A Survey Study Examining Teachers' Perceptions in Teaching Refugee and Immigrant Students

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Abstract

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There is limited research around best practices in working with refugee and immigrant students. Since teachers spend the majority of the school day with students, their insights about how best to serve these populations of children and adolescents is critical. This dissertation study conducted an online survey study with 139 elementary school general education teachers in a large urban school district to examine teacher beliefs and attitudes about the following factors in meeting the needs of refugee and immigrant children: teachers' perceived self-efficacy, attitudes toward implementing new and innovative practices, cultural competency, prior preparation and overall competency, and perceptions about the needs of refugee and immigrant students. Results indicate that overall, teachers feel confident, culturally competent, and are open to implementing practices to serve refugee and immigrant students; the majority of teachers reported that they didn't think that refugee and immigrant students have unique needs, which conflicts with current research; only minority status was found to be a unique predictor of beliefs around student needs. Implications and future research are discussed.

Keywords: refugee, immigrant, acculturation, multicultural education, multi-tiered systems of support, self-efficacy, evidence-based practices, competency, student need

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CHAPTER 1

INTRODUCTION

The number of foreign-born individuals in the United States has increased significantly over time. From April 1, 2000 to March 31, 2010, the number of immigrants was estimated between 11.9 to 13.5 million (U.S. Department of Commerce, 2014), and presently, children in immigrant families account for one out of every four children in the U.S.; please note (25 percent or 18.4 million) (Hernandez, 2012). Since formal U.S. refugee resettlement began in 1980, approximately 1.8 million refugees have been invited to live in the U.S., and refugee arrivals range roughly between 40,000 to 75,000 each year (Bridging Refugee Youth and Children's Services, 2014). About 40% of refugees under the age of 18 resettle in the U.S. (Ellis et al., 2013). Please note that these statistics include both first- and second-generation immigrant families.

The United States has and continues to be a nation of immigrants. In 2010, there was an estimated 9 million refugee and immigrant children (Ruiz, Kabler, & Sugarman, 2011). The number of refugee and immigrant families continue to grow dramatically, as well as the need to provide appropriate interventions to support their adjustment and success in American society. While there are no specific statistics on the number of refugee and immigrant families in the U.S., projections indicate that by 2050 one in five Americans (19%) will be an immigrant as compared to one in eight (12%) in 2005, with Latinos constituting up to 29% of the population at that time (Yakushko, Backhaus, Watson, Ngaruiya, & Gonzalez, 2008).

Overall, these statistics demonstrate that the refugee and immigrant population has increased over the last few decades and appears to be on an upward trajectory. With the increase in the number of refugee and immigrant children in schools, educational services will need to

adjust and adapt to the needs that these children and families present to the educational system (Nwosu et al., 2014). School systems that fail to make this adjustment are likely to insufficiently attend to the needs of refugee and immigrant students, resulting in continued cycles of poverty and negative outcomes. Although refugees represent specific types of immigrants with unique experiences, all immigrants have been shown to be at increased risk for the previous outcomes.

Problem Statement

Considering that during the last 10 years there has been a tremendous influx of refugee and immigrant children and their families into Western countries, the acculturation process is a common experience for many inhabitants in the U.S. (Kosic, 2004; Migration Policy Institute, 2011). Currently, estimates indicate that there are about 39.9 million immigrants in the U.S. Twenty-four percent of school-age children have parents who immigrated to the U.S. (Migration Policy Institute, 2011), and of these individuals, 77% of them were born in the U.S. to immigrant parents and 23% were born outside of the U.S. (both first-generation immigrants) (Mather, 2009). Immigration is a considered a worldwide phenomenon, involving many millions of people and most countries (Berry et al., 2006; United Nations Population Report, 2002). It is a life-changing cultural and geographic transition that usually involves unique adversities and difficulties that can precipitate social, emotional, and behavioral problems (Rogers-Sirin, Ryce, & Sirin, 2014).

Social, Emotional, and Behavioral (SEB) Needs

As mentioned above, SEB problems can be triggered or exacerbated by acculturation. There is ample research demonstrating that SEB problems serve as barriers to academic success and increase the likelihood of short- and negative long-term outcomes for children and adolescents (Beesdo-Baum & Knappe, 2012; Forness, Freeman, Paparella, Kauffman & Walker,

2012). Presently, approximately one in five students exhibit mental health concerns significant enough to warrant a formal diagnosis (Costello, Mustillo, Erkanli, Keler, & Angold, 2003; Hoagwood & Erwin, 1997). Indeed, prevalence rates of youth with psychiatric disorders have been shown to range between 15 to 25 percent (Dowd, 2011).

SEB problems are a concern, given the associations of negative effects (McLeod & Kaiser, 2004; Raver, 2003; Wang & Eccles, 2012). Behavioral problems can include anger, problems with authority, concentration difficulties, rule testing, withdrawal, age-inappropriate behavior, and lower academic attainment (Strekalova & Hoot, 2008). With regard to school-based outcomes, students with SEB problems are significantly more disengaged, absent, and truant from school, suffer from poor academic achievement, engage in school bullying, and have drugs and alcohol problems to name a few of the common trends (Arthur, Hawkins, Pollard, Catalano, & Baglioni, 2002; Cook, Burns, Browning-Wright, & Gresham, 2010; Hinshaw, 1992; McIntosh, Chard, Boland, & Horner, 2006).

If symptoms and disorders are not treated, school problems arise, such as significant deficits in attention, abstract reasoning, and long-term memory for verbal information (Beers & DeBellis, 2002), and decreases in student academic performance and behavior, including decreased problem-solving and reading ability (Delaney-Black et al., 2003), lower grades (Hurt, Malmud, Brodsky, & Giannetta, 2001), and higher truancy and absenteeism (Beers & DeBellis, 2002). Moreover, students with SEB concerns are five times more likely to dropout from school than their classmates, decreasing rates of graduation, a phenomenon associated with the presence of multiple risk factors (Chapman, Laird, Ifill, & Kewal Ramani, 2011; Grogger, 1997; Hoagwood & Erwin, 1997).

There are several ways in which SEB problem result in untoward economic impact particularly those due to dropout. Long-term negative outcomes arise, including developmental disruptions, long-term serious mental and physical health problems, (Pynoos, Steinberg, Schreiber, & Brymer, 2006) and increased involvement in child welfare and juvenile justice systems, which have been shown to be higher for refugees and immigrants (Ford, Chapman, Hawke, & Albert, 2007). High school graduates, on average, earn $9,245 more per year than high school dropouts (Doland, 2001). Only 40% of adults who dropped out of high school are employed, compared to 60% who completed high school, and 80% of those with bachelor's degrees (Alliance for Excellent Education, 2003b); 75% of America's state prison inmates consist of high school dropouts (Harlow, 2003). SEB problems are at the forefront of contact with the juvenile justice system, with estimates indicating that there are roughly two million people in United States prisons and jails (Taifa & Beane, 2009). Researchers estimate that programs resulting in a one percent increase in high school graduation rates would save approximately $1.4 billion in incarceration costs each year (Alliance for Excellent Education, 2003a).

To add to the list of negative outcomes, there are additional long-term effects associated with students with SEB concerns (Beesdo-Baum & Knappe, 2012; Forness et al., 2012). Individuals experiencing SEB problems during school are at a significantly higher risk of unemployment in adulthood and have a shorter lifespan (Wagner, & Newman, 2012). In addition, research indicates that between 50 to 70 percent of youth involved in juvenile correctional facilities have been diagnosed with at least one psychiatric disorder (Dowd, 2011). Although both academic and mental health supports have increased, there is continued need to support students with SEB concerns and needs, especially those at-risk for dropout from high

school, as the co-occurrence of negative life events increases significantly (Wagner, & Newman, 2012).

Students with SEB problems and those in need of services are disproportionately students living in low-income households and in the context of poverty (Duncan & Brooks-Gunn, 1997; Qi & Kaiser, 2003; Weitzman, Edmonds, Davagnino, & Briggs-Gowan, 2014), placed in the foster care system (Dowd, 2011), exposed to adverse experiences (i.e., trauma) (Ashman, Dawson, & Panagiotides, 2008; Briggs-Gowan et al., 2010; Carter, Garrity-Rokous, Chazan-Cohen, Little, & Briggs-Gowan, 2001; Goodman & Brand, 2009; Qi & Kaiser, 2003), and students of color (Weitzman et al., 2014).

Greater than 15% of the U.S. population, equaling to 43.2 million people, live in poverty (U.S. Census Bureau, 2010). Being born into poverty exposes children to a host of environmental risk factors linked to the development of SEB problems interfering with their learning, particularly when educated in school contexts in which educators are under-prepared and under-skilled to address their needs. As a result, a significant proportion of students who live in poverty fail to receive an appropriate education and earn a sufficient living wage. Ultimately, these children are in need of being taught skills and educated in supportive school environments that enable them to develop the resilience to overcome the adversity that comes along with poverty. Refugee and immigrant students are included in these statistics. Unfortunately, many educational systems find it difficult to battle the multiple barriers when educating students who are reared in disadvantaged contexts and the corresponding SEB needs that many of them bring with them to school (Weitzman et al., 2014).

Although academic and mental health services have increased, supporting students with SEBs is critical, especially with this unique population (Wagner, & Newman, 2012). It is quite

clear that school systems must be prepared to address the wide range of needs of refugees and immigrants. However, the school-based infrastructure for addressing their needs appears to be fragmented and reactive (Adelman, & Taylor, 2010; Forman, Olin, Hoagwood, Crowe, & Saka, 2009). What is needed is a coordinated, proactive service delivery framework, as educational systems need to be better prepared to understand and be responsive to the SEB and mental health needs of refugee and immigrant children and their families with these backgrounds and experiences.

Current Research Needs

The continued influx of refugee and immigrant families into the U.S. presents unique challenges to schools and community-based organizations that are faced with the task of meeting the needs of these individuals. Too often there are holes in the amount of services being provided, including appropriate evidence-based practices (EBPs), for this population (Pumariega, Rothe, & Pumariega, 2005). Being under-served represents a significant concern, as research demonstrates that refugee and immigrant children and adolescents are in dire need of mental health services due to social/emotional/behavioral and mental health needs (Bhugra & Gupta, 2010; Dow, 2011a; Henley & Robinson, 2011).

Refugees and immigrants have barriers including, but not limited to, communication difficulties, misunderstanding of social cues and customs, and acculturation issues that may push mental health and psychotherapy to the back of the list (Birman & Chan, 2008). Before providing services to these families, understanding their unique and individual needs is crucial. Unfortunately, the current EBP literature is limited on how to best support refugee and immigrant students. There are minimal to no cultural adaptions in existence, and most studies do not identify these students within the sample or examine moderators of treatment effectiveness.

Often, they are included with many populaces under the phrase "diverse populations," and there is little research showing success specifically with refugee and immigrant families, a group that succumbs to trauma, which can result in need for mental health services.

Currently, there is limited research regarding implementer beliefs and attitudes towards utilizing EBPs with refugee and immigrant children and adolescents, especially since available EBPs are scarce, meaning that cultural adaptations and cultural competence are not just options, they are requirements. Assessing educator beliefs and attitudes around best serving refugee and immigrant populations is vital, as there is currently limited research on not just EBPs, but utilizing cultural adaptations and competence in the classroom and school setting. This is step one in learning more about being at the forefront as refugee and immigrant families are entering school systems.

Children who have refuged or immigrated to the United States, especially under demanding and challenging circumstances, face particular barriers in receiving services, including clinic, community, and/or school-based. There are currently laws around protecting refugee and immigrant's students well-being, but what about mental health services and simple care, from a setting in which students spend a majority of their day? (Ruiz et al., 2011). Schools are optimal places to begin step one.

Overview of the Study

To better understand the social/emotional/behavioral and mental health needs of refugee and immigrant children and adolescents, a survey was created and directed towards teachers around their beliefs and attitudes in working and serving this population in terms of their social/emotional/behavioral and mental health needs. This allowed the researcher to look at the starting point in best serving this population of students and their unique needs due to

acculturation experiences and its implications. The results of this study provide pertinent information that school psychologists can utilize to best support teachers in the classroom as consultants of change.

School Psychology Implications

School psychologists are members of school educational teams that support students' ability to learn and succeed and teachers' ability to teach and serve students. This profession, which bridges the gap between education and psychology, possesses expertise in the areas of mental health, learning, and behavior, which in turn helps children and adolescents to succeed the areas of academics and social/emotional/behavioral (National Association of School Psychologists, 2014). School psychologists work as consultants to get students what they need, and this is usually done through partnerships with teachers and staff.

As the focus of this dissertation project is on the social/emotional/behavioral and mental health needs of refugee and immigration students, critical information will be provided and can be accessed by school psychologists to help teachers around practices. By focusing on the beliefs and attitudes of general education teachers, school psychologists will better understand what teachers need in order to provide appropriate practices and supports to refugee and immigrant students. As school psychologists work closely with teachers to put these interventions into place and assess data to help students succeed at school, it is crucial to examine where teachers are at and determine what steps are needed to help serve these diverse populations of children and families. What does the literature say, and where are the gaps?

CHAPTER 2

LITERATURE REVIEW

The review of literature that follows is intended to provide adequate coverage of the background research that builds the case for and significance of this dissertation study. This chapter is organized according to the following. First, definitions are provided to understand the distinct differences between refugees and immigrants. Second, acculturation is discussed in relation to the process experienced and strategies used by refugee and immigrant children and their families. Third, the mental health needs of these populations and the potential negative short- and long-term outcomes are discussed. Last, a discussion of the literature on evidence-based and culturally responsive practices and the corresponding frameworks that can be utilized to best serve these populations of students and their families as part of a multicultural educational approach is provided. Throughout this literature review specific gaps in the extant research and practice will be highlighted to identify needs for further research to better understand how to approach promoting mental health and academic success of refugee and immigrant children. The end goal is to build the significance for a survey study that examines how one of the main service providers (i.e., teachers) perceive refugee and immigrant students and their competence to promote the social, emotional, and behavioral well-being of these students.

Definitions of Refugee and Immigrant Populations

This dissertation study uses two terms describing groups that are involved in the acculturation process: refugees and immigrants. In order to fully understand the unique social/emotional/behavioral and mental health needs of groups of children who are involved in acculturating to a dominant culture, it is important to delineate the differences between a refugee

and an immigrant to better understand the experiences of each child/adolescent and his or her family. Understanding the similarities and differences between refugees and immigrants is fundamental, due to the increases in the number of both immigrants and refugees into the United States. It should be noted that different researchers may utilize slightly disparate definitions and explanations, and it is imperative to observe the unique circumstances each family has undergone. However, while both groups may have somewhat diverse experiences, both refugees and immigrants go through the acculturation process.

Immigrant Status

An immigrant generally volunteers to leave his or her home, and is a foreign born person who has been allowed to reside in the United States by the government. These individuals come to the U.S. with temporary visas, which allow them to remain for a certain time or under clear conditions (i.e., students or tourists), or they may be granted permission allowing them to remain indefinitely (i.e., through the use of a "green card"). This group of individuals has also been called legal permanent residents (Fong, 2007). The U.S. Department of Commerce (2014) defines international migration as the movement of a group of people across a national border, which encompasses both immigration (migration to a country) and emigration (migration from a country) or the combination of the two (net international migration). An undocumented immigrant (also referred to as an unauthorized or illegal immigrant) is a person who is present in the United States without permission from the government (Ruiz, Kabler, & Sugarman, 2011). There were approximately 12 million illegal immigrants in the U.S. in 2007 (Immigration Sabotage, 2007). Undocumented immigrants may be similar to refugees in the sense that they are fleeing their home country in pursuit of safety, resources, health care, a better life, etc. (Larchanche, 2012).

There are also instances of special immigration status for minor immigrants under Special the Immigrant Juvenile Status, enacted under section 203(B)(4) of the Immigration and Nationality Act. Under this legislation, immigrant visas can be issued to juveniles who are eligible for long-term foster care due to abuse, neglect, or abandonment and for whom reunification with their birth family is not possible (Ruiz et al., 2011). As a result, they are often dealing with psychological and interpersonal difficulties associated with the adverse experiences that resulted in the need to immigrate to the U.S. Many of the youth who immigrate to the United States under this provision go through the challenges associated with acculturating after exposure to the dominant culture.

A distinction should be made between first- and second-generation families. A first-generation immigrant usually refers to a person (child or adult) who was born in one country and relocated (immigrated) to another country; this is the traditional definition. However, it can also mean a child or children born in the country that their family has relocated to, meaning that a child's status is dependent on the family (Bersani, 2014; Schwarzbaum & Thomas, 2008). Consequently, the term second-generation refers to children of first-generation parents.

Refugee Status

Unlike an immigrant, McBrien (2006) refers to a refugee (also referred to as an asylee) as an individual seeking asylum on the grounds that he or she has a well-founded fear of persecution on the basis of race, religion, membership in a social group, political opinion, or national origin in his or her home country. Refugees are often included under the title of immigrants but they usually experience significantly more trauma that potentially negatively impact their development and functioning than the children of voluntary immigrant families; essentially, they are considered a subset of immigrants with unique circumstances (McBrien,

2006). However, unlike an immigrant, a refugee leaves his or her birth country because of safety and self-preservation due to political and/or religious persecution and oppression usually with no option of returning, especially during times of turmoil.

Distinctly, those seeking sanctuary from persecution are considered asylum-seekers (rather than refugees), and they can apply for asylum in order to receive legal protection (Bridging Refugee Youth and Children's Services, 2014). After one year of residence in the U.S., refugees and asylees can apply for legal permanent residency, and after five years, legal permanent residents may apply for U.S. citizenship. Refugees and asylees leave their homes because of a fear of persecution due to race, religion, nationality, political opinion, or membership in a particular social group. Refugees are granted legal permission to resettle in the U.S. before they arrive, whereas asylees receive permission to stay in the U.S. after they have already arrived.

Refugees and asylees may leave behind family members, friends, customs, and familiar environments, resulting in many of them being displaced from their social support networks and other resources. Children and adolescents may be separated from their relatives, parents, pets, and everyone that they knew to flee to a safer place (Fong, 2007; U.S. Department of Commerce, 2014), and it may take years before they are reunited with their families, if at all. Immigration restrictions may complicate situations involving being re-united with family members, even immediate family member, which can lead to difficulties in adjusting socially and emotionally.

The Acculturation Process

Regardless of ones status, refugees and immigrants alike experience the acculturation process. Acculturation is defined as “a cultural change that is provoked by the clash of two or more autonomous cultural systems” (Djuraskovic & Arthur, 2009, p. 19). Djuraskovic and

Arthur (2009) report that acculturation is an adaptation in which individuals must break away from their original cultural group to start to become members of the new, dominant society (the culture that they have immigrated into). It is a dual process of cultural and psychological change, a transition, that this population must endure as they learn a new culture while trying to maintain aspects of their original heritage. In essence, it a process that unfolds over time that occurs when groups or individuals attempt to immigrate into a different culture context (Banks, 2012; Berry, 2005; Berry, Phinney, Sam, & Vedder, 2006; Phillimore, 2011).

Acculturation Strategies

Berry (1997, 2009) examined migration and the acculturation process as a series of phases that eventually leads to permanent settlement in a host society. There are generally two distinct groups involved in the acculturation process, including a dominant group that is representative of hegemonic culture and has greater influence and power and a non-dominant acculturating group that must undergo various forms of adaptation in response to the hegemonic culture (Berry, Poortinga, Segall, & Dasen, 1992; Dow, 2011b). As a result, Berry (1997) focuses on two main issues: (1) Cultural maintenance (To what extent are cultural identity and characteristics considered to be important, and how are they maintained?) and (2) Contact and participation (To what extent should individuals become involved in other cultural groups, or should they remain predominantly among themselves?). Using these two issues, a conceptual framework can be constructed to describe what Berry refers to as acculturation strategies. By classifying positive or negative ("yes" or "no") responses to these issues and examining how they intersect, four categories of acculturation strategies emerge.

The first strategy, the assimilation strategy, is from the point of view of non-dominant groups, when individuals do not wish to maintain their cultural identity and function with the

cultural context and adopt characteristics of the dominant culture. Next is the separation strategy, which involves individuals who place a high value on maintaining consistency with their native culture and also purposefully resist or avoid interaction with others from the dominant culture. Integration is the next acculturation strategy that consists of a desire and commitment to both maintain one's original culture, while also being willing to engage in daily interactions with other cultural groups. In short, the integration strategy represents maintaining some degree of cultural integrity, while at the same time seeking to participate as a member of the larger, dominant culture. Lastly, the marginalization strategy consists of limited interest in maintaining consistency with one's original culture (often for reasons of enforced cultural loss, meaning that the new culture has been imposed to the point that it has become a way of life), as well as limited interest in or opportunities to interact with the dominant culture (often for reasons of exclusion or discrimination) (Berry, 1997; Berry et al., 2006).

Of these four acculturation strategies, Berry (2001) argues that the integration strategy is associated with the most effective, positive outcome for refugees or immigrants. As a result, the primary task for a refugee or immigrant is to successfully adapt to the dominant culture of their new environment, while retaining the important aspects of their original cultural identity. It is important to note that these strategies are not stages but rather work in a potentially dynamic or circular fashion. For example, a refugee individual may begin with the separation strategy by avoiding interactions with those from the dominant culture. Over time, through exposure and attainment of knowledge of the new culture, he or she may move to the integration strategy and maintain the native culture while slowly beginning to interact with customs associated with the dominant culture. Individuals and groups may hold varying attitudes towards these four ways of acculturating, and their actual behaviors may vary correspondingly. When considered together,

these attitudes and behaviors comprise what Berry calls acculturation strategies (Berry, 1990).

Acculturation, Stress, and Immigration

The acculturation process, for refugee and immigration populations, causes stress, as this is often a defining feature of the immigration process. Those who immigrate to another country for protection and safety or for opportunity are likely to experience both migration and acculturation stress. Migration stress refers to the displacement and disorientation due to being forced to adjust to a new home–let alone a brand new country (Birman & Chan, 2008). Children and adolescents must make new friends and search for resources without the previously available support from family, friends, neighbors, and others. These difficulties can result in students feeling a lack of connection and sense of belonging, and in turn, these feelings have been linked to poor academic and life course outcomes (Sulkowski, Demary, & Lazarus, 2012). Students have a hard time making friends, not only due to language implications, but also due to cultural differences experienced in and outside of schools. In addition, there is limited access to previously available resources for children and families.

Acculturation stress is a significant, emotional process that consists of adjusting to new circumstances in a novel, cultural context, including learning the norms and rules of the new country, which can be very confusing for children, especially at a young age (Birman & Chan, 2008; Rogers-Sirin et al., 2014). Acculturative stress is caused by the difficulties experienced in the process of acculturation and migration and manifests in psychological and physical problems and impacts an individual's overall wellbeing (Berry, 1998; Kosic, 2004). Acculturation stress occurs because of a variety of factors, including the conditions within which one lived before immigrating, the motivation for immigrating, and separation of families and loved ones (Organista, Organista, & Kurasaki, 2002).

There are specific stress factors for refugee children. They may in particular experience war and genocide, resulting in search for safety and family relocation to refugee camps, which has been shown to be associated with other traumatic experiences and post-traumatic stress disorder (PTSD) (Ruiz et al., 2011). Refugee children and adolescents share the experience of involuntary and often violent break from their homelands resulting in a difficult immigration process (Rousseau, Drapeau, & Corin, 1996). If they do not receive appropriate supports and care from compassionate providers, learning difficulties, school performance (including GPA and IQ), behavioral problems, somatic problems, need for special education, and symptoms of depression can surface (Rousseau et al., 1996).

As a result of acculturation, many refugee and immigrant children experience the effects of poverty. Official poverty rates for immigrant children are significantly higher (21%) than for native-born children (14%). Among populations in poverty, there is increased anxiety about essential needs, such as health care and food (Anyon, 2014). Nearly half of immigrant families have incomes below the poverty line, compared with 34% of native children (Center for Health and Health Care in Schools, 2010); overall, 61% of children of immigrants live in low-income families (Anyon, 2014). In 2009, 15.5 million children, more than one in five, were poor, which represented the steepest single year rise in poverty since 1959 (Children's Defense Fund, 2011).

In addition to poverty and low SES, additional risk factors that may specifically predispose refugee families and asylum seekers to psychiatric symptoms and disorders include: exposure to war, state-sponsored violence and oppression, including torture, imprisonment in refugee camps, human trafficking, physical displacement outside one's home country, loss of family members and prolonged separation, the stress of adapting to a new culture, and unemployment, among others, which may lead to PTSD (Porter & Haslam, 2005). These unique

risk factors demonstrate that refugee and immigrant children are a highly diverse population, with potentially unique SEB needs, depending on the presence of certain risk and protective factors. Research investigating differences between immigrant groups have revealed considerable variability among first generation immigrants (Bourque, van der Ven, & Malla, 2011). Schools may be at the forefront to support these groups as they transition to a new country and enter communities and educational systems in which multiple stressors may be present, including trauma.

Refugee and immigrant families have a range of different needs, and service providers may not always be familiar with the diverse cultures of these families or even the way that individuals from particular culture backgrounds understand and perceive mental health issues (Center for Health and Health Care in Schools, 2010). Moreover, children and their caregivers may not speak English, and the current screening, identification, and assessment tools developed to identify and treat children with mental health needs may not have been tested for effectiveness or be of appropriate use with particular culturally and linguistically diverse groups of people, including refugees and immigrants (Birman & Chan, 2008).

Research demonstrates that these families have limited access to certain types of care (medical, mental health, social work, etc.). Due to the limited access to resources, there may be a reluctance to identify and diagnose children from other countries because of the difficulties with accurately teasing out whether a problem is due to cultural adjustment or symptoms of a mental health disorder (Birman & Chan, 2008). In the mental health clinic setting, culture, family dynamics, and other contextual factors affect how people label and communicate their distress, explain the causes of their mental health problems, perceive mental health providers and clinicians, and respond to treatment (Center for Health and Health Care in Schools, 2010), which

can complicate diagnostic decision making and treatment planning. Considering the above, refugee and immigrant children and adolescents may not receive services due to limited access, as well as the difficulty that comes with appropriate diagnoses.

Immigrant and refugee groups experience significant gaps in social, economic, and legal statuses that are greater than the gaps between Caucasians and African Americans in the United States (Rumbaut & Komaie, 2010). These disparities create the context for refugee and immigrant children to experience significant hardship and disenfranchisement from particular systems of care and thereby limiting their access to quality services.

Language Barriers and Migration Stress

There are additional difficulties that refugee and immigrant families face that are important to consider. Most first-generation refugee and immigrant children and their families must also become proficient in English in order to be successful in schools, in the workforce, and in civic life more broadly. Families, especially school-aged children, are confronted with the need to learn a new and foreign language rapidly. Although language acquisition is critical to successful adjustment, this may hinder their proficiency of their native language, as it may be relegated to secondary status behind the push to learn English. The tension between the dual languages has an impact on ethnic identity development, as it has been shown to negatively impact the identities of adolescents from different cultural groups (Phinney, Romer, Nava, & Huang, 2001).

The constant expectation to learn the second language quickly in order to satisfy the new culture can affect young children in particular to become delayed in their cognitive and social development (Cummins, 1994; Villalba, 2009). This is concerning considering that research indicates that basic interpersonal communication skills can take between one to two years to

develop, and cognitive academic language proficiency skills can take between five to seven years (Rhodes, Ochoa, & Ortiz, 2005). Students must focus on language while being exposed to interactions and academic assignments that they may not comprehend fully, leading to a propensity for anxiety and potential depressive-related disorders (Phillimore, 2011). While language does not directly cause PTSD, the experience of learning a new language can exacerbate PTSD symptoms. The same can be said with behavioral concerns, both internal and external, that can be a result of the language acquisition and acculturation process.

Acculturation, Trauma, and Mental Health

From stress to learning a new language, the process of immigrating to the U.S. can be a traumatic experience and significant stressor, as the transition from one country to another is not just a physical one, but a highly emotional one as well. It significantly affects multiple aspects of life functioning, and immigrants and refugees may differ with regard to trauma exposure. In addition to trauma that may accompany the immigration and acculturation process, many refugee children and families are also exposed to traumatic experiences in their native countries, which precipitated the move to the U.S. (Stein, Friedman, & Blanco, 2011). Refugee and immigrant children and their families have a wide range of experience, including, but not limited to, cultural shock, psychological distress, and experience of loss and bereavement (Benish-Weisman, 2009). In addition, these children and families must adapt and adjust to a new social, cultural, and linguistic world, which presents its own unique challenges (Ward, Bochner, & Furnham, 2001). Resettlement presents many challenges to those involved. Given the influx of refugees and immigrants, families may require supports targeting psychological distress (Centers for Disease Control and Prevention, 2012).

Statistics show that around 60 to 65% of children are exposed to a traumatic event before

they reach adulthood (Copeland, Keeler, Angold, & Costello, 2007; Finkelhor, Turner, Omrod, & Hamby, 2009; Fitzgerald & Cohen, 2012), and many children and adolescents will experience repeated exposure or multiple types of traumatic events over their lifetime (Copeland et al., 2007; Finkelhor et al., 2009). Rates of trauma exposure for youth in war-involved or high-conflict countries are even higher, with refugee and immigrant children being at the top of the list (Derluyn, Broekaert, Schuyten, & De Temmerman, 2004). While some children and adolescents are resilient in the face of trauma, others who are exposed to traumatic events, such as violence or war, develop posttraumatic stress symptoms and PTSD. PTSD is the direct result of being involved in traumatic experiences that threatens the sense of safety and livelihood of refugee and immigrant children and their families (Centers for Disease Control and Prevention, 2012).

According to the Diagnostic and Statistical Manual of Mental Disorders, (DSM-V; 2013) the diagnostic criteria for a PTSD diagnosis is a history of direct or indirect exposure to a traumatic event and four presenting symptoms: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. Re-experiencing the event, avoidance, and hyper-arousal are three key features of PTSD (American Psychiatric Association, 2013). While some children may not present symptoms to warrant an official diagnosis, many are likely to exhibit PTSD-like symptoms in response to stressors in life (American Psychiatric Association, 2013). When viewing refugee and immigrant children functioning from a trauma lens, research indicates that they are significantly more likely to be exposed to traumatic events and develop symptoms consistent with a diagnosis of PTSD (Aragona, Pucci, Mazzetti, & Geraci, 2013; Kinzie, 2006; Steel, Silove, Bird, McGorry, & Mohan, 1999).

Upon arrival to the Unites States, many refugee and immigrant children and families may

experience additional trauma not just from the stress of migration and acculturation, but also from relocating to high poverty communities in which affordable housing is available yet contextual risk factors are present, including violence and drug trafficking (Birman & Chan, 2008; Rousseau et al., 1996). This, coupled with acculturative and financial stress, creates unique mental health risks for this population (Organista et al., 2007; Suárez-Orozco & Suárez-Orozco, 2001). All of the possible stressors combine to create strain on the psychological wellbeing and behavioral adjustment of refugee and immigrant children (Dow, 2011b). As a result, there is a need to attend to the social, emotional, and behavioral needs of refugee and immigrant children to promote their academic and life success.

Entering the U.S. as undocumented persons represents a significant factor affecting the mental health of immigrants, as lacking legal status is anxiety provoking, with the fear of being deported as a constant source of discomfort (Suárez-Orozco & Suárez-Orozco, 2001). Undocumented citizens, therefore, are particularly at risk for a number of mental health issues, which may result in enhanced parental stress that negatively impacts children's adjustment and wellbeing. Significant psychiatric symptoms upon arrival are common and often impact the success of the transition for families moving to the U.S. (Centers for Disease Control and Prevention, 2012).

Refugee and immigrant families may experience a variety of stressors that can lead to sleeplessness, anxiety, depression, PTSD, and suicidality that may or may not be connected to specific traumatic events (Phillimore, 2011). These effects are more likely for refugees and immigrants from war-torn countries or individuals experiencing conflict or ordeals with the immigration process (Marotta, 2003). These symptoms and disorders result in negative life course outcomes, such as partner or domestic violence, substance use, and other serious

psychiatric disorders (Dow, 2011b; Straussner, 2000). In addition, current research demonstrates that individuals and families who directly and indirectly experience discrimination, prejudice, and discrimination on a regular basis may represent traumatic experiences in and of themselves and cause PTSD symptoms as well (Bryant-Davis & Ocampo, 2005; Villalba, 2009).

Additional subjective experiences can include feelings of grief and loss from leaving behind living and deceased family members, which in turn can cause mood and anxiety symptoms in individual immigrants and families. Separation from one's family shows a link with increased distress among immigrant children, particularly when a family is broken when one or more adults immigrate before the rest of the family to get established (Suárez-Orozco & Suárez-Orozco, 2001). The grieving process is often unaddressed in many service settings, such as schools, particularly when providers are unaware of the experiences of the children whom they serve (Frater-Mathieson, 2004; McBrien, 2005).

Overall, refugees and immigrants present greater levels of psychological distress than the general population (Fazel, Wheeler, & Danesh, 2005; Porter & Haslam, 2005). Thus, utilizing a screening method to assess for trauma and PTSD for children is key to detect needs when they exist and respond with the delivery of targeted treatments that reduce risk for negative outcomes and increase successful adjustment (Birman & Chan, 2008). In addition to treatments, there is a need for preventative supports that proactively teach all children, including refugee and immigrant children, social and emotional skills that enable them to effectively manage their emotions, build positive relationships with others, and effectively solve interpersonal problems (Taylor, & Dymnicki, 2007).

Due to the fact that some refugee and immigrant children and adolescents are minority youth, it should be noted that the research base around EBPs available to ethnic minority youth

are “probably efficacious” or “possibly efficacious treatments” for anxiety-related problems, attention deficit-hyperactivity disorder (ADHD), depression, conduct problems, substance use problems, trauma-related syndromes, and other clinical problems. However, no well-established treatments have been identified (Huey & Polo, 2008) for a population that has mental health needs. Refugee and immigrant children and adolescents have mental health needs and the settings in which they are served need to be equipped with high quality practices that identify needs (i.e., screening) to intervene when needed in order to address presenting problems and cultivate wellbeing.

Mental Health Service Delivery

“School-based mental health services can potentially address the needs of refugee and other vulnerable children in a framework that is locally driven, community focused and accessible,” (Fazel et al., 2005, p. 297) especially for students who would not access services otherwise. In fact, both children and adult immigrants, particularly those who recently immigrated, are significantly less likely to pursue and receive mental health services than their non-immigrant peers (Brown, Ahmed, Gary, & Milburn, 1995; Cuff, Wallwe, Cuccaro, Pumariega, & Garrison, 1995; Cunningham & Freeman, 1996; Kataoka, Zhang, & Wells, 2002; Podorefsky, McDonald-Dowdell, & Beardslee, 2001; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). The limited access to mental health services is due to a range of contextual barriers, including limited language support services, unfamiliarity with accessing local health services, and the cultural stigma of “mental health,” among others (Cohen, Rivara, Marcuse, McPhillips, & Davis, 2005; Jaycox et al., 2002). Any approach needs to factor these barriers into the equation in order to ensure access to high quality services.

Issues in Accessing Mental Health Services

However, while there are some EBPs and services that are available, accessing these programs and practices is difficult for families due to having to abandon what is important, lose what is familiar, and accept what is contrary to previously held beliefs to conform to the rules of a new, host society. The health and mental health of refugee and immigrant families can deteriorate, making proper EBPs crucial (Dow, 2011b; Rogers-Sirin et al., 2014). Although society generally conceptualizes mental health as a function of individual level risk factors, family, community, and cultural level factors also play a significant role deeply in the mental health adjustment of children and their caregivers (Rogers-Sirin et al., 2014).

To understand the mental health service needs among refugee and immigrant youth, it is vital to understand the intersecting contexts within which they learn, play, find support, and develop identity (Rogers-Sirin et al., 2014). For example, students are not just embedded in schools, they also grow and learn in their homes, neighborhoods, daycares, workplaces, community settings, and others. All of these environments provide experiences for children and adolescents. In addition, Berry (2005) states that while refugees and immigrants are going through the acculturation process, they are better trying to understand their cultural identities through participation, maintenance, attitudes, and behavioral shifts. This is one of that reasons that assessment tools and the therapeutic interventions used by mental health providers must be culturally appropriate and evidence-based, and aligned with the current acculturation of the individual and family (Dow, 2011b).

In light of the psychological and acculturation stress, increased exposure to trauma, and other mental health problems that refugees and immigrants may experience result in significant barriers preventing accessing appropriate health and mental health services. This is due to the lack of an understanding of the mechanisms around how mental health services work (Marotta,

2003), and many families tend to live in areas where mental health services and EBPs are scarce (Phillimore, 2011). Access becomes even more difficult and complicated given the paucity of bilingual, bicultural mental health providers in the United States. Not only does this limit access to mental health services, but it also makes it difficult to form a therapeutic relationship when the individual is able to connect with providers; however, it should also be noted that the therapeutic relationship is more critical than sharing the same culture between therapist and client, but the lack of mental health providers in general in the U.S. exacerbates the problem further (Villalba, 2009). To intensify the issue, there is a stigma of mental health services (Corrigan, Roe, D., Tsang, 2011; Ping, Tummala, & Roberts, 2008). The limited access to mental health-related services to help with migration and acculturation stresses represents a significant problem (Murphy, Ndegwa, Kanani, Rojas-Jaimes, & Webster, 2002). This prevents refugees and immigrants from integrating with the new culture, as they struggle to develop relationships with local people, seek employment, learn a new language and participate in broader aspects of civic life (Phillimore, 2011).

Even if refugee and immigrant families are able to receive mental health services, there are issues with providers being under-trained and lacking cultural competence. Lack of awareness, understanding, and skills on the part of mental health providers regarding the experiences and unique acculturation and traumatic stress of refugees and immigrants further perpetuates the gap between prospective clients and available mental health practitioners (Villalba, 2009). Thus, bringing EBPs and mental health services into another setting is crucial, one in which students spend ample time, the school setting. Schools are idea settings to address the under-utilization of mental health services for refugee and immigrant children. It is the ideal environment to increase access to high quality practices, as schools remove multiple barriers that

may prevent access to services (e.g., transportation, child care, etc.).

Evidence-Based Practices (EBPs)

Access to high quality care typically refers to receiving EBPs. Evidence is defined as something, which shows that something else exists or is true (Merriam-Webster, 2014). An example of evidence is the material used in a court of law to aid in solving a crime. In education, evidence is gathered from research and utilized to justify and put into place appropriate assessment and interventions practices for students to succeed both academically and behaviorally. Thus, the best available research evidence allows researchers, practitioners, and policy-makers to determine whether or not a program, practice, or policy is actually achieving the positive effects that it was intended to evoke (Puddy, Wilkins, U.S. Centers for Disease Control and Prevention, & U.S. National Center for Injury Prevention and Control, 2011).

There are many terms that researchers have coined to identify and describe empirically-supported practices. For example, the terms empirically-supported treatments or evidence-supported treatments have been used. EBP is a more modern term that refers to the conscientious, explicit and judicious use of the current and best evidence in making decisions about the care of an individual. It includes integrating individual clinical expertise with the best available external clinical evidence from systematic research (Duke University Medical Center, 2014). Simply put, EBPs are defined as programs, interventions, and other practices (i.e., assessments) that are supported by empirical evidence (Weisz, Jensen-Doss, & Hawley, 2006).

While this is a board definition, organizations have different definitions and standards for identifying practices as evidence-based (Children’s Services Council, 2007), but there are common elements used across these different definitions and standards to assess whether a practice or program is deemed to be evidence-based. There are diverse organizations in which

EBPs can be accessed, such as: (1) The Promising Practices Network (PPN; Promising Practices Network, 2014); (2) The What Works Clearinghouse (WWC; Institute of Education Sciences, 2014); (3) The National Registry of Evidence-Based Practices (NREPP; U.S. Department of Health and Human Services, 2014a); (4) The Association for Behavioral and Cognitive Therapies (ABCT; Association for Behavioral and Cognitive Therapies, 2014); (5) Harvard Family Research Project (HFRP; Presidents and Fellows of Harvard College, 2014); and (6) Southwest Educational Development Laboratory (SEDL; Southwest Educational Development Laboratory, 2014).

Although differences exist among standards to identify EBPs, it is quite common for them to be characterized into the following three categories: (1) well-established, (2) probably efficacious, and (3) possible efficacious (Huey & Polo, 2008). These three categories are hierarchical in nature and represent the degree of empirical evidence supporting a particular practice. For instance, well-established treatments are supported by the highest quality evidence and must satisfy specific criteria involving at least two high-quality (i.e., random assignment, adequate sample size) between-groups trials by different investigative teams showing that treatment is superior to placebo or another treatment, or equivalent to an already established treatment. Probably efficacious treatments require only one high-quality randomized control trial (RCT) comparing treatment to placebo (or alternative treatment) or two trials comparing treatment to no treatment. Lastly, possibly efficacious treatments have at least one study showing the treatment to be efficacious but not meet criteria as well-established or probably efficacious (Huey & Polo, 2008). In addition to these research methods, single case designs have also been included in these categories (Kratochwill et al., 2010).

Although EBPs have been shown to be effective via rigorous research, there continues to be a lack of consensus among researchers and practitioners regarding their adoption and utilization within everyday service settings, such as schools. Despite the lack of consensus, there is clear evidence indicating that the adoption and use of EBPs results in significantly better outcomes than usual care (Garland, Bickman, & Chorpita, 2010; Weisz et al., 2006). In this vein, Weisz et al. (2006) argues that interventions and practices that have been scientifically researched and shown to work are more likely to benefit consumers than interventions that have not been tested empirically, shown to be worse, or have opposite effects. However, those who debate the use of EBPs contend that they are often too manualized and rigid, too strict, and are not flexible enough to appropriately meet the needs of all clients, especially those who are at-risk, such as refugee and immigrant populations (Chorpita, 2007).

To combat this, proponents of EBPs state that these programs and practices produce socially significant outcomes, especially in school settings, such as the reduction in need for special education classes, increased academic engagement and success, reduction in school dropout rates, reduction in unemployment, reduced use of welfare and food stamps, fewer arrests, and improved school-family partnerships (Children’s Services Council, 2007). These types of outcomes are critical for at-risk populations in order to facilitate their life success, prevent social issues from emerging, and reduce the economic burden on society as a whole. The more rigorous the research supporting a particular program, intervention or practice, the more compelling the evidence is supporting it and justifying it’s adoption and implementation (backed by RCTs, quasi-experimental studies, and single-subject designs) (Puddy, Wilkins, U.S. Centers for Disease Control and Prevention, & U.S. National Center for Injury Prevention and Control, 2011). Many refugee and immigrant children and adolescents are considered at-risk and,

therefore, would benefit from the implementation of EBPs. Despite the potential promise of EBPs to promote positive outcomes for refugee and immigrant children and adolescents, it is unclear whether they have been shown to be effective for this population.

The refugee and immigrant population is one of the fastest growing groups of people in the United States, but unfortunately, mental health services, including therapists ability to provide CBTs, do not appear to be following at the same rate (Nwosu, Batalova, & Auclair, 2014; Ruiz et al., 2011). In addition, there have been few educational research studies that describe how recently arrived refugee and immigrant students and their families make their transition to United States schools and even fewer documenting EBPs with this population (Roxas & Roy, 2012).

Although there is dearth of empirical research that has investigated the efficacy of specific treatments designed for refugee and immigrant children, there are empirically supported treatments that offer promise and in some cases have demonstrated efficacy for diverse populations and could translate well with refugee and immigrant families. Treatments with evidence of effectiveness for child and adolescent PTSD and comorbid symptoms are available, and the majority of these treatments are grounded in cognitive behavioral therapies (CBT; Wetherington et al., 2008). CBT is an approach based on the notion that the way an individual thinks about a situation determines how he or she responds in terms of affect and behavior. In essence, a person’s thoughts and feelings impact their behaviors (Chorpita, Bernstein, & Daleiden, 2008; Hollon, 1998). Common elements in CBT specific to PTSD include: (1) Psychoeducation about PTSD, anxiety, and the prevalence and impact of trauma; (2) Relaxation and affective modulation skills for managing physiological and emotional stress; (3) Exposure or gradual desensitization to memories of the traumatic event and to reminders of the traumatic

event; and (4) Cognitive restructuring of inaccurate or maladaptive/unhelpful cognitions (Chorpita et al., 2008; Dorsey, Briggs, & Woods 2011).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a popular EBP for ages 3-18 that is utilized for trauma exposure, PTSD and co-occurring sequelae in about 12-20 sessions (Cohen, Mannarino, & Deblinger, 2006; Dorsey et al., 2011; Fitzgerald & Cohen, 2012). TF-CBT has been shown to be effective for refugee and immigrant populations, including cultural adaptations made for Latino, Cambodian, and African American populations (Cohen et al., 2006), in addition to foster families (Dorsey et al., 2014). Research for TF-CBT currently includes six published RCTs, as well as some small trails and studies. Nine "PRACTICE" components make up TF-CBT: (1) Psychoeducation; (2) Parenting skills, (3) Relaxation skills; (4) Affective modulation skills; (5) Cognitive coping skills; (6) Trauma narrative and processing; (7) In vivo exposure; (8) Conjoint child-parent sessions; and (9) Enhancing safety. The crucial component of TF-CBT includes exposure to trauma, which is done with step six—the trauma narrative.

A program similar to TF-CBT, Cognitive Behavioral Intervention for Trauma in Schools (CBITS), is a popular school-based EBP for ages 10-15 that is used for students who have been impacted by trauma; it includes about 10 weekly sessions (Dorsey et al., 2011). CBITS has one RCT (Stein et al., 2003), one quasi-experimental trial (Kataoka et al., 2003), one field trial (Jaycox et al., 2010), and it is registered as an EBP under the NREPP (U.S. Department of Health and Human Services, 2014b). CBITS incorporates psychoeducation, relaxation training, cognitive coping skills, gradual exposure to trauma memories through trauma narrative, in vivo exposure, affective modulation skills, cognitive restructuring, and social problem solving. CBITS has been implemented with a variety of populations, such as immigrants, urban ethnic

minorities, those with low socioeconomic status (SES), middle class populaces, and international groups, and it has shown to be effective.

In addition to trauma-based CBTs, there may be students, especially refugee and immigrant populations that may have multiple needs and supports. For these circumstances, clinicians may use a modularized approach for anxiety, depression, and conduct problems, all areas that a refugee or immigrant child may be suffering from (Weisz et al., 2012). In essence, the core components of EBPs that have these focuses are combined into one to help aid with all needs concurrently. The common elements of effective programs or treatments are distilled into an organized framework for making decisions and delivering specific clinical services that are tailored to the client's needs.

One of the few studies on EBPs comes from Hinton, Pich, Hofmann, and Otto (2013). The authors examined Culturally Adapted Cognitive Behavioral Therapy (CA-CBT), which focuses on acceptance and mindfulness techniques for Latino and Southeast Asian refugee populations, through a Nodal Network Model (NNM) of Affect. The authors argue that acceptance and mindfulness are therapeutic for refugees and minority populations because they increase psychological flexibility, decrease somatic distress, decrease rumination, serve as emotion regulation techniques, decrease bias to threat, and form part of a new adaptive processing mode. These outcomes have been documented as effective with Latino refugees (Hinton et al., 2011), as well as Southeast Asian and Cambodian refugee population (Hinton et al., 2004, 2005).

Roysircar (2009) provides one of the few articles focusing on EBPs in relation to culturally sensitive treatment (CST). CST consists of culturally adapting EBPs, including utilizing specific interventions developed for a particular culture, or involving the adaptation of

an already established EBP to fit the cultural needs of the client. CST can include: (1) The incorporation of the client's cultural values into therapy; (2) Racial, ethnic, and linguistic matching of client and therapist; (3) Therapy provided in the client's preferred language; (4) The explicit cultural or multicultural paradigm of the agency or clinic providing services; (5) Consultation with individuals who are familiar with the clients' culture; (6) Outreach efforts to recruit underserved populations; (7) Provision of services such as childcare to promote client retention; (8) Oral administration of materials for illiterate clients; (9) Cultural sensitivity training for professional staff; and (10) Provision of referrals to outside agencies for additional services. Therapists and implementers need to be trained in order to effectively bridge the gap between EBPs and these culturally sensitive treatments, which allows the provider to be culturally relevant, rather than sticking strictly to a manualized format that might not work well with refugee and immigrant populations and could be threatening to families.

Roysircar (2009) recommends continued research in CST in terms of therapy conceptualization, assessment, and outcome. However, it is critical to remember that refugee and immigrant children and adolescents are embedded and interact within multiple environments, such as schools, and teachers and staff, in particular, should utilize CST when adapting EBPs with refugee and immigrant populations. Morland (2007) provides some guidelines for practitioners when implementing promising practices for culturally and linguistically diverse student populations, including creating partnerships, engaging the entire family, supporting staff, and fostering ethnic identity, which is key and is required whether using CST or examining personal biases within therapy or school-systems.

Cultural Adaptations

While there are a few EBPs available to refugee and immigrant students, including

treatments that have been culturally-adapted, implementers may experience challenges with delivering the EBP or specific intervention components for this particular population of students to ensure that is delivered in a culturally-relevant and meaningful manner. As a result, many researchers and practitioners argue that cultural competence is key to being able to culturally adapt EBPs in way that increases engagement in the intervention and ensures that is appropriately delivered (Jones, 2009; Samuels, Schudrich, & Altschul, 2009).

Cultural competence is defined as a set of corresponding behaviors, attitudes, and policies that come together in a system, agency, or among professionals and allows that entity to work successfully in cross-cultural situations (Isaacs & Benjamin, 1991). Operationally defined, cultural competence transforms knowledge about individuals and populaces into specific standards, policies, practices, and attitudes used in appropriate cultural settings to improve the quality of services and EBPs, leading to better, more positive outcomes (Davis, 1997; Jones, 2009). One of the key steps in building cultural competence is building awareness of others, which includes self-reflection, multicultural awareness, and learning about different cultural styles through training, professional development, and translating research into practice (Jones, 2010).

Cultural adaptations are defined as "the systematic modification of an evidence-based treatment (EBT) to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns meanings and values" (Cabassa & Baumann, 2013, p. 3). Using cultural adaptations in implementation science allows a deeper experience and focus on culture; this allows EBPs to be more responsive to the needs and preferences of diverse populations, including refugees and immigrants. By focusing on the relevance, acceptability, effectiveness, and sustainability of treatments, there is an increased likelihood of client

engagement and positive outcomes (Cabassa & Baumann, 2013).

There are several reasons for adapting EBPs to be more culturally appropriate for families, which go beyond individualizing interventions for a single student. These include improving connectedness with the target community, increasing treatment relevance, decreasing the possibility of unwanted surprises, increasing involvement and participation of members of other cultural groups, building support for programs by those cultural group members, even if they do not participate or get directly involved, increasing the chances for success of the intervention and its community impact, and building future trust and cooperation across cultural lines. However, it should also be noted that not every intervention or EBP needs to be adapted, and it must be done so effectively before proceeding, as recommended by the Community Tool Box (2014).

The Community Tool Box is a service of the Work Group for Community Health and Development at the University of Kansas that provides free, online resources to build healthier communities and bring about social change through tips and tools (Community Tool Box, 2014). This resource provides a series of steps that practitioners can follow when adapting programs in a an ethical fashion, including: Conducting research, (2) Consulting with individuals, (3) Spending time in the cultural setting, if possible, (4) Proposing the adaptation, (5) Asking for feedback, (6) Making necessary modifications and changes, (7) Finding appropriate and qualified individuals who will run the EBP, and (8) Planning and starting the EBP. Collectively, these steps enable practitioners to place culture at the forefront of the EBP implementation process from the beginning to the end.

When adapting interventions and programs, it is also essential to keep the core components but modify other areas to be culturally competent (Cabassa & Baumann, 2013). In

order to do this, implementers should make culture more visible in the implementation process, determine if adaptations are needed, examine what to adapt in order to balance fidelity and adaptation in the implementation of EBPs, examine who should drive the process of implementation and adaptation of EBPs in usual care settings, expand the contextual lens to inform adaptations and implementation strategies, and examine when to adapt EBPs, if necessary, in the implementation process (Cabassa & Baumann, 2013). Essentially, core components are kept while making cultural adaptations concurrently. As mentioned above, the core components of CBT include psychoeducation, relaxation and affective modulation skills, exposure, and cognitive restructuring (Chorpita et al., 2008; Dorsey et al., 2011). Delivering these in a culturally competent way consists of utilizing cultural awareness (being conscious of similarities and differences among cultural groups) and cultural sensitivity (understanding needs and struggles of persons from one's own cultural in addition to other cultures). To be culturally competent in CBT, for example, the therapist should understand the culture and background of the client and use culturally-appropriate assessments and measures (Center for Mental Health Services, 2003).

When using adapted instruments, educators, therapists, and professionals must remember to be extremely cautious when examining the results, especially with populations such as refugee and immigrant peoples, as there is limited research on what works best for them. At times, follow-up may need to be completed with clinical assessment, which may include going beyond the school setting towards additional resources, such as the local community. A thorough understanding of the child and family's situation and cultural background can serve in determining diagnosis of a mental disorder and drafting an appropriate treatment plan, which may include an intervention, such as CA-CBT, depending on the needs of the child and family.

Multi-Tiered Systems of Support (MTSS)

An ideal location in which motivation can be increased and coping strategies can be taught is within the school setting. Schools provide tremendous opportunities to facilitate access to mental health services if an appropriate framework of supports, such as multi-tiered systems of support (MTSS), is in place. Delivering evidence-based mental health services through an MTSS framework can help overcome contextual barriers that prevent refugee and immigrant students from obtaining the care that they need (Allensworth, Lawson, Nicholson, & Wyche, 1997; Greenberg Garrison, Roy, & Azar, 1999; Rousseau et al., 2007). Screening may identify children and adolescents at-risk and provide interventions in the school environment in which students spend a majority of their day and have peer and teacher support (Masia, Klein, Storch, & Corda, 2001).

Using a MTSS framework, mental health services can be effectively integrated into the school setting to best serve refugees and immigrants, as well as all students. Given the many negative outcomes endured by students with SEBs, there has been work completed and in-process among researchers, policymakers, and educators. The use and uptake of programs and practices helps to aid or even prevent these challenges. This is especially true for children and adolescents with unique needs, such as refugee and immigrant children and adolescents. All students, regardless of cultural background, should have the opportunity to learn and succeed in an educational environment (Adelman & Taylor, 2004; Wagner, Newman, Cameto, & Levine, 2006). Researchers focused on improving school-based services have developed numerous EBPs that address students' SEB needs to promote better academic and life success (Cornell, Allen, & Fan, 2012; Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011; Greenberg et al., 1999; Horner, Sugai, Todd, & Lewis-Palmer, 2005; Roorda, Koomen, Split, & Oort, 2011).

MTSS based on the public health model has been advocated for by researchers as a way to organize and utilize a continuum of services individualized to meet each student's needs through interventions and EBPs (Cook et al., 2010; Doll & Cummings, 2008). MTSS is a proactive, prevention-oriented service delivery framework that targets improving all students' SEB and academic needs through the implementation of a continuum of EBPs; this allows for appropriate and ongoing data-based decision-making (Rones & Hoagwood, 2000; Strein, Hoagwood, & Cohn, 2003; Walker et al., 1996). This service delivery framework offers promise for refugee and immigrant populations, as they have specific SEB needs that can be addressed through data-based decisions, ensuring that these individuals receive appropriate preventative and intervention practices to meet their needs. This is an improvement upon the traditional refer-test-place model of care, in which student services are reactive, rather than proactive; the model has not demonstrated positive improvements for students, as many "fall through the cracks" and essentially need to "fail" to attain much-needed academic and mental health services (Cook et al., 2010; Doll & Cummings, 2008). MTSS instead allows each student to receive what is needed, which is uniquely important for refugees and immigrants.

The delivery of EBPs within school settings through MTSS offers tremendous promise to improve outcomes for students. Moreover, EBPs can be implemented at multiple levels to address the needs of all students, some students who are identified as at-risk, and a few students who have been nonresponsive to lesser interventions. Indeed, MTSS has been advocated as a framework to organize and orchestrate the delivery of a continuum of EBPs to better address the needs of all students within a school system and help guide decisions with regard to EBPs (Cook, Burns, Browning-Wright, & Gresham, 2010; Doll & Cummings, 2008; Melnyk, Fineout-Overholt, & Mays, 2008).

Currently, there is a limited amount of research that outlines how best to proceed with implementing an MTSS framework in schools that serve relatively large populations of refugee and immigrant children. There are some recommendations mentioned below focused on strategies in which schools can start this process. First, schools must review student records, including those from overseas, as records may provide school personnel with additional information regarding health and psychological history, in addition to disabilities that may be present with the student who has immigrated from another country (Centers for Disease Control and Prevention, 2012). Then, screening for PTSD and depression is key, as these are two prominent risk factors for refugee and immigrant children, among multiple other risk factors and co-morbid disorders discussed above (Centers for Disease Control and Prevention, 2012).

For some students, within-school services are not enough, and school providers must use clinical expertise and judgment to contact resettlement agencies to determine whether emergency or routine referrals are needed. If symptoms of depression or PTSD significantly interfere daily function, urgent follow-up care is recommended. The presence of suicidal or homicidal ideation should prompt immediate referral. When PTSD symptoms are severe, it is optimal for the refugee or immigrant family to be referred to an agency with special expertise in working with these unique mental health issues. Schools must devise a place regarding referring outside the school setting (Centers for Disease Control and Prevention, 2012). However, before this set-up can take place, MTSS must be fully implemented, but the question resides in where to start? MTSS offers tremendous promise to organize and orchestrate the delivery of effective school-based practices for refugee and immigrant children; however, research has clearly revealed that there is a significant gap between what works and what is actually implemented in schools.

While research is currently limited, Ellis et al. (2013) provides recommendations a continuum of mental health specific that specifically supports refugee students. Tier 1 should include community resilience building through engagement, education, and outreach, Tier 2 should include child resilience building through school-based skills groups, Tier 3 should consist of Trauma Systems Therapy (TST) in enduring/understanding school-based skill-building psychotherapy, and Tier 4 could include additional TST in surviving and stabilizing with home-based care (Ellis et al., 2013). Students move up the tiers depending on their needs. While this is specific to refugee students, Ellis et al. (2013) report that it would most likely benefit immigrant children as well.

MTSS utilizes EBPs such as TST (a phase-based model of trauma treatment in which both social environmental stressors and trauma-related emotional deregulation are the focus of treatment) (Ellis et al., 2013) in the continuum of these services because these practices are supported by the most current empirical evidence available to date (Weisz, Jensen-Doss, & Hawley, 2006), and in some cases, have been shown to be culturally sensitive and modifiable to a larger audience. However, it should be noted that only some EBPs have been shown to be investigated with a diverse population of students (Morales & Norcross, 2010). Given the research behind these practices, there is a strong push to apply EBPs into everyday school settings to improve outcomes for children instead of adopting practices that do not have the same evidence or have opposite, harmful effects (Weisz et al., 2006). Although research has demonstrated that the implementation of EBPs has occurred in schools, the continued use of them under naturally occurring educational conditions is vital, and schools must be on board before implementation can occur. Too many times, programs are implemented, but there is limited upkeep or continued use of EBPs (Forman, Fagley, Chu, & Walkup, 2012). Moreover,

although research to establish school-based EBPs is laudable, there is inadequate guidance on how best to integrate and adapt practices for use with refugee and immigrant populations.

To combat the issues that refugee and immigrant students face, a well-articulated plan in place can outline how schools intend to address the unique needs they present and could interfere with their ability to be successful in school. This population exhibits a clear need for proactive services and efforts by educators to bridge school-home partnerships, specifically as they relate to promoting social-emotional well-being and sense of belonging within schools, considering the experiences that many of them have endured. An MTSS framework provides the structure and practices that can enables school teams to create plans to provide a continuum of supports and gather relevant data to inform decisions about refugee and immigrant students' unique needs.

When forming a plan for refugee and immigrant children, Birman and Chan (2008) recommend involving consultants (i.e., parents, professionals, etc.) from the local immigrant and refugee communities to help plan the screening process to identify appropriate measures that can be utilized to assess mental health needs and get an accurate picture of the child or adolescent. Further, it is recommended that a multidisciplinary team approach be used, which includes individuals with different areas of expertise to provide relevant input and fully consider a culturally-sensitive process to support students. In line with this, appropriate linguistic translation is required for many refugee and immigrant families to be active participants in their child's schooling process. It is critical that educators sit at the forefront of understanding the needs of refugee and immigrant children and utilize EBPs and other culturally-relevant practices to support these individuals and provide them with an effective educational experience.

Multicultural Education

However, while providing EBPs within a MTSS framework can be helpful for refugee and immigrant students, as well as all students, the current research is limited on what works best for these diverse populations. Thus, it is not enough simply to utilize EBPs; teachers and staff must use these within multicultural education settings through the use of culturally responsive practices. Schools represent an ideal setting for refugee and immigrant students to build their cultural identities and receive supports to address the acculturation and traumatic stressors they are experiencing, especially since there are challenges associated with accessing mental health services in clinics as mentioned above. In schools, there is access to students, whereas going to a mental health clinic may be hard and almost impossible for families depending on childcare needs, transportation, work conflicts, and others. Refugee and immigrant children and adolescents live in multiple environments, and since they spend a good portion of their young lives in schools, teacher and staff perceptions can have a big weight on students (Roysircar, 2009) through their instructional judgments and actions (Knopp & Smith, 2005). Teachers serve as role models for students and can effortlessly convey attitudes and personal perceptions about the classroom subject matter, and their values about learning, diverse populations of students, the community, and society at large (Gallivan, 1998).

Bikmetov (2008) reports that schools and the family perform shared social functions, including instruction (the transmission of information, knowledge, abilities, and skills), that of upbringing (the shaping of the person’s worldview, value orientations, and qualities of personality), and exercising control over the content of the student’s life activity. Bridging this gap between school and home allows educational environments to build rapport and relationships with students and families; this can in turn help foster social/emotional/behavioral skills and mental health needs. While refugee and immigrant students are building their cultural

identifications and identities at home, they are also doing this at school (Ramsey, 2000), making schools a great environment for students to get the services that they need.

Culturally Responsive Practices

A culturally responsive school environment fosters cultural identities, recognizes the impact of acculturation stress and migrations tress and serves mental health needs. It starts with creating a climate for cultural appreciation, respect, and trust in the classroom, and teachers and educators must move away from teaching that ignores diversity (monocultural teaching). This is the basis for multicultural education, which is a field of study whose major aim is to create equal educational opportunities for students from diverse racial, ethnic, social-class, and cultural groups (Sfeir-Younis, 1995).

Djuraskovic and Arthur (2009) discuss the acculturation process of refugees from former Yugoslavia, who were between the ages of 18 to 25 upon arrival to the United States. Study results indicate four central categories that emerged as a result of the data obtained regarding the experiences of these individuals, including: (1) Triggers of immigration (loss of country and effects of war); (2) Land of opportunities (freedom, the hope for a better life, and culture shock); (3) The acculturation process (circular and multifaceted); and (4) Identity reconstruction (ethnic identity loss and reform). The authors further report that the counseling and school psychology literature has provided little attention to the refugee community. With limited research and EBPs available to best support refugee and immigrant populations, it becomes even more critical to assess current research and to make culturally appropriate adjustments based on the individual needs of the child or adolescent and his or her family.

One way to do this is to critically listen to the stories of refugee and immigrant children in order to understand their perspective, identify specific needs, and pinpoint opportunities to

support them (Roberts & Locke, 2001). While clinicians, teachers, educators, and others in the child or adolescent's life may not be able to fully understand his or her experience, undivided attention allows the school system to establish trust and belonging with the student's experience. This, coupled with the attainment of background and cultural information through a multifaceted and multicultural lens, is key to developing shared goals and supporting the well-being of the student. Researchers have recommended that teachers must first recognize barriers that they encounter, which may be a byproduct of the history of trauma a child experiences prior to their arrival in this new country (Strekalova & Hoot, 2008).

Educators supporting these students need to develop a more compassionate and sensitive perspective when working with them to better understand the experiences and potential stressors they are bringing to the educational table. This is validated with Feuerverger's (2011) ethnographic study of newly-arrived students of different racial, linguistic and religious backgrounds as they confront the process of immigration and personal and social displacement within the context of a Toronto inner-city high school. This work uncovered several cultural stories including families' struggles, the lives that were left behind, and the new lives that were created. By reading and discussing these stories, the audience is able to develop a more solid understanding of the different struggles that each individual endured as he or she made the transition to U.S. schools.

Feuerverger (2011) further argued that the students try not to dwell on the losses, or in some cases, the rage that they continue to feel. For example, one student discusses discrimination due to a lack of the English language, while another student talks about the anxiety that came along with the process. Some feel lonely, being forced to leave family members and friends behind in their home countries. Others missed years of schooling in their birthplace and need to

catch up both academically and socially/emotionally as a result. It is vital to understand that each story is very diverse. It is also important for an educator to remember that if he or she has met one family who has immigrated, he or she has only met just one family who has immigrated, because each family's experience is vastly unique. However, there are practices that can help all students in the classroom environment, with quality relationships between teachers and students being the first step, as indicated by research. Positive teacher-student relationships are crucial, as it is correlated with positive outcomes and culturally responsive practices (Cornelius-White, 2007; Pigford, 2001; Van, & Van, 2011).

Classroom-Level Approach

Sfeir-Younis (1995) argued that in order for a classroom to use culturally responsive instructional practices, the following should be included: (1) Teachers should be aware of their own cultural identities that make an effect on classroom dynamics, (2) Reflective cultural diversity should be incorporated in classroom norms and ground rules, (3) Culturally diverse styles of communication should be appreciated and welcomed, and participation of all students should be expected, (4) Diverse cultural styles should be demonstrated in course content, readings, assignments, and tests and evaluations, (5) Power in the classroom should be shared (i.e., conflict becomes constructive and negotiated), and (6) Classroom processes and dynamics should be incorporated in content and readings. When all six are incorporated into the classroom, instruction and teaching practices become culturally responsive, allowing the teacher to reach and better understand each student in his or her classroom. For example, teachers must first look at their own cultural identities before better understanding the identification and needs of all students with diverse cultural styles and how these impact the classroom environment. Then,

teachers can become reflective practitioners, better understand cultural styles, and learn to incorporate these into classroom practices and content to begin to share power with students.

Systems-Level Approach

Banks (1995, 2004, 2012) took Sfeir-Younis' ideas one step further to actively combat institutionalized prejudice and racism for diverse groups, with refugee and immigrant groups among them. In so doing, he recommended five core dimensions that characterize multicultural education: (1) Content integration (infusing the classroom curriculum with material from diverse groups, such as new authors and historical content); (2) Knowledge construction (using cultural frames to shape the identification and interpretation of educational content); (3) Prejudice reduction (teachers and school educators and staff working to prevent and reduce prejudice and stereotyping through the inclusion of an antiracist curriculum); (4) Equity pedagogy (culturally responsive instructional practices designed specifically to increase the academic achievement of lower performing students and to create greater equity); and (5) Empowering school culture (changing school structures and processes to empower all students, with particular attention to eliminating institutionalized racism in school practices). Collectively, according to Banks, these five dimensions work together to enable students to become their own individuals and have the ability to express themselves while at the same time creating collectivism and teamwork in class so that every student can learn and grow.

Sfeir-Younis (1995) and Banks (1995, 2004, 2012) both provide ways of conceptualizing how to bring culturally responsive practices into the classroom and integrating them within the broader school structure for culturally and linguistically diverse students. However, it should be noted that these practices are only effective when race and power are explicitly addressed (Howard, 2010), allowing refugee and immigrant youth, and all students to benefit. In turn,

student achievement often improves, and school outcomes and intergroup relations improve (Zirkel, 2008).

An example of how schools can explicitly address diversity and power begins with the school personnel (Anyon, 2014; Howard, 2010). Time must be set aside for teachers to engage in open and honest discussions in which the structural inequalities are openly examined and a plan is put into place on why, when, and how the extant disparities will be addressed. If staff members are not on board, it is difficult to for a school system to move forward with addressing issues of equity and power, especially if teachers and staff do not recognize and understand the issues themselves first.

English Language Learner (ELL) Programs

Helping students function in the language of the dominant culture becomes critical to successful adjustment and long term success. In terms of language acquisition, most school districts establish English language learner (ELL) programs. Most often these programs are set up for ELL students to receive mainstream instruction, including reading, writing, and math, and then also pullout classes to receive English language instruction and support (Gunderson, Murphy, & D'Silva, 2013). However, current research shows that inclusive practices may be the optimal approach for ELL and refugee and immigrant students (Brice, Miller, & Brice, 2006).

Theoharis and O'Toole (2011) recommend that the focus should not be on pullout but instead on reducing class size so that more attention can be made on community building and proving ELL instruction in classrooms through a co-teaching approach between classroom and ELL teacher. As a result, language acquisition would occur more naturally and generalize to the environment thereby increasing academic achievement and home-school connections with ELL families. Although there are significant advantages of having smaller class sizes, there are

economic realities that often prevent this from happening. If smaller class sizes are ever possible, it will take policy and funding that enables smaller class sizes in schools that serve high proportions of ELL students. When considering the full range of needs of refugee and immigrant children, it is clear that multicultural education must go beyond just ELL support, and for teachers to be aware of these culturally responsive practices, including multicultural teaching practices and inclusion and transferring and culturally adapting EBPs to fit the populations and fit real world settings; this is key to ensure that vulnerable populations of children, such as refugee and immigrant children, receive the high quality services possible. However, while these are ample resources around EBPs and what works best, these are not always getting implemented in schools.

Implementation Science

There is currently an "implementation gap" in education that refers to the chasm between what practices research has shown to be effective and the practices that are actually implemented in schools (Evans & Weist, 2004; Rones & Hoagwood, 2000; Wilson, Floden, & Ferrini-Mundy, 2001). Data indicates that EBPs improve outcomes, especially for children at risk, but research demonstrates that they are not being fully utilized in schools (Durlak & DuPre, 2008). Despite the push for EBPs and mental health services through frameworks such as MTSS, research indicates that the programs and practices implemented in schools are not typically based on scientific evidence (Evans & Weist, 2004).

Given the limited number of EBPs in schools, a field of implementation science has begun to emerge to help bring interventions into practice. The term implementation is defined as the deliberate use of strategies to introduce or adapt EBPs within real-world settings (Mitchell, 2011). Implementation science is defined as the scientific study of the uptake and transfer of

EBPs into professional practice and public policy, the primary objective behind their establishment (Eccles & Mittman, 2006). The implementation science literature has grown exponentially over the past decade and researchers have learned about the factors that serve as barriers or facilitators to the adoption and use of innovative practices new to a school system. There are significant barriers present within many school systems that interfere with the organization and implementation of mental health-related EBPs, preventing effective outcomes (Forman et al., 2013).

To establish an understanding of the factors influencing the adoption and use of EBPs, an organizational framework (i.e., MTSS) is needed to understand the individual and contextual factors associated with accurately and consistently implementing EBPs and mental health services. Aarons, Hurlburt, and Horwitz (2011) developed a four-phase framework that provides a way of better understanding the challenges and ingredients to successfully implementing EBPs. First is the exploration phase, which pinpoints awareness of either an issue that warrants attention or an improved approach to an organizational challenge. Next is the preparation phase, followed by the active implementation phase, and finally, the sustainment phase. However, the exploration phase is first in line before implementation occurs, focusing on attitudes and beliefs of individuals within the system, as they are critical if EBPs and mental health services can be explored and implemented with integrity. By identifying the problem and coming to the realization that change is possible over time, EBPs can be implemented and sustained, especially for at-risk populations, including refugee and immigrant children (Aarons et al., Horwitz, 2011).

Cultural Adaptations and Implementation Science

Using cultural adaptations and bridging them with implementation science can increase attention to culture, particularly at the individual and implementer levels. This way, EBPs can

become more responsive to the needs and preferences of diverse populations, such as refugee and immigrant students (Cabassa & Baumann, 2013). Implementation science is defined as "the scientific study of methods to promote the integration of research findings and evidence-based interventions into health care policy and practice" (Cabassa & Baumann, 2013, p.3). This is the goal, as it is imprudent to have EBPs but not utilize them in settings such as clinics and schools, wherein children and adolescents, such as refugees and immigrants, can benefit from them.

There needs to be a dialogue between the field of cultural adaptations and implementation science, with cultural adaptations providing support on what is and is not appropriate to adapt and how to go through the process. Implementation science provides an examination of how contextual factors impact how treatments (adapted or not) are utilized and sustained in usual care settings, such as schools, to increase the use and upkeep of EBPs (Cabassa & Baumann, 2013).

Treatment fidelity, or the application of an intervention as it is designed, is a critical issue for the successful implementation of EBPs (Harn, Parisi, & Stoolmiller, 2014), and this is a crucial concern when adapting instruments, as they can be adapted to the point that they are no longer measuring what they say they are measuring. To combat this, one approach, as mentioned above, is to consider the core functional elements and forms of treatments, while also actively reflecting on how cultural, social, psychological, environmental, and historical factors influence behaviors differently across refugee and immigrant populations (Cabassa & Baumann, 2013; Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999).

In addition, Cabassa and Baumann (2013) propose using an ecological validity model that looks at eight domains (language, persons, metaphors, content, concepts, goals, methods, and context) that an implementer should consider to enhance the cultural congruence between

participants and the intervention (Bernal, Bonilla, & Bellido, 1995). Lastly, organizational contexts need to be taken into consideration, such as resource availability, provider training, and environment culture, to fit the EBP to the practice setting (Aarons & Palinkas, 2007). This is especially true in school settings.

Schools are ideal settings for screening and identifying children and adolescents who may have been exposed to traumatic events or at-risk for developing mental health problems. If set up effectively, schools can provide evidence-based mental health services, such as social emotional learning (SEL) curriculum, PBIS as preventive supports, or TF-CBT and CBITS, to students affected by childhood PTSD-like symptoms and co-occurring mental health and behavioral problems (Fitzgerald & Cohen, 2012). In schools, universal practices such as the SEL curriculum and PBIS align well with the intricacies of the educational environment, as the SEL curriculum is an instructional tool that provides prevention for internalizing concerns (Caldarella, Christensen, Kramer, & Kronmiller, 2009) and PBIS works as a school-wide, prevention framework to enhance positive behavior, by decreasing negative behaviors of students and staff (Bradshaw, Mitchell, & Leaf, 2010; Bradshaw, Reinke, Brown, Bevans, & Leaf, 2008; Killu, Weber, Derby, & Barretto, 2006). Some students, especially refugees and immigrants, might not otherwise receive needed preventative or treatment services if they must navigate complex systems on their own to pursue services.

Cross-Cultural Psychology

In order to effectively transfer and culturally adapt current EBPs into classrooms and schools, cross-cultural psychology provides a useful framework to integrate these practices into real world settings in which children naturally exist, such as schools. Cross-cultural psychology states that humans are part of the natural world and part of the cultural world, placing culture as

one of the most significant influences on the lives and functioning of all people, including refugee and immigrant populations. Cross-cultural psychology focuses on addressing the following questions: What is culture; where is culture, and how can it be accessed? (Berry, 2009). It is important for educators as well as mental health providers to have self-reflection around these questions to best support refugee and immigrant children and families, and all students.

Within the acculturation process, it is important for refugee and immigrant youth to build their cultural identity, a strong, bicultural identity to serve as a buffer against acculturative stress and some of the negative mental health outcomes that may accompany it (Rogers-Sirin et al., 2014). Cultural identity consists of the attitudes, feelings, and perceptions about the degree of affiliation and belongingness towards one's cultural group (Berry, Kim, Power, Young, & Bujaki, 1989; Samnani, Boekhorst, & Harrison, 2013). Supporting students to acquire robust cultural identities is often not a part of EBPs, but is a necessary component to effective multicultural education and mental health intervention.

Given that immigrant families represent a wide variety of socioeconomic, cultural, and linguistic backgrounds and often face multiple challenges attempting to navigate the educational system (Rogers-Sirin et al., 2014), bringing EBPs and mental health services into schools and into classrooms are also critical, especially since most youth may not access any support or services otherwise. There is a need to integrate EBPs but ensure that they are delivered within culturally responsive environments in which the educators possess some degree of cultural competence. In addition, adaptations are needed when utilizing EBPs with diverse populations, such as refugee and immigrant populations. These are needed to facilitate the effective deployment of EBPs for these populations.

While there are recommended approaches on how to incorporate mental health services (Sfeir-Younis, 1995; Banks, 1995, 2004), how best to serve a racially and ethnically diverse student body continues to be an ongoing debate and has been for more than a century (Zirkel, 2004). Schools are complex social environments with a plethora of barriers, such as time, schedules, and academic goals and expectations, among many others. These obstacles go beyond schools, since there are constant tensions and conflicts among competing viewpoints around values, programs, and practices around ethnic, racial, social, cultural, and linguistic diversity in teacher education programs, especially in multicultural education (Gay, 2005). Not all preparation programs have ample courses on culturally responsive practices, and thus, teachers are not sure what to do when they enter school doors.

Preparation Programs

While not all teacher preparation programs have requirements for multicultural education courses, some advocate that is should be a mandatory requirement (Gay & Kirkland, 2003). Teachers play a vital role in deciding how to utilize educational theories to form appropriate educational experiences for students. This can be achieved through planning curricular content, selecting classroom materials, delivering effective differentiated instruction, and collaborating with caregivers to establish a school-home partnership; each of these represent opportunities to effectively integrate multicultural education practices (Gallivan, 1998). Bringing more multicultural courses and requirements into preparation programs would allow teachers to have conversations around racism and issues of power, how to appreciate cultural differences, and reflection in personal beliefs and classroom practices (Gay & Kirkland, 2003).

Outside the class setting, multicultural competence training for students in counseling and counseling psychology programs has become a requirement (Ramsey, 2000). Current research

demonstrates that between 42% to 59% of counselor preparation programs require at least one multicultural counseling course, 89% of counseling psychology doctoral programs require a course on multiculturalism, and most counseling programs have one or more electives in the area of multicultural education and counseling (Quintana & Bernal, 1995; Ramsey, 2000). In addition, professional development should highlight the worldview of the client, from the perspective of being a refugee and immigrant in the United States (Villalba, 2009). Despite the requirements for this training, there is limited research examining whether this training actually results in counselors being more culturally competent and effectively adapting practices in a culturally responsive way to facilitate access and effectiveness of mental health-related services. This is critical, because as of right now, there is a gap on the number of EBPs being accessed in and outside schools, and also in therapy environments. However, to date, there is limited research examining teachers' preparation to effectively teach and meet the needs of refugee and immigrant children. Similar trends are seen in psychotherapy.

Gaps in Research and Practice

The dropout rate for psychotherapy is between 20 to 80%, with many families receiving less than half of the prescribed intervention (Armbruster and Kazdin 1994; Gomby 2000; Ingoldsby, 2010; Masi, Miller, & Olson, 2003). While there are no current statistics of drop-out rates for refugee and immigrant populations, those families with greater risk are more likely to drop out of treatment (Ingoldsby, 2010; Snell-Johns, Mendez, & Smith, 2004). Factors such as single-parent status, socioeconomic disadvantage, parent psychopathology, ethnic minority status, and low-income and poverty status show lower rates of engagement in clinical services; refugee and immigrant children are included in this statistic (Ingoldsby, 2012; Nock and Ferriter 2005; Snell-Johns et al., 2004). Time demands and scheduling conflicts, high costs of living, and

lack of transportation, and childcare needs exacerbate the problem further (Garvey, Julion, Fogg, Kratovil, & Gross, 2006).

One reason for drop-out is the mismatch between cultural adaptations and family needs (Cabassa & Baumann, 2013), and while there are some guidelines and steps, knowing where to start and what exactly to adapt in each instrument or program is not an easy task. The research states that in order to fix this problem, the focus must be on treatment relevance and acceptability, cognitions and beliefs about treatment, a plan to combat daily stresses and external barriers to treatment, and therapeutic alliance (Ingoldsby, 2010). Thus, before implementation science and cultural adaptations are taken into consideration for refugee and immigrant children, work must be done on the front end to ensure that attitudes and beliefs of implementers, such as teachers, are appropriate and ready for implementation of culturally-adapted EBPs, especially to this at-risk population.

While research shows that mental health services and multicultural education in schools is key, there is limited research around how best to frame these into appropriate interventions and EBPs for refugee and immigrant children and families, as the research around EBPs for this population is scarce. Presently, more research is needed on immigrant populations to begin to understand their mental health and multicultural needs (Rogers-Sirin et al., 2014). There is a large amount of opinion and speculation with little substance that can be used to effectively guide policy or program development (Berry, 2009). In the absence of very clear policy and practice guidelines, knowing specifically how to start and what to implement can be confusing for teachers and mental health providers.

Gaps in Practice

There are significant barriers for teachers in practice. Research reveals that there are also

major barriers for teachers in the field in terms of multicultural education (Tarman & Tarman, 2011). For example, some of the teacher-level barriers include: (1) Not understanding multicultural education, (2) Not knowing how to best utilize effective multicultural education practices in schools, (3) Not being motivated to learn about effective multicultural education practices, (4) Being resistant to learn effective multicultural education practices, and (5) Not realizing and taking self responsibilities as educators for using effective multicultural education practices (Gallivan, 1998). Beliefs and attitudes around multicultural education and culturally responsive EBPs are low, and it is well known that educators' beliefs can have a significant impact on the mental health well-being of refugee and immigrant children and adolescents (Rogers-Sirin et al., 2014).

Implementation science can aid schools in planning for the adoption and use of EBPs or other innovative practices within an MTSS framework that target promoting the well-being and success of refugee and immigrant children. Although most research provides a framework for screening and providing mental health services and EBPs through MTSS, there continues to be limited research on where to start in terms of providing these interventions for students in school settings, especially for refugee and immigrant children (Fazel et al., 2005). Few programs have been evaluated in the school-based settings (Hoagwood & Erwin, 1997), and there are even significantly fewer resources that are deemed effective for immigrant or refugee children (O'Shea, Hodes, Down, & Bramley, 2000; Rousseau et al., 2007; Stein et al., 2002).

Before implementation science helps ensure the adoption and use of EBPs, educators must acquire cultural competence, including empathy, seeking to understand, and being open to one's implicit biases. Self-reflection for teachers is critical in better understanding themselves to then have the ability to be open to the stories of students (Strekalova & Hoot, 2008). When

working with refugee and immigrant populations, Feuerverger (2011) recommends listening to the voices of children and adolescents, as hearing their stories can be powerful in better understanding them (Roberts & Locke, 2011). Coupled with the attainment of background and cultural information through a multifaceted and multicultural lens, shared goals are devised.

Teachers, staff, and educators must sometimes re-examine their own internal biases around working with refugee and immigrant children. As Hickey (2012) put it, teachers must sometimes unlearn what they thought they knew and work towards re-learning what it means to teach these populations in practice. Rather than seeking solutions for specific students, it is recommended that school teams first ask questions to better understand the needs and prepare to implement supports in a culturally-sensitive manner (Morales & Norcross, 2010). As a result, implementer beliefs and attitudes are pivotal to target the unique needs of refugee and immigrant children.

Belief Impact on Specific Populations

People's beliefs perspectives about diverse refugee and immigrant groups are varied, particularly among service providers who are responsible for reaching out to and providing care for groups in need. Beliefs appear to be most negative towards Mexican immigrants followed by Dominicans, Cubans, and Puerto Ricans. Correspondingly, research demonstrates that prevalence rates of depression are highest for Mexican and Puerto Rican populations than Cubans (Organista et al., 2002). Additional research studies have yielded findings that indicate an increased risk for depression among Latino immigrants who have experienced discrimination (Gee, Ryan, Laflamme, & Holt, 2006).

Less research has been done about attitudes toward African immigrants because ethnicity and race are generally seen as one in the United States. Since African immigrants are viewed as

"Black" in mainstream U.S. culture, this racial identification is more prone to discrimination and prejudice than due to country (or island nation) of origin (Organista et al., 2002). African refugees and immigrants experience institutional barriers (Rogers-Sirin et al., 2014). The effects of racism against Black Americans are associated with increased likelihood for depression, suicidality, anxiety, and PTSD-like symptoms and disorders (Grimmett, Locke, Ellis, & Carlson, 2009; Utsey & Constantine, 2008).

Asian immigrants are another group that struggle with stereotypes and discrimination, but unlike Hispanic and African refugees and immigrants, this population is often viewed as the "model minority." This perspective puts a different type of pressure on these students, including high expectations in terms of academic achievement, behavior, high IQ, and faster language acquisition (Singh, 2009; Sue & Sue, 2003). However, motivational factors and coping strategies help to alleviate acculturative stress and can help all refugee and immigrant children, regardless of race or country of origin (Kosic, 2004). As can be seen, beliefs and attitudes can have a huge toll on the mental health of individuals. As a result, when looking at appropriate EBPs to help aid refugee and immigrant populations, implementer attitudes and beliefs are highly critical in order to create positive outcomes.

Attitudes and beliefs are not just felt by refugee and immigrant students as they enter schools, but they are also present as soon as refugee and immigrant populations enter U.S. soil. As mentioned previously, the viewpoints espoused by individuals within the mainstream culture can be negative (i.e., beliefs that refugees and immigrants will work for lower wages, undocumented immigrants are using services and benefits that they do not deserve, etc.), exacerbating acculturative and other sources of stress that impact a person's mental health status. Ultimately, refugees and immigrants can experience discrimination, stereotypes, and prejudice

due to racism, power struggles, anti-immigrant attitudes (especially refugees and immigrants who do not hold legal status), or a combination (Rogers-Sirin et al., 2014). Just like attitudes of those in power have a weight in society, they also determine treatment for students.

A good example of beliefs is that of the healthcare industry, as EBPs by health professionals are essential for not just improving the quality of health care and patient outcomes, but also with increasing professional role satisfaction. However, even with this in mind, only a small percentage of nurses and other health care professionals are consistently using this approach in their day-to-day practice (Melnyk et al., 2008). This is one of the reasons that it takes an about 17 years to translate research findings into clinical practice and positively impact clients' outcomes (Balas & Boren 2000). Overall, the strength of beliefs in EBPs is essential to their implementation (Melnyk et al., 2008).

Teacher Beliefs and Attitudes

Treatment adoption and implementation is dependent on several factors, including attitudes and beliefs of practitioners, characteristics of client populations (in this case, refugee and immigrant populations), characteristics of usual practice, organizational factors, and resource availability (Mitchell, 2011). The question lies in how practitioners (in this case, implementers) perceive EBP treatment, specifically for refugee and immigrant populations. In essence, attitudes are crucial to successful EBP implementation (Aarons & Palinkas, 2007).

Once students enter schools, beliefs and attitudes continue to have a big weight on their mental health, as teachers decide what is implemented and how it is done. Educators must be aware of their own implicit biases and prejudicial beliefs toward refugee and immigrant children and adolescents, as these attitudes impact their well-being and academic success. Murray and Marx (2013) investigated this notion, showing support that these threats do indeed exist. The

authors examined young adults' views on authorized versus unauthorized immigrants and refugees. Study participants reported more prejudicial attitudes, much greater perceived realistic threats, and greater intergroup anxiety when responding to questions about unauthorized compared with authorized immigrants. Perceived realistic threat, symbolic threat, and intergroup anxiety were significant predictors of these prejudicial attitudes.

An essential aspect of implementing EBPs into schools is the idea that teachers and staff must be ready and on-board; this requires that work must be done on the front-end (Ikeda, Rahn-Blakeslee, Nieblina, Allison, & Stumme, 2006). This is especially true with refugee and immigrant children and adolescents, a population with unique needs and supports that are currently not being served with optimal mental health services (Ruiz et al., 2011). As teachers' are the main implementers of EBPs and have a significant impact on students, teacher self-efficacy has been shown to be a crucial element determining whether teachers actually promote desired outcomes for students. Teachers who have high self-efficacy are more likely to exhibit positive practices and enhance the intrinsic motivation of their students (Guo, Connor, Yang, Roehrig, & Morrison, 2012; Skaalvik, & Skaalvik, 2007)

Before an MTSS framework can be effective for refugee and immigrant children, research demonstrates that the beliefs and attitudes of implementers (in this case, classroom teachers) play a significant role in determining whether mental health-related EBPs are likely to be effective for refugee and immigrant populations and if practices will be adapted and used with integrity (Nelson & Steele, 2007). Individual belief barriers have proven time and time again to prevent the implementation of appropriate interventions. There is a direct link between implementer beliefs and attitudes and implementation of mental health and EBP services for students, especially those with specific needs, such as refugee and immigrant children (Aarons &

Palinkas, 2007; Grol & Grimshaw, 2003; Haney, Czerniak, & Lumpe, 1996). However, there has been limited attention spent on educators' beliefs and attitudes as they relate to serving refugee and immigrant children specifically.

In school settings, teachers are the main implementers when it comes to interventions for at-risk or students in need, due to the day-to-day interactions that they have with students in and outside of classrooms (Han & Weiss 2005). Teacher beliefs and attitudes are critical in being at the forefront before implementation of EBPs and mental health can begin in schools (Pajares, 1992), as they are in a position to decide whether an EBP is adopted, implemented with fidelity, and sustained over time success (Battistich, Schaps, Wilson, 2004; Dusenbury, Brannigan, Hansen, Walsh, & Falco, 2003).

Taking this into consideration, teacher attitudes and beliefs are key as teachers are at the forefront when refugee and immigrant parents and families walk into classrooms. It is believed that the beliefs and attitudes of teachers are a prerequisite for appropriate change and adaptation in practices to occur (Guskey, 1986). Teachers determine whether effective practices are used, something that is critical for refugee and immigrant children (Pajares, 1992). Research demonstrates that teachers' beliefs toward mental health services and EBPs are directly correlated to their use and uptake (Bowden, Lanning, Pippin, & Tanner, 2003; Gingiss, Gottlieb, & Brink, 1994; Parcel, O'Hara-Tompkins, Harrist, & Basen-Engquist, 1995). It is critical that teachers understand and know how to utilize appropriate SEB supports and interventions. However, the research around how best to serve refugee and immigrant students is extremely scarce and limited, and there is currently a gap in the research literature regarding where to start. Thus, starting with teacher beliefs around the needs of refugee and immigrant students is essential.

It is critical to understand that racial, ethnic, and cultural attitudes and beliefs are always present, are often problematic, and significantly shape teaching conceptions and actions. This is important for all students, but perhaps more important when considering those who serve refugee and immigrant students. As they are at the forefront to have the first experience in school settings, since families may not be able to convey an understanding of schools to their children. When distorted beliefs and attitudes are present in classrooms, they interfere with the delivery of effective supports that are delivered in a culturally competent manner. However, most teachers are unaware of their power, belief systems and the importance of them in the classroom (Gay, 2010). While there has been research around the beliefs, attitudes, and perceptions of practicing teachers toward students of color, there is almost none that specifically looks at beliefs and attitudes towards refugee and immigrant students (Gay, 2010). Future research should explore specific ways of working with educators to adopt culturally responsive beliefs and attitudes towards these students and their families. Such research will advance multicultural education research in meaningful ways.

Purpose of this Dissertation

Overall implementers, such as teachers, hold beliefs, attitudes, and preparation that are critical in the adoption and upkeep of culturally, responsive EBPs to effectively address the mental health needs of students (Aarons & Palinkas, 2007; Grol & Grimshaw, 2003; Haney et al., 1996). Given that teachers spend a large majority of time with students and are frontline providers of services, they represent important sources for conducting research in order to uncover specific findings that inform the development of approaches that effectively support teachers to serve refugee and immigrant students. Currently, there is a gap in the extant research base regarding teachers' beliefs, attitudes, and competence in working with refugee and

immigrant students. This gap is notable considering the number of refugee and immigrant students being educated in American schools each year.

The purpose of this dissertation study was to conduct a survey study with elementary school teachers in a large urban school district to examine their beliefs and attitudes about various factors associated with teaching refugee and immigrant children that have been linked to promoting positive student outcomes. Specifically, the survey was designed to assess teachers' perceptions of self-efficacy, attitudes toward implementing innovative, effective practices (i.e., EBPs), perceptions of their own cultural competence, prior preparation and overall competency, and beliefs regarding the needs of refugee and immigrant students. Focusing on teacher beliefs and attitudes represents an important starting point for research to better understand how to support teachers in delivering high quality (e.g., increasing their self-efficacy or improving beliefs towards adopting EBPs), cultural responsive practices for refugee and immigrant students. Given that schools are the optimal setting for the delivery of EBPs, teachers are central to transferring what works from research to the school setting in order to ensure that refugee and immigrant children have access to high quality services that address their underlying needs. The main research question that guided this dissertation study was:

1. What are the beliefs and attitudes of teachers in teaching refugee and immigrant students in terms of their social/emotional/behavioral and mental health needs?

To answer the main research question, the following sub-questions regarding teachers' beliefs and attitudes were addressed:

1. To what extent do teachers believe they are capable of producing positive outcomes for refugee and immigrant students (i.e., self-efficacy)?

2. To what extent do teachers report favorable attitudes towards implementing innovative, effective practices (i.e., EBPs) for refugee and immigrant students?
3. To what extent do teachers perceive they possess adequate cultural competency in serving refugee and immigrant students?
4. To what extent do teachers believe they are sufficiently prepared and competent to teach refugee and immigrant students?
5. To what extent do teachers perceive refugee and immigrant students have notable needs that should be addressed in schools?
6. To what extent do teachers' ratings across the different constructs assessed in the survey correlate to one another?
7. To what extent do teachers' ratings of their self-efficacy, cultural competency, and adequacy of preparation predict their willingness to implement innovative practices for refugee and immigrant children after controlling for demographic variables?
8. To what extent do teachers' demographics and their ratings of cultural competency and adequacy of preparation predict self-efficacy, attitudes towards implementing new and effective practices, and perceived student needs for refugee and immigrant children?

As discussed above in the literature review, there are a variety of limitations (e.g., beliefs, inadequate training, etc.) that are likely to undermine teachers' ability to effectively meet the needs of refugee and immigrant students. As a result, it was hypothesized that teachers on average would report low levels of self-efficacy as it relates to teaching refugee and immigrant children. In addition, attitudes toward implementing EBPs and perceptions regarding cultural competency were anticipated to be low due to limited insufficient preparation and training in

working with these diverse populations. Preparation was expected to produce mixed responses, as pre-service preparation would differ depending on university training location and professional development opportunities. Next, it was hypothesized that teachers would perceive refugee and immigrant students to have high needs, given the issues surrounding their acculturation experiences. Lastly, examining relationships across categories, it was anticipated that there would be a positive correlation between perception of preparation and cultural competency and self-efficacy and implementation of innovative practices.

CHAPTER 3

METHODOLOGY

Setting

The sample used for this dissertation study was elementary-level general education teachers from a large, urban district in the Pacific Northwest region of the U.S. This school system serves a diverse student body of roughly 30,000 students from kindergarten through 12th grade. With regard to ethnicity, students are 1.3% American Indian/Alaska Native, 9.9% Asian, 1.8% Hawaiian/Pacific Islander, 17.6% Black/African American, 13.9% Hispanic/Latino, 47.4% White/Caucasian, and 8.1% Multiracial. 61.1%, (nearly 18,000) students receive free or reduced priced lunch. Although there is no specific data on the number of refugee and immigrant students, it is estimated that 7.6%, or about 2,200 students are transitional bilingual. Of these students it is believed that roughly 1,000 students are refugees or immigrants according to statistics provides by central administration staff. Special education rates are roughly 12.4%, or around 3,500 students, and it should be noted that there is a history of disproportionately of minority students in special education; with some students being educated outside of their neighborhood schools and instead in self-contained classrooms. All of the above statistics are based off of the 2013-2014 academic year.

Sample of teachers. At the time of this study, there were roughly 2,000 teachers in the district, with a large percentage of teachers working in elementary schools. Six hundred and twenty one of the teachers possessed general education certification and worked at the elementary level. The sample of participants was recruited through a district listserv that was compiled by central administration staff using a database of all elementary general education teachers (Dillman, Smyth, & Christian, 2009; Kalton, 1983). From this listserv, a convenience

sampling approach was utilized to attain the maximum number of respondents as possible to answer the foregoing research questions guiding this dissertation study.

A total of one hundred and thirty nine teachers responded to the survey and completed it in its entirety (see Table 1 for the demographic and background information). Years of teaching experience indicated that more than half the sample, 64.7%, had 11+ years of experience. Contrarily, years of teaching refugee and immigrant students were more split, with a big portion of teachers having experience for 0-2 years (29.5%) and 11+ years (37.4%). One hundred and twenty seven of the participants, or 91.4%, were female, and 12 participants, or 8.6%, were male.

The majority of teachers were white/Caucasian (81.3%). One hundred and thirty five of the participants, or 97.1%, self-identified as Non-Hispanic/Latino, and four participants, or 2.9%, self-identified as Hispanic/Latino. These same statistics were seen for teacher immigration status; 135 teachers (97.1%) identified as not being an immigrant and four teachers (2.9%) identified as being an immigrant.

Procedure

This dissertation used a cross-sectional survey design to assess teachers' perceptions about serving refugee and immigrant children. Approval from the University of Washington Institutional Review Board (UW IRB) was obtained before the dissemination of the survey, receiving exempt status, with a determination period from 03/27/2015 to 03/26/2020. Before sending out emails with links to the web-based survey, central administrators from the school district were contacted to determine the appropriate procedures/rules for sending out the survey and obtaining consent. The district research review committee reviewed the proposal on 03/26/2015, requesting that the information be shared with all elementary school principals before dissemination. Principals were informed on 04/13/2015, and none of them chose to opt

out of the study.

To protect the research participants, all survey information was confidential, and no identifiable information was collected and recorded (i.e., respondent name, school placement, etc.). After approval was obtained from both the school district and UW IRB, an email was sent to the teachers indicating that they had been selected to participate in a survey, with a link to the survey and instructions on how to complete it. In order to provide teachers with ample time to complete the survey and minimize any amount of undue burden on them, they were provided with a window of time (two weeks) to complete it and be informed that all participation was completely voluntary.

Survey research methods were employed to gather data from teachers. Specifically, a survey was designed to gather self-report data from respondents about their perceptions about particular phenomena of interest (e.g., serving refugee and immigrant children). Dillman et al. (2009) reports that survey research methods are more feasible than other approaches to gather data from a relatively large number of respondents, which was one of the main goals of this study. The survey research methods were used to pinpoint important findings that could serve as the stepping-stone for future research, as it is often informs the design and testing of interventions.

One of the advantages of a web-based survey that enables anonymity for respondents is that it helps reduce social desirability, as there is no interviewer that may put pressure on respondents to provide certain answers (Dillman et al., 2009). Moreover, the survey approach allowed the research to access a wider range of respondents, increasing the probability that there a more representative sample would be obtained in order to generalize results to school districts

with similar demographics. With a web-based survey, respondents may also be less prone to acquiescence and more likely to answer questions honestly.

Centralized administrative staff helped facilitate the distribution of the web-based survey and deliver incentives for respondents who completed the survey. Emails to the web-based survey were sent in four waves. Two days before the initial survey email, a pre-notice email was sent out on 04/27/2015, informing respondents that a questionnaire was coming (see Appendix B). In Wave 2, on 04/29/2015, the survey was sent with a detailed informed consent and a link to the web-based survey, including an opportunity to receive an incentive via a raffle for completion of the survey (see Appendix C). One week after Wave 2, Wave 3 consisted of a thank-you email sent to express appreciation for responding and express hope the survey would be completed if it had not yet been completed; this last email was sent on 05/06/2015 (see Appendix D). The survey closed on 05/13/2015, giving respondents two weeks to complete it.

Although a low response rate of 22.4% was secured, it was consistent with prior survey research with teachers (Cook, Heath, & Russell, 2000). Moreover, a sufficient sample size was obtained to perform statistical analyses with adequate power to detect mild to moderate effects. SurveyMonkey.com was utilized to create a user-friendly survey that could be readily accessed by participants by clicking on a link provided in the survey email. SurveyMonkey is an online application that allows survey designers to create and upload their survey online and collect data for analysis and interpretation. It is important to that since low incentives were provided, results are generalizable to teachers who are likely to respond to web-based surveys with minimal incentive.

Measures

In total, the survey instrument included 31 close-ended items assessing five different

conceptual categories: Category 1: seven items assessing self-efficacy, Category 2: seven items assessing attitudes towards implementing practices; Category 3: six items assessing cultural competency; Category 4: five items assessing competency/preparation; and Category 5: six items assessing student needs. Each of these categories used a 4-point Likert scale. Categories 1-4 (self-efficacy, implementing practices, competency/preparation, and cultural competency) included the following scaling format: "Not at All True," "Barely True" "Moderately True," and "Exactly True." The student needs category, included the following agree-disagree statements: "Not at All," "Slightly Agree," "Moderately Agree," and "Greatly Agree." These statements mirrored the original statements used on the existing scales. A 4-point scale has been shown to gather data with sufficient variability between respondents and is likely to decrease neutral responses and reduce satisficing (Alwin, 1997; Dillman et al., 2009). Definitions were provided for specific terms used throughout the survey to ensure that respondents fully understood what each question was asking. Four background questions were also included at the beginning of the survey and three demographic questions at the end of the survey. For the self-efficacy, implementation of practices, and cultural competence categories, the words "refugee and immigrant students" were added to each statement.

Conceptual Categories. The survey instrument was a web-based questionnaire that included multiple items assessing different categories of teachers' perceptions about their work with refugee and immigrant children. These five categories included self-efficacy, implementation of practices, cultural competence, competency/preparation, and student needs. The competency/preparation and student needs categories are research-constructed items developed for the purposes of this study. It should be noted that Cronbach's alpha was greater than 0.75 for all metrical scales.

The Teacher Self-Efficacy Scale (Schwarzer, Schmitz, & Daytner, 1999) was used and adapted around self-efficacy for the purposes of this questionnaire, and seven out of the original 10 statements were included. Cronbach's alpha for this scale was 0.91. Similarly, the "Evidence-Based Practice Attitude Scale" (Aarons, 2014) was adapted around implementing practices for the purposes of this questionnaire, and seven out of the original 15 statements were included. The purpose of including these items was to assess openness and willingness to implement new and effective practices as they emerge or as a person is exposed to them via training. Cronbach's alpha was 0.90 for this scale.

Items from the Multicultural Competencies Survey (Vassallo, 2012) were used and adapted to assess cultural competency. A total of six out of 63 items that assess different aspects of cultural competency were included in the survey, including awareness, knowledge, attitude, and skills. Only six items were includes in order to avoid cognitive overloading during the survey. The items included comprehensively encompassed to get an overall picture of cultural competency. Cronbach's alpha for this scale was 0.77. Finally, the competency/preparation and student needs scales were made up, as there are no existing scales to measure these two outcomes; competency/preparation included five items and student needs consisted of six items. As Cronbach's alpha was 0.79 and 0.85 respectively, this indicates that the items in each scale were similar and measuring the same construct.

The resources needed to complete this study included access to a laptop or desktop computer. Teachers in the district already had access to laptops or computers in their classrooms/offices and were required to have email as part of district policy. A web link was created that connected respondents to the survey via a recruitment email.

To ensure that the survey was designed in accordance with established guidelines

(viewed as appropriate and understandable by the target respondents), the survey was piloted with a group of teachers before administering the survey to receive feedback and make needed revisions to the instructions and wording of the items. Essential changes were made before submitting the survey instrument for final IRB approval. The survey items themselves were evaluated with regard to their wording and terminology to maximize comprehension and ensure professional language.

Definitions. Self-efficacy was defined as beliefs about how confident general education teachers feel in working with refugee and immigrant students. Implementing practices consisted of attitudes teachers have towards implementing new/effective practices for refugee and immigrant students. Cultural competency refered to beliefs about teachers' own cultural competency in working with refugee and immigrant students. Competency/preparation was beliefs about how sufficiently prepared and competent teachers feel in working with refugee and immigrant students. Lastly, student needs were defined as teacher perceptions of the needs of refugee and immigrant students. See Appendix D for the questionnaire itself, including background information, survey items and demographic information (please note that this is an example and looked visually different on SurveyMonkey).

Data Analytic Plan

Background questions, belief survey items, and demographic information were included in the survey to address the proposed research questions guiding this study and examine differences based on gender, years of teaching experience, ethnicity, and race. Below are the quantitative analyses employed to address each of the proposed research questions.

Proposed Quantitative Analysis

Descriptive and inferential statistics will be utilized to answer the overarching question:

1. What are the beliefs and attitudes of teachers in teaching refugee and immigrant students in terms of their social/emotional/behavioral and mental health needs?

As mentioned above, this question was broken up into the following research questions:

1. To what extent do teachers believe they are capable of producing positive outcomes for refugee and immigrant students (i.e., self-efficacy)?
2. To what extent do teachers report favorable attitudes towards implementing innovative, effective practices (i.e., EBPs) for refugee and immigrant students?
3. To what extent do teachers perceive they possess adequate cultural competency in serving refugee and immigrant students?
4. To what extent do teachers believe they are sufficiently prepared and competent to teach refugee and immigrant students?
5. To what extent do teachers perceive refugee and immigrant students have notable needs that should be addressed in schools?
6. To what extent do teachers' ratings across the different constructs assessed in the survey correlate to one another?
7. To what extent do teachers' ratings of their self-efficacy, cultural competency, and adequacy of preparation predict their willingness to implement innovative practices for refugee and immigrant children after controlling for demographic variables?
8. To what extent do teachers' demographics and their ratings of cultural competency and adequacy of preparation predict self-efficacy, attitudes towards implementing new and effective practices, and perceived student needs for refugee and immigrant children?

Research Question 1 focused on obtaining ratings from teachers regarding their confidence in effectively teaching and meeting the needs of refugee and immigrant children. To answer this research question, a combination of descriptive and inferential statistics were employed. The descriptive statistics consisted of measures of central tendency (mean and median), variability (range, standard deviation, or SD), and proportion of responses, and the descriptive statistics enabled an examination of the average and range of teachers' self-efficacy as it related to serving refugee and immigrant children. Inferential statistics included correlations and a multiple regression was performed to examine certain variables associated with greater self-efficacy. A multiple regression with sequential predictor entry was performed that included an aggregated variable capturing the amount of self-efficacy as the criterion variable and gender, race, ethnicity, and years of experience as predictor variables. This analysis enabled an examination of the relative predictive ability of the predictor variables and identification of the strongest predictors of teachers' self-efficacy as it related to serving refugee and immigrant children.

Research Question 2 focused on examining the degree to which teachers possessed favorable attitudes towards implementing evidence-based practices for refugee and immigrant students. To answer this research question, similar to the first question, a combination of descriptive and inferential statistics was used. The descriptive statistics consisted of measures of central tendency (mean and median), variability (range, SD), and proportion of responses, and the descriptive statistics enabled an examination of the average use of practices. Inferential statistics including correlations and a multiple regression analysis with sequential predictor entry was performed to examine certain predictor variables (gender, race, ethnicity, and years of teaching experience), associated with implementation of practices (criterion). These analyses

examined whether there was an association between teachers' demographic characteristics and their attitudes towards implementing of evidence-based practices for refugee and immigrant students.

Research Question 3 examined teachers' perceptions regarding their competency and preparation to effectively teach refugee and immigrant students, while Research Question 4 focused on teachers' cultural competence specifically with regard to serving these populations of students. Again, descriptive and inferential statistics was used to answer these research questions. The descriptive statistics consisted of measures of central tendency (mean and median), variability (range, SD), and proportion of responses, and the descriptive statistics will enable an examination of the average degree of competency. Inferential statistics including correlations and a multiple regression analyses with standard predictor entry were performed to examine certain variables associated with greater competency. The survey analyzed whether there was an association between background and demographic characteristics, the predictor variables, (e.g., years of teaching experience) and competency/cultural competency (criterion) when working with refugee and immigrant populations.

It should be noted that a composite was created for cultural competency and competency/preparation for the purposes of inferential statistics analysis, as the two outcomes were significantly correlated ($r = 0.38$, $p < 0.01$); the composite was named "competency" to encompass both constructs and generate an overall competency variable. They were merged because they provided very similar results, and empirical data indicated that combining the items allowed for more variability of responses, resulting in normative data to utilize for the purpose of multiple regression analysis. Both constructs (cultural competency and preparation/competency had items focused on capability.

Research Question 5 concentrated on examining teachers' perceptions regarding the needs of refugee and immigrant children (criterion). Again, to answer this research question, a combination of descriptive and inferential statistics were calculated. The descriptive statistics consisted of measures of central tendency (mean and median), variability (range, standard deviation, or SD), and proportion of responses, and the descriptive statistics enabled an examination of the average and range relationships. Inferential statistics included correlations and a multiple regression with sequential predictor entry was performed to examine certain predictor variables (gender, race, ethnicity, and years of teaching experience) were associated with student needs. Once again, analyses were conducted with survey data to analyze whether there was an association between demographic characteristics, the predictor variables, (e.g., years of teaching experience) and student needs (criterion) when working with refugee and immigrant populations.

Research Question 6 was answered using correlations among the different variables. Lastly, Research Questions 7 and 8 examined relationships across categories using a series of simultaneous multiple regressions to examine the different outcomes. In addition to demographics in Research Question 6, competency was also included as a predictor variable for the outcomes self-efficacy, beliefs about implementing practices, and student needs. It was hypothesized that as competency increased (both cultural competency and beliefs about prior preparation), self-efficacy and beliefs about implementing practices would increase, and in turn, teachers would better understand the student needs of refugees and immigrants.

In Research Question 7, demographics were controlled for; self-efficacy and competency were used as predictor variables, and teachers' willingness to implement new and effective practices was used as the outcome variable. It was predicted that as self-efficacy and competency

increased, teachers' willingness in implementing practices would also increase. In Research Question 8, demographics were controlled for; cultural competency and competency/preparation were used as predictor variables, and self-efficacy, attitudes towards implementing new and effective practices, and perceived student needs were used as the outcome variables. It was predicted that as competency increased, self-efficacy and attitudes towards practice implementation would also increase, and teachers would perceive refugee and immigrant children as having high needs.

CHAPTER 4

RESULTS

Descriptive Statistics

Table 2 includes the means, standard deviations, and zero-order correlations among all variables. Table 3 includes additional descriptive statistical information by each variable item. In order to answer research question one, descriptive statistics for the self-efficacy variable and each of its items were examined. Overall, the seven items assessing teachers' perceptions of their self-efficacy had a mean of 3.39, with a standard deviation of 0.56. The median was 2.86, with a range of 2.29. Across all items, over half of the respondents (52.21%) rated their self-efficacy as "To a Great Extent," with the remaining respondents indicating "To a Moderate Extent," and even less with regard to their self-efficacy as "A Slight Extent" and "Not at All" in teaching refugee and immigrant students. Overall, roughly half of the teachers rated most of the self-efficacy items "To a Great Extent," resulting in a slight negative skew. These findings indicate that half of teachers reported feeling greatly confident in their ability to teach and serve refugee and immigrant students, while the other half reported lower self-efficacy.

In order to answer research question two, descriptive statistics for the implementing innovative, effective practices items was examined. Overall, the seven items assessing teachers' perceptions of their willingness to implement new and effective practices had a mean of 3.48, with a standard deviation of 0.49. The median was 3, with a range of 2. Across all items, over half of the respondents (55.29%) rated their willingness to implement new and effective practices as "To a Great Extent," with the remaining respondents indicating "To a Moderate Extent," and even less with regard to their willingness to implement practice as "A Slight Extent" and "Not at All" in teaching refugee and immigrant students. Overall, more than half of the teachers

endorsed “To a Great Extent” on these items, resulting in a negative skew; these results closely mirror the self-efficacy scale discussed above. This finding indicated that a little over half of the teachers reported having favorable attitudes towards implementing new and effective practices for refugee and immigrant students.

In order to answer research question three, descriptive statistics for the cultural competency variable and each of its items were examined. Overall, the six items assessing teachers’ perceptions of their cultural competency had a mean of 3.56, with a standard deviation of 0.39. The median was 3.09, with a range of 1.83. Across all items, over half of the respondents (60.55%) rated their cultural competency as “To a Great Extent,” with the remaining respondents indicating “To a Moderate Extent,” and even less with regard to their willingness to implement practice as “A Slight Extent” and “Not at All” in teaching refugee and immigrant students. The majority of teachers, about half, rated most items “To a Great Extent,” resulting in a negative skew. To answer question three, this indicates that most teachers feel culturally competent in their ability to teach and serve refugee and immigrant students. However, approximately 40% of respondents indicated that they felt moderately or even lower in their culturally competency to effectively meet the needs of refugee and immigrant.

In order to answer research question four, descriptive statistics for the competency/preparation variable and each of its items were examined. Overall, the five items assessing teachers’ perceptions of their competency/preparation had a mean of 2.33, with a standard deviation of 0.69. The median was 2.5, with a range of 3. Across all items, the data were fairly normally distributed. The descriptive statistics indicated that there was variability in how teachers perceived their competency and adequacy of prior training in preparing them teach

and serve refugee and immigrant students. Few teachers reported being sufficiently prepared to teach refugee and immigrant students

In order to answer research question five, descriptive statistics for the student needs variable and each of its items were examined. Overall, the six items assessing teachers' perceptions of refugee and immigrant students' needs had a mean of 2.88, with a standard deviation of 0.59, indicating variability in the teachers' perceptions of the needs of their refugee and immigrant students. The median was 2.5, with a range of 3. Across all student needs items, the data were fairly normally distributed. About a third of teachers (30.72%) did not believe that refugee and immigrant students exhibit significant needs as compared to their non-immigrant peers, which contradicts empirical research on the needs of refugee and immigrant students across social, emotional, and academic domains of performance. 25.10% of the teachers, however, reported that they believed refugee and immigrant students exhibit notable needs in the context of school that should be addressed with effective practices.

When the variables self-efficacy, implementing practices, cultural competency, and competency/preparation are combined, teacher's perceptions had a mean of 3.19, with a standard deviation of 0.39. The median was 2.89, with a range of 1.77. Across all items, almost half (45.90%) of the respondents rated their perceptions of the four outcomes as "To a Great Extent," with the remaining respondents indicating "To a Moderate Extent," and even less with regard to their willingness to implement practice as "A Slight Extent" and "Not at All" in teaching refugee and immigrant students. This finding suggested that nearly half of the teachers reported confidence, willingness to implement new and effective practices, being culturally competent, and feeling competent and adequately prepared. Please see Table 3 for more information.

Correlations

In order to conduction correlational analyses using the demographic data, dummy codes were created. Also, the student needs items were reverse coded due to the negative wording of the items in that scale. Years of teaching refugee and immigrant students and teacher immigration status were removed from each model, as they did not provide additional information; teaching refugee and immigrant students was significantly correlated with teaching years ($r = 0.57$, $p < 0.01$) and competency ($r = 0.28$, $p < 0.01$) and teacher immigration status was significantly correlated with minority status ($r = 0.25$, $p < 0.01$) and Hispanic/non-Hispanic status ($r = 0.23$, $p < 0.01$). The variables did not explain any unique variance in the criterion variable so they were removed from the models.

As mentioned above, Table 2 includes the zero-order correlations among all variables, as well as the means and standard deviations. Consistent with the hypotheses guiding this study, a number of significant bivariate correlations were uncovered. As one can see, the self-efficacy variable was correlated with the implementing practices variable, with $r = 0.39$, $p < 0.01$, indicating a moderate positive correlation between the two outcomes. As teachers' ratings of self-efficacy increased, they were more likely to endorse favorable attitudes towards implementing practices.

Self-efficacy was also correlated with competency ($r = 0.60$, $p < 0.05$), as teachers ratings of their confidence to teach refugee and immigrant students increased, they were more likely to report feeling competent in their ability to serve these populations of students. This finding is consistent with prior research linking self-efficacy to teacher effectiveness in the classroom (Holzberger, Philipp, & Kunter, 2013).

Consistent with the hypothesis guiding this study for implementing practices, a number of significant bivariate correlations were found. The implementing practices variable was

correlated with the competency variable ($r = 0.23$, $p < 0.01$), indicating a positive correlation between the two outcomes. As teacher's ratings of their willingness to implement practices increased, they were more likely to feel more competent in their ability to teach refugee and immigrant students (they believe they are both culturally competent and received prior preparation in working with these refugee and immigrant students and families). This result is similar to what was seen with self-efficacy above. These findings mirror prior research linking competence and willingness to implement new and effective practices (Callahan, Henson, & Cowan, 2008; Ely, Kennedy, Pullen, Williams, & Hirsch, 2014).

The correlational results for the student needs category was not consistent with the foregoing hypothesis. However, a number of significant bi-variate correlations were uncovered. The student needs variable was correlated with the demographic variable gender, with $r = -0.18$, $p < 0.05$, indicating a negative correlation between the two outcomes. Since females were coded as 1, this finding indicated that females reported significantly lower student needs than males. This suggested that male teachers perceive refugee and immigrant students to have higher needs than their female counterparts.

Student needs was also correlated with minority status, with a significant positive correlation of $r = -0.23$, $p < 0.01$. Given that non-minority respondents were coded as 1, this indicated that the non-minority teachers' ratings of student needs were lower than the minority teacher respondents. This is inconsistent with current research and indicates perhaps a lack of awareness of the needs that these students present (Kirmayer, Guzder, & Rousseau, 2013; Strekalova & Hoot, 2008). Lastly, teaching years and Hispanic/non-Hispanic were not correlated with any variables.

Regression Models

A series of multiple regression analyses were performed for each of the dependent variables included in this study. Please see the Appendix A for specific equations and the models performed for each of the variables. For ease of results and interpretation of multiple regression analysis, years of teaching experience, gender, minority status, and Hispanic/non-Hispanic were effect coded. Normality, linearity, and homoscedasticity of residuals were examined for each model to ensure that linear regression model assumptions were tenable; all were tenable, with the exception of some negative skew in the outcomes self-efficacy and implementing practices. Cultural competency also showed some negative skew, but the composite competency showed normality. Interpretation of the multiple regression was based on model statistics and individual predictor statistics. Specifically, each outcome variable was assessed individually using different predictor variables to determine if there were any unique effects. In order to perform multiple regression analysis that included five predictors with sufficient power (>.80) to detect a moderate effect size at the $p < .05$ level, at least 78 respondents were needed. Analyses were conducted without any transformations to the data, and the following is a discussion of the results for each of the dependent variables.

Self-Efficacy. As stated above, a multiple linear regression with sequential predictor entry was used to predict beliefs regarding self-efficacy. Results in Table 4, Block 1, include demographics (years of teaching experience, gender, minority status, and Hispanic/non-Hispanic) and show that demographics did not account for significant variation in the criterion vairable, self-efficacy, $R^2_{\text{total}} = 0.03$, $p = 0.348$. Block 2, which included beliefs about competency, did account for significant unique variation in self-efficacy, $R^2_{\text{change}} = 0.35$ and $R^2_{\text{total}} = 0.38$ ($b = 0.41$, $SE = 0.047$, $t(133) = 8.65$, $p < 0.001$, $sr^2 = 0.35$), when holding the variance accounted for by all other variables constant. Specifically, results indicated that for

every one standard deviation increase in competency, self-efficacy was predicted to increase by 0.41 points.

Implementing Practices. A multiple linear regression with sequential predictor entry was also used to predict beliefs regarding practice implementation. Using demographics and teachers' beliefs about competency as predictor variables, results in Table 5, Block 1, include demographics (years of teaching experience, gender, minority status, and Hispanic/non-Hispanic) and showed that demographic variables as a whole did not account for significant variation in the criterion variable, implementing practices, $R^2_{\text{total}} = 0.03$, $p = 0.325$. Block 2, which included beliefs about self-efficacy, did account for significant variation in self-efficacy, $R^2_{\text{change}} = 0.08$ and $R^2_{\text{total}} = 0.11$ ($b = 0.17$, $SE = 0.050$, $t(133) = 3.468$, $p = 0.001$, $sr^2 = 0.08$) above and beyond that attributable to the other variables included. Specifically, for every one standard deviation increase in competency, implementing practices was predicted to increase by 0.17 points. Block 3 included competency and also accounted for additional variation in the outcome, implementing practices, $R^2_{\text{change}} = 0.07$ and $R^2_{\text{total}} = 0.18$ ($b = 0.17$, $SE = 0.049$, $t(132) = 3.338$, $p = 0.001$, $sr^2 = 0.07$), when holding the variance associated with other variables constant. Specifically, results suggested that for every one standard deviation increase in competency, one could expect a .17 increase in attitudes toward implementing practices.

Competency. A multiple linear regression with standard predictor entry was used to predict beliefs regarding competency; it should be noted that the competency includes both cultural competency and competency/preparation. Results in Table 6 include demographics predictors (years of teaching experience, gender, minority status, and Hispanic/non-Hispanic) and showed that demographics did not account for significant variation in the outcome, implementing practices, $R^2_{\text{total}} = 0.04$, $p = 0.276$. Demographics were not found to be not

predictive of competency. For example, gender (being male vs. female) was not predictive of a teacher's perception of his or her own competence.

Student Needs. Lastly, a multiple linear regression with sequential predictor entry was used to predict beliefs regarding student needs. As presented in Table 7, Block 1, the demographic predictors (years of teaching experience, gender, minority status, and Hispanic/non-Hispanic) did account for significant variation in student needs, $R^2_{change} = 0.09$ and $R^2_{total} = 0.09$. Minority status was found to be a unique predictor of beliefs about student needs ($b = -0.17$, $SE = 0.063$, $t(134) = -2.70$, $p = 0.01$, $sr^2 = 0.05$). Specifically, for those teachers that identified as non-minority, beliefs about student needs were predicted to decrease by 0.17 points, holding all else constant. Block 2, on the other hand, did not account for significant variation when competency was added to the model, with $R^2_{total} = 0.10$, $p = 0.694$.

CHAPTER 5

DISCUSSION

Despite the significant increase in refugee and immigrant students in American public schools, little empirical research has been conducted to examine teacher-level factors that may be associated with their effectiveness in meeting the needs of these students. As a result, the overall purpose of this study was to examine teachers' beliefs and attitudes as it relates to serving and meeting the social, emotional, and behavioral needs of refugee and immigrant students. To accomplish this, survey methods were employed to gather data from teachers regarding their (a) self-efficacy beliefs, (b) attitudes towards adopting and implementing evidence-based practices (called "implementing practices"), (c) perceptions of their own cultural competency, (d) beliefs about their competency and adequacy of prior preparation, and (e) perceptions of the needs of refugee and immigrant students. Survey data were collected from general education elementary teachers in a large urban school district that serves a population of refugee and immigrant students. These data were used to examine teachers' beliefs and to develop a better understanding of the variables that are likely to impact teachers' effectiveness in teaching and serving refugee and immigrant children.

Given that teachers spend the majority of the school day with students, they represent proximal influences on student outcomes and the primary implementers of effective practices. Research has demonstrated the importance of beliefs and attitudes as being critical to the adoption and upkeep of culturally, responsive EBPs to effectively address the mental health needs of refugee and immigrant students (Aarons & Palinkas, 2007; Grol & Grimshaw, 2003; Haney et al., 1996). Understanding the beliefs and attitudes of teachers is critical to determine next steps with regard to both research and practices in order to determine how best to support

teachers' with effectively meeting the needs of refugee and immigrant students. Thus, it becomes critical to conduct this research with teachers functioning in everyday schools environments in order to understand how best to promote their effectiveness to meet the needs of refugee and immigrant students.

Currently, there is a gap between research and practice; namely, interventions that are deemed "evidence-based" do not always make it into the classroom setting. While research provides knowledge around what may work best, it may not be reaching students, and it may not pertain to the supports that teachers need to effectively teach refugee and immigrant populations. Knowing more about teacher beliefs and perceptions allows researchers to locate the holes and support teachers through the use of implementation science; for example, through professional development or preparation courses. As a result, close attention should be paid to the following results and their implications for current and future practice.

Results from this study show that overall, teachers feel confident, culturally competent, and are open to implementing practices to serve refugee and immigrant students; across all three of these constructs, more than half of teachers endorsed responses indicating to a great extent. While some of these results may be attributed to satisficing, teachers' self-reported confidence and cultural competence are high, and they appear to be willing to implement new and effective practices. However, it should be noted that the survey addressed teachers' beliefs and perceptions and did not assess whether teachers were actually implementing EBPs (see Appendix D at the end of this study for the survey in its entirety). Although over half of teachers reported that they were confident, culturally competent, and had favorable attitudes towards implementing EBPs, a significant proportion of teachers reported being less confident, having moderate to low cultural competence, and possessing favorable attitudes towards implementing EBPs. This

suggests that there is significant variability across teachers which may account for why some teachers are able to effectively promote positive outcomes for refugee and immigrant children and others are not.

With regard to teachers' perceptions of the needs of refugee and immigrant students, obtained findings were inconsistent with the hypothesis formulated prior to conducting this study. In particular, results revealed that the over half of the teachers believed that refugee and immigrant students do not exhibit notable needs with regard to their social, emotional, and behavioral functioning. This is concerning considering results from prior research indicating that these students are likely to display greater needs for social, emotional, and behavioral supports than the general population of students (Beesdo-Baum & Knappe, 2012; Forness, Freeman, Paparella, Kauffman & Walker, 2012). Although this study did not assess specific types of needs (e.g., externalizing or internalizing problems), it is possible that refugee and immigrant students exhibit greater internalizing problems, which previous research has shown often go undetected by teachers (Gresham & Kern, 2008).

There was a positive effect of beliefs about teachers' own competency (both cultural competency and perceptions about prior preparation) on self-efficacy ($sr^2 = 0.35$) and teachers' willingness in implement practices ($sr^2 = 0.08$). In addition, self-efficacy ($sr^2 = 0.14$) was also found to be a unique predictor of practice implementation when added to the model. As teachers report that they have high cultural competency and have had adequate prior preparation to properly train them for teaching refugee and immigrant children, their beliefs around their confidence in teaching these students increases, and as a result, they may be more likely to implement new practices.

With regard to refugee and immigrant student needs, demographics (specifically non-minority teacher respondents) had a negative correlation with higher student needs ($sr^2 = 0.05$). As many refugee and immigrant students are from diverse backgrounds and races, minority status may influence beliefs around student needs. As teachers from minority backgrounds may have had more aversive experiences in their lives due to issues of racism in today's society, they may have a better understanding about refugee and immigrant student needs in the classroom setting. Again, over half of the teachers reported that they did not believe that refugee and immigrant students have unique needs that should be addressed. This is inconsistent with the literature (Kirmayer et al., 2013; Strekalova & Hoot, 2008) and perhaps indicates a lack of awareness of the needs that these students present; needs are being overlooked.

Overall, research has linked all of the variables assessed in this study with teacher effectiveness in the classroom. Teacher effectiveness, in turn, reflects the quality of the practices teachers deliver and interactions they have with their students. For example, increasing teachers' self-efficacy improves competency and promotes more favorable attitudes towards evidence-based practices in the classroom setting. Likewise, cultural competency has been shown to be a predicator of teacher effectiveness with diverse students (Cornelius-White, 2007; Pigford, 2001; Van, & Van, 2011). Research should continue to explore the relationship between these factors and teachers' effectiveness in meeting the needs of refugee and immigrant students.

Implications

These results have direct implications for teacher preparation programs and those practicing in schools. Findings indicate that self-efficacy and competence (cultural competence and prior preparation) are related to teachers' willingness to implement new and effective practices. Thus, before delving into professional development or investing in efforts to support

implementation of evidence-based practices, ensuring that teachers feel confident and competent in their ability to implement the interventions is key. This is consistent with recent research linking beliefs to the adoption and use of effective practices (Cook, Lyon, Kurbegovic, Browning Wright, & Zhang, 2015).

For example, if a teacher would like teachers to begin a new, innovative intervention in order to best serve students, especially refugee and immigrant populations, supporting teachers in way that increases their self-efficacy and willingness to implement something new are support are vital to ensuring that the new practice is implemented and hopefully with fidelity. If teachers are simply handed a curriculum, they may not feel competent or confident in their ability to deliver it effectively in order to alter outcomes for their refugee and immigrant students. As a result, mentoring and coaching prior to professional development training could be a fruitful approach to support teachers throughout an implementation effort (not just at the beginning) in order to help support them as they adopt and use a new and effective practice. For example, an "expert coach," or someone who is familiar with the curriculum, could check in with teachers regularly and help create goals on how best to support refugee and immigrant students.

On aspect of this study focused on examining the degree to which demographics variables were uniquely predictive of teachers' perceptions of refugee and immigrant student needs. Results revealed that teachers who self-selected as minority were more likely to also rate higher student needs. This finding suggests that minority teachers are more likely to be aware of the needs of refugee and immigrant students, which implies that teachers from Anglo-cultural backgrounds may benefit from support to better to detect needs of students who are culturally dissimilar to them. This finding also indicates that greater numbers of individuals from diverse cultural backgrounds who are refugees or immigrant should be recruited into the teaching

profession. While demographics of teachers cannot be changed to support students, pairing teacher mentors with refugee and immigrant students may be helpful in having their needs supported; mentor teachers, including ELL teachers, could consult and perhaps co-teacher with homeroom teachers, allowing teachers to be better understand and be responsive to the needs of their students.

Taking into consideration the significant amount of burden teachers experience with their time, alternative supports consisting of pairing younger and older refugee and immigrant students together (and also taking into consideration the stigma that may be associated with “peer buddies”) could also be a useful way for schools to provide supports to those students and is consistent with research on peer mentors and its effectiveness with helping students succeed (Copeland et al., 2002; Hughes & Carter, 2008; Thalluri, O'Flaherty, & Shepherd, 2014).

Lastly, this study found that cultural competency and competency/preparation were highly correlated, resulting in a creation of a composite for the purpose of analysis. This indicated that these two variables were measuring the same construct, which was called “competency” in this case for ease of interpretation of results. This could be due to a variety of factors. While only speculation, this may be due to the fact that a teachers who report feeling adequately prepared received specific curriculum focusing on cultural competency (or multicultural education), which sufficiently prepared them before they began practicing independently in schools (Liu & Milman, 2013). However, this could also suggest that teachers received more training in-service or that they felt more culturally competent on the job from experience.

Limitations and Future Directions

As with all studies, the present study had several limitations that are important for readers to be aware of when interpreting the findings. First, this survey was only disseminated in one large, school district due to time and financial constraints, and thus, generalizability of results is limited. Indeed, the make-up and response of the respondents may look different if the survey was completed by a different sample of teachers from a different district. Convenience sampling was also used due to similar issues of time and resource availability; random sampling would have been optimal, as those that responded to the survey may be different from those who did not complete it.

As part of the requirements of the UW IRB, and further supported by the research team and staff at the school district level, no identifying teacher or student information was collected (including respondent school placement). Given that no data were collected regarding the school in which each teacher was practicing, teachers may be nested within schools within schools. School-level effects may exert an influence on teachers' beliefs and attitudes as it relates to teaching refugee and immigrant students. Future research should attempt to perform multi-level analyses that account for nesting and examine school-level effects on individual-level variables. It should be noted, however, there were 35 possible schools in which the respondents could currently be practicing within. Another limitation reflects the scaling format of the survey items. The principal invesitgator decided to utilize a 4-point scale to avoid a large number of "neutral" responses, but a 5-point scale may have provided for greater variability and, thus, resulted in different responses.

This study had a limited sample size. Future research should include larger samples of teachers that are have higher numbers of male and culturally diverse teachers, including those that self-identify as an immigrant or refugee would allow for a more comprehensive examination

of teachers' beliefs and perceptions. Unfortunately, in this present survey, teacher immigration status was not included in any of the regression models, as it was highly correlated with two other variables, including minority status (0.248) and Hispanic/non-Hispanic status (0.228) and was removed from inferential statistical analysis.

Lastly is the issue of social desirability. As all survey data is self-report, respondents may have had a tendency of to respond to questions in a manner that would be viewed favorably by others, which skews the results. A web-based survey was utilized to enable anonymity for respondents, which would in turn reduce social desirability, but there is no way to know if the respondents answered any or all questions truthfully due to inclination to provide socially desired answers. In addition, the questions around implementation of new and innovative practices asked teachers if they were "willing" or "open to" certain practices, and not if they actually performed them as part of their jobs roles.

Future research should replicate this study across different school districts and U.S. geographical regions, as results may look dissimilar depending on the location in which teachers are embedded. In addition, this survey only included beliefs of general education elementary school teachers, due to time constraints and agreement with the school district policy to complete research and complete this study; future research could focus on secondary teachers and those in other areas and specialties (ELL, special education, gifted, etc.); ELL teachers may have a unique voice, which would be noteworthy to assess in future research, as they work with these population of students more closely in schools, as they build their linguistic, verbal, and cultural knowledge.

Conclusion

The results from this research help pave the way for next steps in supporting general education teachers to optimally teach and serve refugee and immigrant students in U.S. schools. Given that research with this population of students is limited, the results provide information on beliefs and attitudes of teachers, and this information on teacher beliefs can in turn be used to inform next steps with future research studies to build research and resources when working with these populations and their unique needs.

For example, given that a notable number of teachers reported that they did not adequately prepared to serve refugee and immigrant students, university preparation programs that prepare to teachers to work in urban public or charter schools that serve refugee and immigrant students should enhance their curriculum to better prepare teachers to support and attend to the needs of these students. Research indicates that many preparation programs do have courses specifically on multicultural education and culturally responsive teaching practices (Ramsey, 2000), but there was limited research available on what works specifically for refugee and immigrant students, since in most research studies, they were lumped into a category with other populations in need. By bringing research to university campuses and teacher preparation programs (perhaps even during student teaching and training times), teachers can be better prepared to work with students with their social, emotional, and mental health needs, which are pivotal in attaining academic and lifelong successes.

Providers such as school psychologists have unique mental health training as it pertains to schools, and they can be at the forefront of helping get pertinent information to teachers and others educators, which can be beneficial in helping refugee and immigrant students and families access services in the domains of social/emotional/behavioral and mental health. School psychologists take on the role of consultants and service providers and can help teachers become

more prepared and better understand and build relationships. As school psychologists work closely with teachers to put these interventions into place and assess data to help students succeed at school, it is crucial to keep in mind where teachers are at in terms of their self-efficacy, willingness to implement practices, cultural competency, beliefs on prior preparation, and perception about student needs and determine what steps are needed to help serve these diverse populations of children and families.

It is the hope that this dissertation study will allow for more focus on refugee and immigrant populations in preparation programs, in addition to a focus on self-efficacy, evidence-based practices, and cultural competency in the overarching goal of multicultural education. As students go through the acculturation process, which may include language barriers, trauma, poverty, and separation from family, among many others, schools are the places in which services can be provided to best help these students and families positively acculturate and obtain needed resources. Although this study focuses on teachers, the findings may also be true for other educators, which indicates a need

In closing, it is noteworthy to reiterate that self-efficacy and competency predict implementation of new and effective practices, and demographics (specifically minority status) predict student needs. Nearly half of the teachers reported high rates of self-efficacy, cultural competency, and willingness to implement new and effective practices, as it relates to refugee and immigrant populations. However, although many teachers reported overall positive attitudes that have been linked to effectiveness in the classroom, there were several teachers who reported unfavorable beliefs and attitudes that are likely to undermine effectiveness in meeting the needs of refugee and immigrant students. By including a focus on individual teachers and their beliefs and attitudes, school systems can better support teachers through pre- and in-service training in

order to ensure they are well-positioned to have a significant impact on the outcomes of these students.

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Table 1.
Survey Demographics Table

Characteristic	*N*	*%*
MINORITY STATUS		
White/ Caucasian	113	81.3%
Multiracial	11	7.9%
Asian/ Southeast Asian	7	5.0%
Black/ African American	6	4.3%
Native Hawaiian/ Pacific Islander	1	0.7%
American Indian/ Alaskan Native	1	0.7%
YEARS OF TEACHING EXPERIENCE		
11+ years	90	64.7%
9-10 years	6	4.3%
6-8 years	14	10.1%
3-5 years	14	10.1%
0-2 years	15	10.8%
YEARS OF TEACHING REFUGEE AND IMMIGRANT STUDENTS		
11+ years	52	37.4%
9-10 years	12	8.6%
6-8 years	20	14.4%
3-5 years	14	10.1%
0-2 years	41	29.5%
GENDER		
Female	127	91.4%
Male	12	30.0%
HISPANIC/NON-HISPANIC		
Non-Hispanic	135	91.7%
Hispanic	4	2.9%
TEACHER IMMIGRATION STATUS		
Non-Immigrant	135	97.1%
Immigrant	4	2.9%

Note. N=139.

Table 2.

Descriptives and Zero-Order Correlations

Measure	*M*	*(SD)*	1.	2.	3.	4.	5.	6.	7.	8.
Outcomes										
1. Self-Efficacy	3.40	(0.56)	--							
2. Implementing Practices	3.48	(0.49)	.39 **	--						
3. Student Needs	2.88	(0.59)	.13	-0.001	--					
Block 1 Predictors										
4. Teaching Years	0.30	(0.96)	.06	-.07	.08	--				
5. Gender	0.83	(0.56)	-.01	.12	-.18 *	-.01	--			
6. Minority Status	0.63	(0.78)	-.04	-.08	-.23 **	.03	.12	--		
7. Hispanic/Non-Hispanic	0.94	(0.34)	-.16	-.11	.09	.05	-.05	.14	--	
Block 2 Predictors										
8. Competency	<0.001	(0.83)	.60 *	.23 **	.03	.12	.05	-.06	-.13	--

Note. *N*=139. Demographics were dummy coded (11+ Teaching Years=1, 0-10 Teaching Years=0; Females=1, Males=0, Non-Minority=1, Minority=0, Non-Hispanic=1, Hispanic=0). Competency was in points.

* $p < .05$, ** $p < .01$

Table 3.
Additional Descriptives By Item

Measure	*M*	*(SD)*	*Range (min, max)*	Not at All	To a Slight Extent	To a Moderate Extent	To a Great Extent
Outcomes							
1. Self-Efficacy	3.40	(0.56)	2.29 (1.71, 4.00)	1.13%	10.50%	35.77%	52.21%
2. Implementing Practices	3.48	(0.49)	2.00 (2.00, 4,00)	0.63%	6.19%	37.73%	55.29%
3. Cultural Competency	3.56	(0.39)	1.83 (2.17, 4.00)	0.23%	4.68%	33.70%	60.55%
4. Competency/Preparation	2.33	(0.69)	3.00 (1.00, 4.00)	22.90%	36.98%	24.62%	15.56%
5. Student Needs	2.88	(0.59)	3.00 (1.00, 4.00)	30.72%	34.92%	25.10%	8.53%
6. COMPOSITE	3.19	(0.39)	1.77 (2.13, 3.90)	6.22%	14.59%	32.96%	45.90%

Note. N=139. Student Needs used slightly different wording: Not at All, Slightly Agree, Moderately Agree, and Greatly Agree. The Composite measure includes all outcomes with the exception of student needs.

Table 4.
Model Results for Self-Efficacy

	Block 1					Block 2				
	R^2_{change}	R^2_{total}	R^2_{adj}	*b*	sr^2	R^2_{change}	R^2_{total}	R^2_{adj}	*b*	sr^2
Model Fit	0.03	0.03	0.004			0.35 ***	0.38 ***	0.36		
Coefficients										
Intercept				3.67 ***					3.57 ***	
Teaching Years				0.04	<0.01				-0.01	<0.001
Gender				-0.02	<0.001				-0.05	<0.01
Minority Status				-0.01	<0.001				-0.01	<0.001
Hispanic/Non-Hispanic				-0.28	0.03				-0.13	<0.01
Competency									0.41 ***	0.35

Note. N=139. Block 1 F-change test df = 4, 134; Block 2 df = 1, 133; Demographics were effect coded (11+ Teaching Years=1, 0-10 Teaching Years=-1; Females=1, Males=-1, Non-Minority=1, Minority=-1, Non-Hispanic=1, Hispanic=-1). Competency was standardized.

*** $p < 0.001$.

Table 5.
Model Results for Implementing Practices

	Block 1					Block 2				
	R^2_{change}	R^2_{total}	R^2_{adj}	b	sr^2	R^2_{change}	R^2_{total}	R^2_{adj}	b	sr^2
Model Fit	0.03	0.03	0.005			0.08 ***	0.11 ***	0.08		
Coefficients										
Intercept				3.56 ***					3.51 ***	
Teaching Years				-0.03	<0.01				-0.05	0.01
Gender				0.10	0.01				0.09	0.01
Minority Status				-0.05	<0.01				-0.05	<0.01
Hispanic/Non-Hispanic				-0.13	<0.01				-0.07	<0.01
Competency									0.17 ***	0.08

Note. N=139. Block 1 F-change test df = 4, 134; Block 2 df = 1, 133; Demographics were effect coded (11+ Teaching Years=1, 0-10 Teaching Years=-1; Females=1, Males=-1, Non-Minority=1, Minority=-1, Non-Hispanic=1, Hispanic=-1). Competency was standardized.

*** $p < 0.001$.

Table 6.
Model Results for Competency

	R^2_{total}	$R^2_{adjusted}$	$F(4,134)$	p	b	(SE)	$t(134)$	p	sr^2
Competency	0.04	0.008	1.29	0.276					
Intercept					3.07	(0.13)	23.39	<0.001	
Teaching Years					0.06	(0.04)	1.49	0.138	0.02
Gender					0.04	(0.07)	0.59	0.559	<0.01
Minority Status					-0.03	(0.05)	-0.61	0.543	<0.01
Hispanic/Non-Hispanic					-0.17	(0.12)	-1.48	0.141	0.02

Note. N=139. F-change test df = 4, 134; Demographics were effect coded (11+ Teaching Years=1, 0-10 Teaching Years=-1; Females=1, Males=-1, Non-Minority=1, Minority=-1, Non-Hispanic=1, Hispanic=-1).

Table 7.
Model Results for Student Needs

	Block 1					Block 2				
	R^2_{change}	R^2_{total}	R^2_{adj}	b	sr^2	R^2_{change}	R^2_{total}	R^2_{adj}	b	sr^2
Model Fit	0.09 **	0.09 **	0.07			0.001	0.10	0.06		
Coefficients										
Intercept				2.93 ***					2.92 ***	
Teaching Years				0.05	<0.01				0.05	<0.01
Gender				-0.16	0.02				-0.16	0.02
Minority Status				-0.17 **	0.05				-0.17 **	0.05
Hispanic/Non-Hispanic				0.19	0.01				0.20	0.01
Competency									0.02	<0.001

Note. N=139. Block 1 F-change test df = 4, 134; Block 2 df = 1, 133; Demographics were effect coded (11+ Teaching Years=1, 0-10 Teaching Years=-1; Females=1, Males=-1, Non-Minority=1, Minority=-1, Non-Hispanic=1, Hispanic=-1). Competency was standardized.

** $p < 0.01$, *** $p < 0.001$.

Appendix A.
Equations and Models

When analyzing self-efficacy, implementing practices, competency, and student needs as dependent variables, they were left in original metrics, and each model was as follows:

$Y = b_0 + b_1$*TeachingExperience + b_2*Females + b_3*NonMinority + b_4*NonHispanic

In the regression models, each outcome variable was equal to the conditional mean (b_0), plus the unique effects of schools demographics ($b_1 – b_4$).

In addition to analyzing demographics for each teacher belief, sequential predictor entry was selected to better learn which predictors accounted for the greatest number of variance in the system and to analyze the relationships between the different variables. The outcome variables (implementing practices and competency) were standardized.

The final model for the outcome implementing practices in answering Research Question 7 was as follows:

$Y = b_0 + b_1$*TeachingExperience + b_2*Females + b_3*NonMinority + b_4*NonHispanic + b_5*Self-Efficacy + b_6*Competency

Block 1 included demographic predictors, Block 2 included the main effects of competence beliefs, and Block 3 included self-efficacy beliefs. In this regression model, implementing practices was equal to the conditional mean (b_0), plus the unique effects of schools demographics ($b_1 – b_4$), the unique effects of competence (b_5), and the unique effects of self-efficacy (b_6).

The final model for each remaining outcomes (self-efficacy, implementing practices, and student needs) in answering Research Question 8 were as follows:

$Y = b_0 + b_1$*TeachingExperience + b_2*Females + b_3*NonMinority + b_4*NonHispanic + b_5*Competency

Block 1 included demographic predictors, and Block 2 included the main effects of competency beliefs. In the three different regression models, self-efficacy, implementing practices, and student needs were equal to the conditional mean (b_0), plus the unique effects of schools demographics ($b_1 – b_4$) and the unique effects of competency (b_5).

Appendix B.
Pre-Notice Email (Wave 1)

**REFUGEE AND IMMIGRANT POPULATIONS:
A SURVEY OF TEACHER PERSPECTIVES**

Dear Participant:

My name is Dajana Kurbegovic, and I am a doctoral student in the School Psychology Program at the University of Washington-Seattle. I am writing to let you know that you have been selected to participate in a questionnaire titled: "Refugee and Immigrant Populations: A Survey of Teacher Perspectives." You will receive an email in a few days time with further information and instructions. Thank you.

For questions and/or concerns please contact:
Dajana Kurbegovic, EdS, NCSP
PhD Student
School Psychology Program
College of Education
University of Washington-Seattle
dajana89@uw.edu

Appendix C.
Initial Survey Email (Wave 2)

REFUGEE AND IMMIGRANT POPULATIONS:
A SURVEY OF TEACHER PERSPECTIVES

Dear Participant:

My name is Dajana Kurbegovic, and I am a doctoral student in the School Psychology Program at the University of Washington-Seattle. I am currently working on my dissertation, which consists of a study on "Refugee and Immigrant Populations: A Survey of Teacher Perspectives." The survey link below is crucial to better understand the beliefs and current service delivery around working with refugee and immigrant students. Please note that this survey is intended only for **general education teachers at the elementary school level who are CURRENTLY working this school year**. If you are not an elementary general education teacher, please disregard this message.

Please understand that your participation in this survey is completely voluntary, and you can stop the survey at any time. Information provided from this questionnaire will allow teachers and educators to better understand current perspectives, which can aid in knowing where to begin in individualizing services to meet the needs of these populations.

As a thank you for your time in completing the survey, you will be included in a raffle for two possible $100 Amazon gift cards. I appreciate your time in helping further research for refugee and immigrant students.

Please click on the link below to access and partake in the survey within two weeks, by May 13, 2015:

https://www.surveymonkey.com/s/QS7BJHS

For questions and/or concerns regarding this survey please contact:
Dajana Kurbegovic, EdS, NCSP
PhD Student
School Psychology Program
College of Education
University of Washington-Seattle
dajana89@uw.edu

BY CLICKING ON THE SURVEY LINK AND COMPLETING THE SURVEY, YOU HAVE PROVIDED YOUR CONSENT BY HAVING READ THE INFORMATION PROVIDED ABOVE.

Appendix D.
Follow-Up Email (Wave 3)

REFUGEE AND IMMIGRANT POPULATIONS:
A SURVEY OF TEACHER PERSPECTIVES

Dear Participant:

This email is intended to follow-up on "Refugee and Immigrant Populations: A Survey of Teacher Perspectives." If you have completed the survey, I want to express my thank you and appreciation; I understand that you are busy and have taken time out of your schedule.

If you have not had a chance yet to complete the survey, the link is below for your convenience. Remember that you will be placed into a raffle for two possible $100 Amazon gift cards. Your participation is voluntary. Please complete the survey within one week, by May 13, 2015:

https://www.surveymonkey.com/s/QS7BJHS

For questions and/or concerns please contact:
Dajana Kurbegovic, EdS, NCSP
PhD Student
School Psychology Program
College of Education
University of Washington-Seattle
dajana89@uw.edu

BY CLICKING ON THE SURVEY LINK AND COMPLETING THE SURVEY, YOU HAVE PROVIDED YOUR CONSENT.

Appendix E.
Survey Questionnaire

REFUGEE AND IMMIGRANT POPULATIONS:
A SURVEY OF TEACHER PERSPECTIVES

BACKGROUND QUESTIONS

Please read and answer these questions carefully before proceeding with the survey:

1. Are you an elementary school general education teacher (since September 2014 or earlier)? *(mark one)*
   - ☐ Yes
   - ☐ No

2. How long have you been an elementary school teacher? *(mark one)*
   - ☐ 0-2 years
   - ☐ 3-5 years
   - ☐ 6-8 years
   - ☐ 9-10 years
   - ☐ 11+ years

3. Out of these years of teaching, how many have included teaching refugee and immigrant populations? *(mark one)*
   - ☐ 0-2 years
   - ☐ 3-5 years
   - ☐ 6-8 years
   - ☐ 9-10 years
   - ☐ 11+ years

4. Do you consider yourself a refugee or immigrant? *(mark one)*
   - ☐ Yes
   - ☐ No

SURVEY ITEMS

Definitions:
An immigrant is a foreign born person who has been allowed to reside in the United States by the government. A refugee is an individual seeking asylum on the grounds that he/she has a well-founded fear of persecution due to race, religion, membership in a social group, political opinion, or national origin in his/her home country. It should be noted that refugees are included under the category of immigrant; this group of people are considered a subset of immigrants with unique circumstances and experiences.

Directions:
At your earliest convenience, please circle ONE response per question and answer all questions honestly and to the best of your ability. Thanks for taking the time to complete this survey!

CATEGORY 1: SELF-EFFICACY **To what extent are each of the following statements true?** ***(Circle one)***	**Not at All**	**To a Slight Extent**	**To a Moderate Extent**	**To a Great Extent**
1. I am convinced that I am able to successfully teach all relevant subject content to refugee and immigrant students.	1	2	3	4
2. I know that I can maintain a positive relationship with refugee and immigrant parents even when tensions arise.	1	2	3	4
3. When I try really hard, I am able to reach refugee and immigrant students.	1	2	3	4
4. I am convinced that, as time goes by, I will continue to become more and more capable of helping to address my refugee and immigrant students' needs.	1	2	3	4
5. I am confident in my ability to be responsive to my refugee and immigrant students' needs even if I am having a bad day.	1	2	3	4
6. If I try hard enough, I know that I can exert a positive influence on both the personal and academic development of my refugee and immigrant students.	1	2	3	4
7. I know that I can motivate my refugee and immigrant students to participate in innovative projects.	1	2	3	4

CATEGORY 2: IMPLEMENTING PRACTICES **To what extent do you <u>agree</u> with each of the following statements?** ***(Circle one)***	**Not at All**	**To a Slight Extent**	**To a Moderate Extent**	**To a Great Extent**
1. I would be willing to use new types of practices to help refugee and immigrant students.	1	2	3	4
2. I would be open to trying new types of practices for refugee and immigrant students even if I have to follow a treatment manual.	1	2	3	4
3. I would be willing to use research to learn how to implement practices for refugee and immigrant students.	1	2	3	4
4. I am willing to use new and different types of practices for refugee and immigrant students developed by researchers.	1	2	3	4
5. I believe that research-based practices and interventions are useful for refugee and immigrant students.	1	2	3	4
6. I would be willing use manualized practices or interventions for refugee and immigrant students.	1	2	3	4
7. I would be open to trying a new practice or intervention for refugee and immigrant students even if it were different from what I am used to doing.	1	2	3	4

CATEGORY 3: CULTURAL COMPETENCY **To what extent do you agree with each of the following statements? *(Circle one)***	**Not at All**	**To a Slight Extent**	**To a Moderate Extent**	**To a Great Extent**
1. I am aware of the diversity of cultural backgrounds of refugee and immigrant students I am working with.	1	2	3	4
2. I can learn a lot from refugee and immigrant students whose cultural background is different from mine.	1	2	3	4
3. Teaching methods need to be adapted to meet the needs of refugee and immigrant children.	1	2	3	4
4. I have the responsibility to be aware of my refugee and immigrant students' cultural backgrounds.	1	2	3	4
5. I instill pride in refugee and immigrant students' cultures.	1	2	3	4
6. I am aware of refugee and immigrant students' language differences in my classroom.	1	2	3	4

CATEGORY 4: COMPETENCY/PREPARATION **To what extent do you agree with each of the following statements?** ***(Circle one)***	**Not at All**	**To a Slight Extent**	**To a Moderate Extent**	**To a Great Extent**
1. My university preparation program adequately prepared me to meet the needs of refugee and immigrant children.	1	2	3	4
2. I have received sufficient in-service professional development on how best to support refugee and immigrant students in the classroom.	1	2	3	4
3. I have gained lots of experience working with refugee and immigrant children.	1	2	3	4
4. I have taken dedicated coursework in culturally responsive practices for students from diverse cultural backgrounds.	1	2	3	4
5. My school devotes time and energy to discussing effective practices to promote the well-being of refugee and immigrant students.	1	2	3	4

CATEGORY 5: STUDENT NEEDS **To what extent do you <u>agree</u> with each of the following statements?** ***(Circle one)***	**Not at All**	**Slightly agree**	**Moderately agree**	**Greatly agree**
1. Refugee and immigrant children have unique social and emotional needs compared to other students.	1	2	3	4
2. Refugee and immigrant children seem to experience more social problems than other students.	1	2	3	4
3. Refugee and immigrant children seem more anxious or nervous than other students.	1	2	3	4
4. Refugee and immigrant children appear to have more acting out behaviors than other students.	1	2	3	4
5. Refugee and immigrant children seem to be more depressed or sad than other students.	1	2	3	4
6. Refugee and immigrant children seem to be negatively affected by traumatic experiences that have occurred in their lives compared to other students.	1	2	3	4

DEMOGRAPHIC INFORMATION

1. What is your gender? *(mark one)*
   - ☐ Male
   - ☐ Female

2. What is your racial background? *(mark one)*
   - ☐ White/Caucasian
   - ☐ Black/African-American
   - ☐ Asian/Southeast Asian
   - ☐ American Indian/Alaskan Native
   - ☐ Native Hawaiian/Pacific Islander
   - ☐ Multiracial (two or more races)

3. Which ethnicity do you primarily consider yourself? *(mark one)*
   - ☐ Hispanic/Latino
   - ☐ Non-Hispanic/Latino

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY!
YOUR TIME IS GREATLY APPRECIATED.