the effort to support immigrant and international groups, DHS opened the doors of all of its conference rooms in the Downtown building for meetings and events for the immigrant population (Conference Room Guidelines 2010).

One of the most recent efforts carried out in coordination with the Advisory Council is a brief issued recently by the Consumer Health Coalition of Pittsburgh (Bachurski et al. 2011). This brief shows how language barriers complicate LEP clients’ access to health care, cause delays and lapses in service provision, and result in discrimination based on language and ethnicity. The brief provides important statistical data on the language barriers faced by LEP clients in medical facilities in Pittsburgh, which is absolutely crucial in order to bring attention to the issue of barriers faced by LEP clients. A special form developed to help organizations gather necessary data (“Tracking Barriers to Care” form) was distributed among various organizations working with LEP consumers. One hundred twenty-two of these reports revealed the most common barriers affecting LEP consumers who spoke five different languages (Arabic, Burmese, Burundi, Nepali, and Spanish). They included: an agency/institution would not make an appointment for a client unless he/she provided a translator at their own
expense; a requested oral translation would not be provided; lack of informed consent; inappropriate questions by personnel (example, “Why don’t you speak English?”); telephone or mail correspondence was conducted with a client in English even after a request was made to do it in his/her native language (Bachurski et al. 2011:5-6).

The efforts described above demonstrate the importance and vital need for a culturally competent and non-discriminatory solution, which can ensure that all residents of Allegheny County regardless of race, ethnicity, primary language, sex and other such factors, have access to the services they need.

In the next section I describe the provision of prevention, family support and foster care services in Allegheny County.

3.2 Child Welfare System in Allegheny County

The provision of child welfare services in Allegheny County is divided between three entities, with each providing a special type of service. The Children, Youth and Families (CYF) office of DHS provides services for children and families experiencing child abuse or neglect or those in which such a risk exists. The Juvenile Probation Office (JPO) targets delinquent youth by providing placement and support services. Shuman Center focuses on youth awaiting adjudication and provides temporary shelter (DHS CYF 2010).

Allegheny County DHS, Office of Children, Youth and Families is the second largest welfare agency in the Commonwealth of Pennsylvania. It was created in 1963 to comply with federal and state laws which required that child abuse cases be investigated
and was then known as the Office of Children and Youth Services. In 1997, CYF became a part of an integrated Department of Human Services (DHS CYF Profile 2010).

The mission of CYF is to “protect children from abuse and neglect; to preserve families, whenever possible; and to assure permanency, that is, to provide permanent, safe homes for children either by assuring safety within the child’s own family, or by finding an adoptive home or another permanent setting for those children who cannot be reunified with their families” (DHS CYF Profile).

Families usually become known to CYF through incidents of child abuse or neglect reported to the DHS, which are investigated by the caseworkers of the agency. Along with that, preventive services are a big part of CYF’s work. Such services include community-based, family-powered family support centers, First Steps programs, early childhood education and numerous other family-strengthening programs.

The major goal of the DHS CYF is keeping children in their families and assuring their safety and permanency. The majority of children and families engaged with CYF receive services in their homes and communities. However, in some cases keeping a child in his or her family is not possible due to various reasons and risks for a child. In such cases, CYF is ready to provide foster care through the twenty foster care agencies contracted by the DHS or through kinship care.

This research involves family support and first step programs as well as foster care agencies contracted by the DHS, to learn more about their experiences of working with immigrants and refugees. The research participants and findings are described in the Methodology chapter.
3.3 Immigrants in Allegheny County

Before proceeding to the description of the immigrant population in Allegheny County I would like to present some statistical data on the foreign-born population in Pennsylvania, particularly the recent trends and numbers and how they have changed since the 1990s.

According to statistical data from the Migration Policy Institute (MPI 2009), between 2000 and 2009 there was an increase by 36 percent in immigrant population of Pennsylvania (from 508,291 to 691,242). Between 1990 and 2000 the change represented an increase of 37.6 percent (from 396,316 to 508,291) (Table 1).

In 2009, the immigrant population in Pennsylvania accounted for 5.5 percent of its total population. This number was 4.1 percent in 2000 and 3.1 percent in 1990. As seen from the numbers presented in Table 1, the foreign-born population in Pennsylvania has been growing steadily. Immigrants from Asia constituted the majority of Pennsylvania’s foreign-born population in 2009 (36.4 percent). Other places of origin include Africa (7.7 percent), Europe (26.4 percent), and Latin America (South America, Central America, Mexico, and the Caribbean – 26.9 percent). Lower percentage of immigrant population was from Northern America (Canada, Bermuda, Greenland, etc., 2.3 percent) and Oceania (0.3 percent) (MPI 2009) (Table 1).

Children in immigrant families in Pennsylvania accounted for more than 10 percent of the total number: 10.2 percent (or 269,151) of children under age 18 lived with at least one immigrant parent in 2009.

According to the Census 2010 data released in March 2011, the Latino (or Hispanic) population represents the fastest-growing minority group in the state of
Pennsylvania: it increased by 82.6 percent (325,572 people) between 2000 and 2010 (Pennsylvania State Data Center 2011). The Latino population currently accounts for 5.7 percent of the state’s population. The largest increase in Latino population was observed in Philadelphia County: from 128,928 to 187,611, an increase by 45.5 percent or 58,683 people. Allegheny County’s Latino population grew from 11,166 people in 2000 to 19,070 people in 2010, which represented an increase of almost 71 percent (7,904 people). For numbers of the Latino (Hispanic) population presented here see Table 2.

Pennsylvania’s immigrant population also includes refugees resettled in its various regions. According to the Pennsylvania Refugee Resettlement Program (2011), in the period from 2003 to 2008 more than seven thousand refugees were resettled in the twenty-three counties of Pennsylvania (PA Refugee Resettlement Program, Demographics and Arrivals 2011). The three counties with the highest numbers of resettled refugees were Philadelphia (more than 2500), Erie (more than 1120) and Allegheny (1061). Countries of origin of the 1061 refugees resettled in Allegheny County include such countries as Burma, Somalia, Russia, Burundi, Liberia, Bhutan, Uzbekistan, and Sudan. At least thirty refugees came to Allegheny County from the mentioned countries, with Burma (Appendix 3) being a leader from which more than three hundred people had escaped. The exact number of people from each country resettled in Allegheny County is presented in Table 3. Other places of origin included Serbia, Afghanistan, Iraq, Vietnam, Ukraine, Gambia, Iran, the Democratic Republic of Congo, Eritrea, and Belarus. From 2008 on, the refugee population changed. Allegheny County saw a growth in refugees from Burma, Bhutan, and Iraq. From October 2008 till September 2009, 370 more
refugees had been resettled in Allegheny County with the majority of them from Bhutan (178), Iraq (79), and Burma (68) (PA Refugee Resettlement Program 2011) (Table 4).

The most recent available statistical data on refugees resettled in Allegheny County covers the period from October 2009 to April 2010 (PA Refugee Resettlement Program 2011). These data show that 206 refugees arrived in Allegheny County. Refugees from Burma, Iraq and Bhutan represent the three largest refugee populations in Allegheny County during this period, similar to the previous year (31 Burmese, 144 Bhutanese and 20 Iraqis) (PA Refugee Resettlement Program 2011). For the most recent (October 2009 – April 2010) refugee arrivals in Allegheny County see Table 5.

The immigrant population in Allegheny County has been continuously growing. The 2000 US Census found that there were 48,266 foreign-born residents in Allegheny County, which constituted about 7% of the total population (US Census 2000). The 2000 US Census also showed that 6% of the total population did not speak English at home (approximately 79,000 people). Out of this 6%, 19% spoke Spanish, and the rest (80%) spoke a language other than Spanish.

Another interesting trend currently being observed in Pittsburgh is the growing number of secondary migrants. A secondary migrant is a person who changed the destination he/she was originally resettled to. According to Jewish Family and Children Services, among the approximately one thousand Bhutanese refugees in Pittsburgh, four hundred are secondary migrants. According to service providers, Pittsburgh attracts secondary migrants for a variety of reasons, particularly due to the affordability of housing and spreading of the word among the immigrant population about the availability
of jobs here (Advisory Council Meeting). The problem with secondary migrants is that there is not funding allocated specifically to serve the needs of this population.
CHAPTER FOUR
RESEARCH DESIGN AND METHODOLOGY

Chapter Overview

This chapter describes the research design and instruments, the process of collecting and analyzing data, recruitment of research participants and sample size, informed consent procedures, as well as defines important concepts used in the research.

4.1 Research Idea

The idea to conduct this research was proposed by the Family Support, Prevention and Foster Care Committee of the recently formed Immigrants and Internationals Advisory Council of DHS. The Advisory Council was established to advise the Director and Executive Staff of the Department of Human Services regarding the human service needs of immigrant and international county residents. Various committees were formed to address specific issues such as family support, prevention and foster care; employment; cultural competency; translation and interpretation; and many others.

4.2 Research Questions

The main question of this research is as follows:

What is the current experience of organizations providing prevention, family support and foster care with immigrant children and families?

Other questions addressed by the research cover but are not limited to the following: What are the main challenges/barriers to serving the immigrant population?
How are these challenges addressed? How can these organizations make their work more culturally competent? What kind of support do they need?

These as well as other questions were asked of the representatives of the organizations that provide family support, prevention, foster care and other social services to immigrant children and families in Allegheny County.

4.3 Institutional Review Board Considerations

The research was approved in an expedited category by the Duquesne University Institutional Review Board (IRB) (Protocol #11-08) as posing no greater than minimal risk to human subjects.

4.4 Data Collection

Data for this research were collected through interviews. The semi-structured interviews were conducted face-to-face and via phone with representatives of agencies contracted by the Allegheny County Department of Human Services (DHS) to provide family support, prevention and foster care services to county residents and the organizations on the Advisory Council.

Two sets of interview questions were prepared: one set for organizations providing family support and prevention services, and another for those providing foster care. Both closed- and open-ended questions were included in the interview to allow the researcher to get a comprehensive picture of the experience of service-providing organizations with immigrant children and families.
Each interview lasted a minimum of sixty minutes and a maximum of ninety minutes. All interviews were recorded. Upon completion of each interview, it was transcribed into an electronic file using word-processing software. Confidentiality of the participants was protected as described in the Consent Form approved by the Duquesne University IRB.

4.5 Recruitment of Participants

A purposive sampling method was used to recruit the participants of this research as the researcher was only interested in interviewing agencies which had previously or were currently providing services to immigrant children and families.

The list of service-providing organizations was obtained from the Contract Monitoring Division of the Office of Children, Youth and Families (CYF) of DHS. The list included twenty-seven Family Support Centers, three First Steps Programs, and twenty foster care agencies serving the general population of Allegheny County.

Each organization was contacted via phone and the key staff members (executive or site director, coordinator, etc.) were asked if the agency was currently serving or had experience providing services to immigrant children and families. Those who replied positively were invited to take part in the research.

Social service providing agencies included in this research were identified through the Immigrants and Internationals Advisory Council, which consists of representatives of organizations providing services to immigrant populations. They included two resettlement agencies and four social services providing agencies.
4.6 Research Participants

Participants interviewed in this research were the key staff representatives from the following ten organizations:
- Two Family Support Centers: one serving the Latino population, another serving various populations;
- Two refugee resettlement agencies;
- Four social service providing agencies: one working with African and Caribbean refugees and immigrant, another with the Muslim population, a third serving various ethnic groups without a focus on any, and a fourth providing doula and family support services for Latino families;
- One First Steps program;
- One foster care agency working primarily with refugees and immigrants of African descent.

4.7 Informed Consent Procedures

The consent forms provided to the research participants described the research, its goals and procedures; guaranteed anonymity and confidentiality of the subjects; emphasized the voluntary nature of the organization’s participation and the right to withdraw at any time. The consent forms also informed the participants about their right to withdraw any information provided as a response to any interview question.

4.8 Operational Definitions

The following major definitions are used in this research.
Immigrant Children and Families

For this research a broad definition of an immigrant child and family was used. It includes children who were born here and thus citizens, and those who came to the U.S. at an early age.

Immigrant

An immigrant is a person who comes to a country to permanently settle from another country and does so for a variety of reasons, entering the country of their new settlement under various statutes (authorized immigrants, unauthorized immigrants, refugees, asylees, and special immigrant juvenile status). For the purposes of this research the term immigrant will cover those who are in need of various social services due to problems and challenges they are facing.

Refugee

A refugee is defined in accordance with the United Nations High Commissioner for Refugees (2010) as “someone who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country, or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.”

LEP person

An LEP person is someone who does not speak English as his/her primary language and who has a limited ability to read, speak, write, or understand English, thus someone who is of limited English proficiency.
**Cultural Competency**

Cultural Competency is defined in accordance with the Allegheny County Department of Human Services’ guiding principles, which require that all services along with being high quality, accessible, based on strengths of individuals, individually tailored, empowering and holistic also be **culturally competent** meaning that they demonstrate respect for individuals, their goals, and preferences.

**Family Support Center**

Family support centers serve as a prevention strategy of DHS and are based on the philosophy that the most effective way to insure the healthy development and growth of children is by supporting the families and communities they live in. Support centers aim at increasing the strength and stability of families, parents’ confidence in their parenting abilities and affording children a stable and supportive family environment.

Families are admitted to a support center in one of two categories with particular services provided to each:

- Intensive families who have children ages birth through five years receive child development support, home visits, goal planning, health insurance support, medical support, prenatal care, parental education, and other services;
- General families who have children above five years of age are provided with optional services, particularly after-school, summer camp, and year-round programs for youth, counseling, child care, drop-in centers, literacy programs, parenting support groups, transportation and many others.

**First Steps Program**
First Steps is a home-visiting program for families with young children and expecting parents. Since First Steps is a family program its design resembles that of a family support program meaning that it too aims at strengthening families, increasing their stability, increasing parents’ skills and abilities, etc.

Foster Care Agency

Foster Care agencies usually come into play when a child has been or is under a risk of being removed from his/her biological family due to abuse or neglect. The two options available for children are foster care and kinship care. Foster care means caring for a child until his/her parent(s) “can resume full responsibility, or until a permanent home is found” (DHS CYF Profile, Foster and Kinship Care 2010). Providing children with kinship care means placing them with a relative (extended family or close friends of their family). Kinship care is the preferred type of placement: the majority of children removed from the families in Allegheny County are placed with their extended families (grandparents, aunts and uncles, etc.) or close friends of a family.

Refugee Resettlement Agency

The activity of a resettlement agency is regulated by the Office of Refugee Resettlement, U.S. Department of Health and Human Services and the Pennsylvania Department of Public Welfare.

Each year a resettlement agency resettles a certain number of refugees in accordance with the state plan on refugee resettlement submitted annually to the Office of Refugee Resettlement of the DHHS. A major goal of services offered by such agencies is helping refugees achieve self-sufficiency as soon as possible (usually in less than six months after their arrival).
Services provided cover but are not limited to the following: airport pick-up, housing, acculturation services, support in applying for Social Security, medical assistance, food stamps and other public benefits, English as a Second Language training, etc. (Catholic Charities 2010; Jewish Family and Children Service 2010).

**Social Services Providing Organizations**

Such organizations were defined as those providing various services (acculturation, employment, home visits, child and family development) to immigrant and refugee children, families and individuals of various national origins.

**4.9 Data Analysis**

Collected data was analyzed both quantitatively (numerical data such as number of people served, share of adults and children, share of people with various legal statuses, etc.) and qualitatively. Common patterns, trends and themes in answer to each of the sections were identified and summarized.

Questions asked during the interviews were organized into the following sections:

- General information about the organization: numbers of years serving immigrant population, positions on staff, etc.
- Population served (countries of origin, languages spoken, etc.)
- Needs of the population
- Services provided
- Ability of organization to serve immigrant/refugee children and families
- Involvement of the immigrant families with the child welfare system
- Outreach to immigrant communities
• Barriers and challenges during service delivery
• Language barrier
• Positive service outcomes
• Other (This section provided the interviewees an opportunity to talk about aspects of their work which were not covered by the questions.)

Results of the interviews are also organized in accordance with the above-mentioned sections.
Chapter Overview

This chapter describes the results of the interviews and findings of the research, and concludes with a discussion of the findings.

5.1 Research Findings

General Information about the Organization

Interviews were conducted with the key staff of each organization who, depending on the organization, included two site directors (family support center), five executive directors, two directors of refugee services (refugee resettlement agencies), and one program director (doula services providing program). All of those interviewed have been in their current positions since the establishment of the organizations except for two people: one joined the organization a year ago, and the second has been there for three years now.

The organizations involved in this study have been serving immigrant populations for a minimum of two years up to sixty years. Seven organizations were established within the last ten years as a response to the growing human service needs of the new residents of Allegheny County.

Staff of the organizations on average consisted of five individuals whose positions varied, depending on the type of organization. For example, if the primary focus of the organization was working with families, then the staff had a family development...
specialist; if one of the top priorities was to help clients achieve self-sufficiency, then the focus was job readiness provided by an employment specialist.

All of the organizations included in the research had at least a few (two or three) volunteers and only some (three organizations) had regular interns. Most of the respondents expressed that having more volunteers would be very beneficial to their agencies. The major obstacle for having volunteers is the language barrier, which complicates the process of engaging volunteers in appropriate activities. Despite that, agencies are able to involve volunteers in activities which support the staff in their work and do not require direct communication with the populations served. Five respondents described how their organizations were successfully engaging individuals among their clients. The clients involved as volunteers usually spoke English well, which allowed them to serve as interpreters and assist the staff in their day-to-day communications with other clients. There was a clear understanding and consensus among all respondents about situations requiring professional translation and interpretation in which clients’ ability to serve as an interpreter could not be utilized.

**Population Served**

The interviews revealed that the foreign-born population residing in Allegheny County and currently served by the research participants included individuals from almost all parts of the world: Africa, Asia, Europe, Latin America and Africa. The following countries of origin of the clients were mentioned: Afghanistan, Argentina, Bhutan, Bolivia, Burma, Bosnia, Chile, Colombia, El Salvador, Guatemala, Honduras,
Iraq, Kenya, Liberia, Mexico, Morocco, Pakistan, Peru, Puerto Rico, Russia, Serbia, Sudan, Turkey, Uzbekistan, Venezuela, Vietnam, and many more.

According to the two resettlement agencies and one of the family support centers, the majority of their clients came from Burma, Bhutan and Iraq. Another big ethnic group residing in Allegheny County is the Latino population. Other ethnicities mentioned above are either represented evenly in small numbers or just by several individuals.

Languages spoken by populations served by the research participants include but are not limited to: Nepali (spoken by Bhutanese people), Arabic, Karen, Burmese, Swahili, Spanish, Kirundi (spoken by people from Burundi), French, Creole, Mandingo, Mai-Mai, Crown, Russian, Turkish, and many others.

Six organizations served primarily refugees; two of the other four organizations worked specifically with Latino population, while the other two had mixed populations.

The majority of those served were families. The researcher asked the participants to describe an average family served by the agencies. There was no one answer to this question. Some agencies could provide such an image due to their focus on a particular population, for example, a typical Latino family. Organizations serving multiple populations could not provide such an image as it depended on the country of origin of the families they worked with. Nonetheless, there was something similar about the majority of families involved with all the organizations: the majority of families had poorly educated parents both of whom worked, sometimes at multiple jobs. The lack of education had various reasons depending on the origin of a particular ethnic group. For example, the majority of refugees residing in Allegheny County lived in refugee camps with limited or no opportunities for education. The fact that both parents work was
creating additional difficulties in the families, particularly with regard to the development of their children. Parents working at two or even more jobs could not spend much time with their children, help them with their homework, etc. Jobs held by the individuals served by the organizations included in this research are usually low-wage and low-skilled jobs.

**Needs of the Population Served**

All respondents agreed that the populations they serve had complex needs. The needs described by the majority of the respondents covered every aspect of the immigrant and refugee populations’ lives (basic needs in food, health, housing, transportation, child care and development, employment, etc.). Such complex needs are explained by the fact that the families start a new life here in the U.S. and thus need as much support as possible with as many aspects of their lives as possible.

The representatives from both family support centers interviewed for this research expressed that they were not always able to provide child development and parenting support according to the curriculum they used because of the complex needs faced by the families they served. Oftentimes the differences in language, customs, and past experience of immigrant and refugee families combine with other difficulties they experience, and prevent parents from focusing on and engaging in their children’s development and well-being. Family development specialists often spend a significant amount of time helping parents meet the family’s basic needs, which leaves very little time for parenting support and child development services. As one of the respondents put
it, “For refugee and immigrant families, it is often difficult to focus on the children’s well-being when they are concerned about their very survival.”

The majority of respondents had a big concern about the mental health problems of their clients and the difficulties agencies faced addressing them. The mental health problems are mostly experienced by the adult representatives of foreign-born populations due to their previous life experience and difficulties adjusting in the U.S. This is especially true with regard to the refugees, who had to escape their countries due to war or persecution, live for years (sometimes as many as 35 years, as did some Burundian refugees) in refugee camps, and leave everything behind. The majority of respondents stated that mental health issues can also result from the isolation immigrants and refugees experience here, lack of social support networks, cultural differences, unfamiliarity with the local environment, etc.

The majority of those interviewed expressed that transportation was an issue for the families they served. The immigrant and refugee populations live mostly outside the city, which complicates their getting to the jobs, the offices of the agencies where they receive services, attend English classes, etc.

According to several respondents, problems with alcohol use were emerging among the populations they served. The explanation given by the respondents was that easily accessible alcohol was used as a means of coping with the intense stress and frustration experienced by almost all of their clients.

**Services Provided**
Organizations serving immigrant children and families offer the following services to address the needs of their clients: acculturation, employment, child development, youth support, parenting, financial literacy, housing, home visits, doula services (only one program and only to the Latino population), immigration and citizenship services, referrals, etc. These services intend to meet the basic needs of the newcomers and help them achieve such goals as self-sufficiency, family and child development, etc.

The question about whether the services provided by the agencies match the needs of the populations they served was answered positively by the majority of the respondents. However, almost all organizations agreed that usually immigrant children and families have more needs than the agencies can address. The complexity of the needs experienced by immigrant populations makes it difficult for the agencies to serve them effectively. The respondents also mentioned that the populations they served represented only a small portion of the general immigrant and refugee populations residing in Allegheny County and needing social support.

The average time of service provision to a family usually depends on its needs. The majority of the organizations provide their services up to five years. The interviewees agreed that their major goal was helping the families achieve self-sufficiency and that it was important not to “disserve the client” (a quote by one of the respondents) by creating a dependency on the agency.

Ability of Organizations to Serve Immigrant Children and Families
The respondents were asked if there were any needs their organizations could not serve. Six agencies indicated that mental health issues were very difficult to address due to a lack of interpretation services. The same reason complicated the access to substance abuse services, a problem mentioned by four respondents. The respondents expressed how important it was to address mental health and substance abuse issues in a timely manner; otherwise they could result in more serious problems like violence in the family and many others.

Despite the fact that acculturation was a big part of almost all (except for the foster care agency) organizations’ services, it was mentioned among the needs which were difficult to meet.

Families and children who cannot be served by the agencies are referred to other organizations. Referrals can take place among the agencies who participated in the study, meaning those who work primarily with foreign-born populations, as well as those serving the mainstream population. Referring the immigrant children and families to the mainstream organizations is challenged by the language barrier.

Respondents were asked if they had a waiting list for services. Only one organization had a waiting list, with about forty families on it. The fact that only that particular organization had families awaiting their services can be explained by the population they serve. That organization was established to specifically serve the Latino population of Allegheny County. All Latino families in need of services usually turn or are referred to this organization. Another program providing doula and family support services for the Latino population had several families needing their services and waiting for them. The rest of the agencies were not keeping a waiting list, yet had more clients
that they were able to serve. In general, most of the prevention and support services providing agencies stated that they usually go far beyond their abilities and resources in order to help their clients. This was especially stated by the representatives of the family support centers who established a very close connection with the families they served.

Organizations were asked about the circumstances which would allow them to serve more foreign-born clients. The most common responses included more funding, more space and more staff.

**Challenges and Barriers in Service Delivery**

According to the interviewees, they encounter numerous challenges and barriers while providing services to foreign-born populations. Most of these challenges result from the language barrier and a lack of language services. The foreign-born population of Allegheny County speaks numerous languages as well as dialects within a single language. In order to provide services effectively agencies need to be able to interact and communicate with their clients in a way that is easily understood by the client. This, unfortunately, does not happen in most cases. Immigrant and refugee families come to the U.S. with little or no English. Although English as a Second Language classes are a part of their acculturation (especially that of refugees), it is difficult for adults to learn English because of its difference from their native language, lack of education, illiteracy and lack of time.

**Language Barrier**
Several questions concerning the language barrier were asked specifically, based on its frequent mention in the literature on serving immigrant populations. As mentioned earlier, the language barrier was identified as a major obstacle in providing services to immigrant children and families. The respondents said that they encountered the language barrier both internally, while providing services within the organization, and externally, especially when families and children were referred for additional services such as medical appointments. Internally, organizations are able to overcome the language barrier by either using other clients or family members who speak English as interpreters; by turning to professional interpreters; using other options available for some of them, particularly Language Line. Language Line is a call center that provides immediate interpreting services by connecting the caller with an interpreter for more than 170 languages. Interpretation occurs via a land or cell phone. However, not all the agencies have access to Language Line due to its high cost and absence of languages spoken by the population served by a particular agency.

All respondents were aware of the issues involved with the use of family members and especially children as interpreters for their LEP parents or other family members. As stated by the participants, they never used children in situations which involved resolving any issues between the children and their parents, or issues children should not be aware of due to their age, etc.

Participants were asked if they had any documents translated into languages spoken by the populations they served. Only two organizations had such documents, those serving the Latino population. It was possible for these agencies to have translated documents because the only language spoken by their clients was Spanish. It should be
noted, however, that the agencies made the translations by their own efforts; no funds were specifically allocated for such purposes in their budgets.

The practice of addressing the language barrier by other organizations included bringing translators and interpreters whenever there was a need for such services. All respondents mentioned that the documents which required the signature of the clients were explained to them in a language they understood before getting their signatures to ensure that informed consent was obtained. Such documents can include an agreement between the agency and the family on the services to be provided, expectations and responsibilities of the family and the agency, etc.

According to the respondents, the language barrier has a negative impact on service outcomes. It creates delays in service provision, results in denial of services, and, in many cases, changes the very nature of a particular service or intervention. One of the most illustrative examples given by one of the respondents was about a father who had a substance abuse problem and was required by the court to participate in a certain number of hours of group therapy. Instead, this person could only get a very limited number of individual sessions due to the language barrier and because bringing an interpreter into a group would have changed its dynamic. Thus, various challenges and barriers do not allow addressing the problems of the immigrant populations properly.

Addressing the language barrier externally was, based on the responses, much more complicated. My respondents stated that along with their primary responsibilities as family development specialists, employment specialists, or case workers, they were constantly involved in advocacy on behalf of their clients. Another role they are usually performing is educating and raising awareness of various social service providers about
their obligations to provide interpretation services to the LEP clients at no cost in accordance with Title VI.

Among the challenges and problems encountered by the agencies there were some connected specifically to the cultural background of their clients, and some which occur because the system of service provision in Allegheny County was not prepared to serve the immigrant population.

**Outreach to Immigrant Communities**

No formal outreach strategy was found in any of the agencies. Information about the services offered by a particular agency is usually spread through word of mouth: families served by an agency refer or simply bring new families with them. The absence of an outreach strategy was explained by the fact that the organizations already served more people than they could accommodate, as well as by the fact that clients were usually referred and brought to their attention by either their clients or other immigrant or general population-serving agencies. A different type of outreach performed by almost all the respondents was reaching out to other organizations, churches, etc. to solicit help and support from the larger community in serving immigrants and refugees.

**Positive Service Outcomes**

According to the agencies, despite the challenges they face every day in serving their diverse population, they were able to achieve successful outcomes with children and families. Such outcomes include meeting the basic needs of families in food, housing, and health of almost all family members, especially children (immunization, regular
check-ups, etc.) The representatives of resettlement agencies which aim primarily at getting their clients to work as soon as possible expressed that they were doing it well: refugees they served were getting jobs and, most importantly, keeping them. It must be noted that the jobs immigrants and refugees hold are entry-level ones which do not require any specific knowledge, skills, or experience. Such jobs are usually also the lowest-paid ones, so many immigrants work two jobs simultaneously to be able to provide for their families.

**Involvement of the Immigrant Families with the Child Welfare System**

The interviewees were asked about their involvement with the office of Children, Youth and Families (CYF) of the DHS. As mentioned in the earlier chapter, the CYF is mandated by law to protect children from abuse and neglect. Questions asked about CYF involvement included the following: Are any families among those currently served by your agency involved with CYF? How many families and children? What were the reasons for the CYF involvement? How were the cases addressed? Organizations were also asked to provide information on the history and reasons of past CYF involvements and the ways the cases were resolved.

Only two families served by two of the agencies included in this research were currently involved with CYF. Other agencies had only a few, usually less than three, cases of such involvement in the past. The major reasons for CYF attention were neglect and corporal punishment. The respondents explained the predominance of neglect and corporal punishment cases among immigrant families by their lack of understanding of local child-bearing practices and requirements (for example, the age at which a child can
and cannot be left home alone, etc.), as well as by cultural differences (in some cultures parents are allowed to use physical force against children).

The foster care agency representative interviewed for this research provided a further insight on the reasons that bring immigrant families into the CYF system. This interviewee mentioned that the reasons for CYF involvement with immigrant and refugee families were different from those bringing local families to the attention of CYF. Particularly, the problems which bring children from immigrant families into foster care can be easily addressed as they usually occur due to the lack of familiarity with American child care. Local families usually experience more serious problems like substance abuse and drugs, which are more complicated and cannot be overcome by a simple intervention.

Other

The respondents expressed that in order for them to be able to provide services to immigrant children and families in an effective and culturally competent way, the following needed to be in place: better coordination of services among providers of various services; awareness of service providers and the larger community about immigrant populations, their needs and the ways of addressing these needs in culturally competent ways; willingness of service providers to cooperate; awareness of service providers about their legal obligations as recipients of federal funding, etc.

5.2 Discussion

As seen from the interview results described above, the experience of organizations providing prevention, family support and foster care services has some
major similarities with regard to service provision, needs of populations served, as well as obstacles and challenges affecting the process of service delivery. Some of the major findings are discussed below.

**Population Served**

Analysis of the responses revealed that the differences were mostly connected to the origin of the population served and their legal status. These two factors are closely connected, as populations of certain countries can only come to the U.S. in one or another way. For example, most of the Bhutanese and Burmese population comes as refugees due to the political situation in Bhutan and Burma. The Iraqi population is usually granted the so-called special immigration visa which is issued for Iraqi individuals who have helped the U.S. military (mostly as interpreters and translators) during the war in Iraq. Among immigrants from Latin American countries, a high number of those from Mexico cross the U.S. border illegally.

As shown in the literature review, different legal statuses are associated with different public benefits, which can either facilitate or impede the integration of the newcomers into American society and affect the general well-being of immigrant families and children (Dinan 2005; Fix 2009; Mather 2009; Grantmakers in Health 2005; Pine and Drachman 2005; Torrico 2010; Van Hook et al 2004).

The common characteristics of immigrant families revealed by the literature review were true with regard to the families served by local organizations. The majority of immigrant families residing in Allegheny county and receiving services from the interviewed organizations consisted of both parents (an approximate average based on the
results of all interviews is 85 percent) (Dinan 2006; Fortuny et al. 2010; Lincroft 2006; Mather 2009). Another characteristic found by numerous research studies is the low income of families and a low level of educational attainment of parents in such families (Hernandez 2004; Lincroft 2006; Lincroft and Dettlaff 2010; National Center for Children in Poverty 2002; National Center for Children in Poverty 2004; Shields and Behrman 2004;). Even though the research did not ask a specific question about the income of those served by research participants, the notion of the low income of those served emerged during the interviews.

Numerous studies reviewed for this research showed that a low educational level of parents prevented them from engaging with the school system in general and did not allow them to help their children with their homework (Kugler 2010; Mather 2009). Interviewees described the similar experience of parents they worked with. Organizations interviewed for this study also explained that even if parents had the necessary skills to support their children, they would not be able to do so because of the lack of time and the need for both parents to work sometimes at two jobs to be able to provide for the family.

**Challenges and Barriers in Service Delivery: Language Barrier**

As revealed by the literature review and this study, the language barrier created substantial obstacles in service delivery. Among such obstacles are delays in service provision, denial of services, and the change of the very intervention. The literature review showed how the language barrier affected service delivery and thus the well-being of the immigrant population (Bachurski, Bennet, and De Chellis 2011; Dobrzycka 2008; Earner 2007; Earner and Rivera 2007; Frates 2004; Fortuny 2008; Fortuny et al. 2009;

Both the literature review and this study revealed that the majority of obstacles are experienced at various medical facilities (IOM 2002). Respondents from this study uniformly expressed that referring their clients to medical facilities did not always result in their getting appropriate services, and even if services were delivered there were delays or deviations from the regular way of providing a particular intervention. Encounters with medical facilities do not happen just from time to time; they are an integral part of social service delivery. One of the first steps of the majority of the organizations engaged in this research is the assessment of medical conditions of all family members they work with. This is why it is very important that immigrants have access to health services.

**Involvement of the Immigrant Families with the Child Welfare System**

This study revealed that one of the major reasons for the CYF involvement with the immigrant families was neglect. Neglect usually resulted from a lack of understanding of American parenting practices and cultural differences. The literature review confirmed this finding (Earner 2007). This finding contradicted that of the Annie E. Casey Foundation, according to which immigrant families enter the child welfare system for the same reasons as the general population (Lincroft 2006). Parents in immigrant families have difficulties understanding and adjusting to parenting styles practiced in the U.S. Interviews also showed that the lack of understanding was reciprocal. A lack of understanding of the culture of a given immigrant family by a U.S. child welfare worker
can result in removal of a child from a family, which in its turn can have a dramatic effect on both parents and the child (Serving Foreign-Born Foster Children 2004).

Other

As shown in the literature review, cultural and linguistic competence is crucial in the process of delivering services to foreign-born populations to ensure their equal access to the benefits they are entitled to, as well as their well-being and health (Cohen 2003; Child Welfare League of America 2001; Cross et al. 1989; Lum 2003; Martinez et al. 2004; McPhatter 1997; McPhatter and Ganaway 2003; Mederos 2003; Woodroffe and Spencer 2003). Even though the immigrant population in Allegheny County is still relatively small, this should not prevent service-providing agencies from delivering culturally and linguistically appropriate services.

Statistical data show that a rapid growth in Allegheny County’s foreign-born population happened within the last ten years and that it continues to increase. The literature review identified cultural and linguistic competency of service providing agencies as one of the biggest requirements of today’s changing America (National Center for Cultural Competence 2010). Research studies reviewed in the first chapter of this report suggested that cultural and linguistic competence of service providers and absence of language and cultural barriers result in effective and efficient services and help prevent various challenges and unnecessary expenditures (National Standards 2001; OMB 2002).
CHAPTER SIX
CONCLUSIONS AND RECOMMENDATIONS

Chapter Overview

This chapter contains conclusions and offers recommendations based on the research findings.

6.1 Conclusions

This research studied the experience of social service agencies with immigrant children and families with a specific focus on prevention, family support and foster care services.

Through interviews with key staff of such organizations in Allegheny County, I learned that the agencies experience some common challenges.

The Growing Diversity of the Region

All organizations (except for the foster care agency) were overwhelmed by the number of immigrant families and the amount of their needs. This finding confirms the latest data from the U.S. Census and Pennsylvania Refugee Resettlement Program, which show the growing diversity of the Allegheny County’s population: each year the county receives almost two hundred refugees and even more immigrants, with the Latino population being the fastest-growing minority group. It is important that these changes are reflected in the service delivery system, which must be able to effectively respond to the needs of all county residents.

The Language Barrier is the Major Obstacle
The biggest common challenge of all organizations serving immigrant children and families was the language barrier. The language barrier is the major obstacle restricting the access of immigrant populations to many of the services (especially health services) available for those with English proficiency and creating numerous other difficulties for service providers. Allegheny County’s population in need of human and health services speaks many languages and this requires corresponding changes in the service delivery process.

6.2 Recommendations

Based on the research, interview results and findings, the major recommendations are as follows.

Ensuring Access of All County Residents to the Services

It is absolutely crucial to ensure equal access to the existing services (and creating new ones where and when necessary) for all county residents and especially the immigrant populations who, due to their experience, are usually the most needy ones. Access can be ensured by eliminating the language barrier, the major obstacle in the process of delivering services to the immigrants. Agencies receiving federal funding are mandated by law to ensure a reasonable access to all those in need of their services. The government has interpreted this to mean that services must be available in a language those needing the services can understand. In order to improve access, agencies should document their encounters with limited English proficient individuals to identify those in greatest need, the languages in which services are most needed, and build their language provision strategies based on such data.
The Language Bank currently being established by the Immigrants and Internationals Advisory Council of the Allegheny County DHS is one of the ways to address the language barrier. It will serve as a community resource for providing language services to both service providers and individuals. The “Tracking Barriers to Health Care” initiative described in this study also serves as a good example of how documenting the language needs of the region’s residents can possibly be approached.

Creating a Welcoming Community

An inevitable part of eliminating the language barrier and creating a welcoming community is raising awareness of the organizations providing human and health services to Allegheny County’s increasingly diverse population.

The advocacy and awareness raising efforts in which the organizations included in this study are constantly engaged on behalf of their clients, will require better coordination in order to present a compelling case for the necessity of meeting the needs of all county residents, especially the most vulnerable ones. When service providers realize that the population of Allegheny County is changing due to the growing number of immigrants and refugees resettling here they can make necessary adjustments in service provision to meet the needs of all county residents. Such a change in Allegheny County’s population is much needed due to its decline and aging, so it is important that the county have a welcoming environment that enables its newcomers to become self-sufficient and productive members of the region.

Engaging the larger community in the process of integration of the newcomers is also very important for it to be successful. Educating the larger community on how and why foreign-born people move to the U.S. can help eliminate the hostility which is based
on a common belief that all people coming to the U.S. do so deliberately (or by choice) and thus need to immediately understand the culture and speak the language. The immigrants and refugees, as one of my interviewees said, “are here to stay” and they bring with them a rich experience, wisdom, traditions, different culture and language, etc., which they can share with their new communities and thus enrich them.

It is important that adjustments in the service delivery system and the community at large happen soon, before the number of the immigrant and refugee population reaches the so-called tipping point, after which it would become even more difficult to serve and integrate them effectively.
CHAPTER SEVEN
RESEARCH LIMITATIONS

Chapter Overview

This chapter describes the limitations of the research, which were divided into two types (external and internal) to provide a better understanding of their nature and the researcher’s control (or lack thereof) over each limitation.

7.1 Limitations

The limitations of this research, which could possibly impose some constraints on the conclusions and recommendations, can be divided into two types

- External – those over which the researcher did not have control;
- Internal – those over which the researcher had some degree of control.

The major limitation of this project is an external one and represents the fact that prevention, family support and foster care organizations in Allegheny County do not usually track the data on immigrants and internationals they may serve, due to various data tracking system constraints. Another external limitation is that not all foster care agencies which confirmed that they had experience with immigrant children and families were able to participate. At least one such organization was not included as there was no one available to represent the program. Another organization was not included due to the fact that the immigrant population they worked with consisted of children from Haiti who lost their parents after the earthquake in January 2010. The decision not to include this
agency was made because these children were not involved with the local child welfare system in the same way as the immigrant families residing here.

The internal limitation of the research is the absence of input from immigrant families that could enhance the understanding of service provision to this population. Future research could include studying the experience of Allegheny County’s various immigrant and refugee populations’ interactions with local social service organizations. Particularly, interviews or focus groups could be conducted to identify challenges and barriers they have encountered and their recommendations on what would make the services provided by local organizations more culturally competent and reflective of the special needs of immigrant and refugee populations.
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APPENDIX 1

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care

Culturally Competent Care:
1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Language Access Services:
4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Organizational Supports:
8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction Assessments, and Outcomes-Based Evaluations.
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected
in health records, integrated into the organization's management information systems, and periodically updated.

11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS Standards and to provide public notice in their communities about the availability of this information.

APPENDIX 2

HOW DO REFUGEES GET TO THE UNITED STATES?

START: The Refugee flees from his/her country of origin.

The refugee registers with the UNHCR. This agency makes sure that the individual qualifies as a refugee under international law.

The UNHCR refers the individual to a U.S. Embassy with a Refugee Processing Post.

An agency contracted with the Department of State’s Bureau of Population, Refugees, and Migration (PRM) prepares a case file (usually called an “Overseas Processing Entity”).

An officer from the Department of Homeland Security’s U.S. Citizenship and Immigration Services (DHS/USCIS) conducts a detailed, face-to-face interview with the individual to determine if s/he qualifies as a refugee under U.S. law.

The refugee’s case is submitted to PRM for final approval for admission and the refugee’s information is sent to the Refugee Processing Center in Arlington, VA.

Meanwhile, the refugee receives a medical examination and usually some type of cultural orientation to the U.S.

The refugee is met at the airport by staff from a local refugee resettlement agency and taken to an apartment that has been prepared for them.

END: Resettlement agencies provide the refugee with services such as case management, assistance learning English and help finding a job.

APPENDIX 3

REFUGEE ARRIVALS IN ALLEGHENY COUNTY BY COUNTRIES OF ORIGIN (2003 – July 2008)

BM – Burma
SO – Somalia
RS – Russia
BY – Burundi
LI – Liberia
BT – Bhutan
UZ – Uzbekistan
SU – Sudan
SR – Serbia
AF – Afghanistan
IZ – Iraq
VM – Vietnam
ZZ – Ukraine
GB – Gambia
IR – Iran
CG – Democratic Republic of Congo
ER – Eritrea
BO - Belarus

Source: Pennsylvania Refugee Resettlement Program. Demographics and Arrival Statistics
TABLE 1

NATIVE AND FOREIGN-BORN POPULATION OF PENNSYLVANIA (1990, 2000, and 2009)

Table adapted from Migration Policy Institute.

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>2000</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td><strong>Total Population of Pennsylvania</strong></td>
<td>11,881,643</td>
<td>100.0</td>
<td>12,281,054</td>
</tr>
<tr>
<td>Native born</td>
<td>11,512,327</td>
<td>96.9</td>
<td>11,772,763</td>
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<tr>
<td>Foreign born</td>
<td>369,316</td>
<td>3.1</td>
<td>508,291</td>
</tr>
<tr>
<td><strong>Foreign-Born Population of Pennsylvania</strong></td>
<td>355,608</td>
<td>100.0</td>
<td>508,282</td>
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<tr>
<td>Born in Europe</td>
<td>186,913</td>
<td>52.6</td>
<td>182,667</td>
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<tr>
<td>Born in Asia</td>
<td>102,930</td>
<td>28.9</td>
<td>182,967</td>
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<tr>
<td>Born in Africa</td>
<td>8,748</td>
<td>2.5</td>
<td>25,413</td>
</tr>
<tr>
<td>Born in Oceania</td>
<td>1,522</td>
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<td>2,178</td>
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<tr>
<td>Born in Latin America</td>
<td>42,202</td>
<td>11.9</td>
<td>99,514</td>
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<tr>
<td>Born in Northern America</td>
<td>13,293</td>
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<td>15,543</td>
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</tbody>
</table>

Sources: US Census Bureau, 2009 American Community Survey (ACS); US Census Bureau, 1990 Census of Population and Housing and Census 2000
**TABLE 2**

**LATINO POPULATION CHANGE IN PENNSYLVANIA (2000-2010)**

Table adapted from Pennsylvania State Data Center. Penn State Harrisburg. March 2011.

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>2000 Total Population</th>
<th>2000 Hispanic or Latino</th>
<th>2010 Total Population</th>
<th>2010 Hispanic or Latino</th>
<th>Numeric Change</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
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<td>Pennsylvania</td>
<td>12,281,054</td>
<td>394,088</td>
<td>12,702,379</td>
<td>719,660</td>
<td>325,572</td>
<td>82.5%</td>
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<td>Philadelphia</td>
<td>1,517,550</td>
<td>128,928</td>
<td>1,526,006</td>
<td>187,611</td>
<td>58,683</td>
<td>45.5%</td>
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<tr>
<td>Allegheny</td>
<td>1,281,666</td>
<td>11,166</td>
<td>1,223,348</td>
<td>19,070</td>
<td>7,904</td>
<td>70.8%</td>
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TABLE 3

REFUGEE ARRIVALS IN ALLEGHENY COUNTY (2003 – July 31 2008)

Table adapted from Pennsylvania Refugee Resettlement Program (Demographics and Arrival Statistics (2003 – July 2008).

<table>
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<tr>
<th>Country of Origin</th>
<th>2003</th>
<th>2004</th>
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<th>2006</th>
<th>2007</th>
<th>2008 (Jan-July)</th>
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<td>35</td>
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<td>13</td>
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<tr>
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<td>Sudan</td>
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<td>3</td>
<td>5</td>
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<td>Iraq</td>
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TABLE 4

REFUGEE ARRIVALS IN ALLEGHENY COUNTY (October 2008 – September 2009)

Table adapted from Pennsylvania Refugee Resettlement Program (Demographics and Arrival Statistics (October 2008 – September 2009).

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Burma</td>
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<td>61</td>
<td>68</td>
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<tr>
<td>Bhutan</td>
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<td>178</td>
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<tr>
<td>Cuba</td>
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<td>Eritrea</td>
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<tr>
<td>Somalia</td>
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<td>4</td>
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</tr>
<tr>
<td>Uzbekistan</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Vietnam</td>
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<td>370</td>
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</table>
TABLE 5

REFUGEE ARRIVALS IN ALLEGHENY COUNTY (October 2009 – April 2010)

Table adapted from Pennsylvania Refugee Resettlement Program (Demographics and Arrival Statistics (October 2009 – April 2010).

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<tbody>
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<td>Burma</td>
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<td>8</td>
<td>31</td>
</tr>
<tr>
<td>Bhutan</td>
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<td>Cuba</td>
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<td>Iraq</td>
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<td>9</td>
<td>20</td>
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