Resettlement and Trauma of Refugees and Asylees in the Bay Area

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Abstract

According to current research, refugees and asylees suffer elevated rates of mental health conditions such as PTSD, anxiety and major depressive disorders. A large body of research indicates that this is a consequence of their conditions during pre-migration and migration. However, emerging research also explains that the period of resettlement can damage the mental health of both refugees and asylees. This research seeks to further explain the relationship between resettlement and trauma from the perspective of service providers in the California Bay Area. Interviews were conducted with 34 refugee and asylee service providers across four counties of the Bay Area. The findings indicate while the resettlement experience for refugees and asylees is highly traumatic in the Bay Area, there are important differences between these groups. Overall, asylees suffer a prolonged period of resettlement and a general lack of guidance. Many service providers believe that these factors, precisely because they affect mental health, make asylee resettlement conditions worse than that of refugees in the Bay Area. Overall, these findings suggest that improving the resettlement program for asylees in the Bay Area must be made an immediate priority. This includes improving both the process of seeking asylum and the resettlement programming that is provided by the state. By emphasizing the opinions and experiences of service providers who work closely with these populations, this research strives to improve the resettlement process in the Bay Area to lessen its current mental health impact on refugees and asylees.

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Chapter I. Introduction

With millions of refugees and asylees fleeing their countries of origin, global and national attention should focus on the well-being of this forced migrant population. Research shows that for refugees and asylees, forced migration is detrimental to their mental health. The processes of pre-migration and migration induce trauma for refugees and asylees, and recent studies suggest that even the process of resettlement can exacerbate the mental health problems of this population, such as, PTSD, anxiety and major depressive disorders. In order to explore the connection between resettlement and refugee mental health needs in the San Francisco Bay Area, this thesis draws on structured interviews with refugee and asylee service providers. Before analyzing these interviews and what they tell us about the mental health needs of refugees and asylees, it is important to convey a sense of the refugee and asylee experiences: how they are similar and how they differ.

The Refugee Experience

In the late 1980s, when Tanvi was just four years old, Bhutan's ruler imposed a policy of "Bhutanization." During that time her home country adopted a "one nation, one people" rule.[1] Tanvi and her family are of Nepali origin, and her ancestors immigrated to Bhutan in the nineteenth century. As a result of "Bhutanization," the Bhutanese government forcibly removed Tanvi's family from Bhutan. Pushed across the border in to Nepal, the family moved into a refugee camp. Tanvi remembers her confusion and fear when her mother woke her up in the middle of the night with a hurried look on her face, and she was quickly shuffled into the back of a car to watch her home fade away through the car window. Her parents anticipated that Nepal

[1] "Bhutan - 2015 UNHCR Subregional Operations Profile - South Asia." *UNHCR News*. UNHCR, 2015. Web. 20 Apr. 2016.

would be a temporary home, perhaps six to eight months, before the hostility would subside and they could return to their life in Bhutan. Unfortunately, these hopes quickly faded and they remained in the Nepali refugee camp for nineteen years.

Tanvi's experience in the refugee camp was miserable. She and her family were chronically undernourished. She ate one meal a day, mostly rice and beans. She ate vegetables about once a month. During a particularly dry season, Tanvi and her sister became extremely malnourished and suffered from Kwashiorkor. Their stomachs swelled dramatically. Tanvi remembers comparing the size of her stomach to that of her sister's and wondering why they were growing if they had no food to eat. During her time in the camp, people constantly died of hunger and disease. She lost two siblings in the camp, and her mother sank into a dark depression.

During the day, Tanvi attended primary and secondary school. She remembers how boring school was, and retrospectively describes it as a low quality education. Often she would go months without returning to school and instead help her mother care for her siblings. During their years in the refugee camp, her parents struggled to find work. Her mother tended to her six brothers and sisters, and her father eventually worked his way up to an administrative level in the camp. It was not until 2008, nineteen years after first arriving in the Nepali camp, that Tanvi and her family were resettled by the International Organization for Migration (IOM). She remembers the tears, and screams and overall exhaustive relief that came with the realization that she and her family would be moving to a permanent home, with promise of food, employment and shelter.

Tanvi's family was resettled in the United States, in Oakland, California. Flying to the U.S., Tanvi brimmed with hope. She would finally receive a proper education, her father would find a job, and she intended to eat three meals a day! She hoped that their life would be similar to their time in Bhutan, and that her mother would again have the time to paint, and her father could again begin practicing as a lawyer. However, when they met their refugee caseworker from the International Rescue Committee (IRC) in the airport, it was clear that resettlement would be a different struggle altogether. She remembers every part of resettlement creating stress for her family. They did not know how to do the small things: pay the bills, send letters, meet deadlines, fill a car with gas. Each of these small daily activities produced anxiety-filled challenges for Tanvi and her family.

With the combined help of their family caseworker, and Tanvi's commitment to becoming a cultural broker for her family, they survived in Oakland. Her father found a secretarial job, and her mother worked in a restaurant. Her younger siblings enrolled in the local public school, and Tanvi eventually worked for a resettlement agency herself. She describes her process of resettlement as both frustrating and exhausting. In her career, she hopes to improve resettlement for refugees in the United States so that they do not experience the degree of stress that she and her family suffered in their first few years of arriving in Oakland.[2]

The Asylee Experience

Growing up in El Salvador, Alfredo had always dreamt of making the Salvadoran national soccer team. He had been playing ever since he could remember, and it looked like he might have a chance to realize his dream. However, in 2014, when Alfredo was 17 years old,

[2] Tanvi's story was adapted from a series of anonymous interviews with refugees, and based on a synthesis of existing literature that describes the refuge pre-migration and migration experience.

getting to soccer practice became life threatening. His regular bus ride traveled through territory held by MS-13, a local, ruthless gang. Since he would arrive from another part of town, MS-13 accused him of belonging to a rival gang. One afternoon after practice, members of MS-13 approached him with knives drawn. They jumped him, stole all of his things, and beat him nearly unconscious. Alfredo narrowly escaped when a nearby man scared off the gang members with a gun. However, MS-13 threatened to kill him when they next found him. When he returned home his family advised him to leave the country, fearing that he would either be forced to join a gang or face an early death. Later that week, Alfredo hugged his mom goodbye and walked out the door with just a Nike bag slung over his back.

Similar to many El Salvadoran minors in recent years, Alfredo was forced to flee his country due to extreme gang violence. He explains: "We're practically forced out of the country when they find out that you're trying to make something of yourself. Maybe they're jealous… but when you don't agree with their way of life, they destroy your dreams like they did with me." [3] The trauma and fear did not end when Alfredo left El Salvador. Like most migrants traveling from Central America to the United States, Alfredo followed "la Bestia" train route through Mexico. For two months, he traveled on the roofs of trains alongside other youth, adults and families seeking safety and asylum in the United States. During his travels, he remained alert and suspicious of everyone. Traveling through some villages, Mexicans would throw rocks at the migrants "ilegales" and condemn their journey.

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[3] Peralta, Eyder. "Why a Single Question Decides the Fates of Central American Migrants." *National Public Radio*. NPR, 25 Feb. 2016. Web. 5 Apr. 2016. <http://www.npr.org/2016/02/25/467020627/why-a-single-question-decides-the-fates-of-central-american-migrants>.

Alfredo remembers two instances when organized criminals stopped his train. The criminal gang forced Alfredo and the other migrants traveling atop the train to stand in a line with their hands up. The criminals took all of their money and valuables, leaving Alfredo with nothing. He was one of the lucky ones, Alfredo explains, since the women were often seized for the illegal sex trade. He explains that many women migrants took oral contraceptives in anticipation of being raped along the journey.

When Alfredo finally arrived at the U.S.-Mexico border, he traveled with a group led by a "coyote" during the night. They crossed the border quickly and quietly. He paid his smugglers by giving them his sneakers. He was barefoot, but on American soil. After spending weeks in Southern California, he made his way up to Central California lured by the promise of working as a migrant laborer on strawberry farms. Following one year on the farm, he learned that he could "seek asylum," so he traveled to San Francisco. After a year of fearing deportation, he was relieved to know that he had the opportunity to become a legal U.S. citizen.

At the age of 18, Alfredo began the two year process to seek asylum. He did not anticipate that his trauma would endure. During those two years, psychiatrists, physicians, lawyers, and the court repeatedly asked him to tell his story of trauma in El Salvador. He was not allowed to work during that time. Alfredo lived on his uncle's couch in Oakland and he always felt like a burden. He describes this period as one filled with anxiety and frustration. He could not sleep, he took up drinking, and he was deeply homesick. During this time Alfredo did not receive mental healthcare, and lacked a support network.

When Alfredo was finally granted asylum, he received minimal assistance in obtaining the social benefits he was now eligible for. Throughout the next couple of years, his anxiety rose,

and he felt deeply depressed after reliving the trauma he faced in El Salvador repeatedly over the past two years.[4]

Background and Definitions

Tanvi and Alfredo's stories are not unique. Their circumstances of pre-migration and migration are consistent with thousands of other refugees and asylees who resettle in the United States. Throughout this research, it is important to keep in mind their stories and the continuous trauma which forced migrants, similar to Tanvi and Alfredo, endure prior to resettlement. But Tanvi and Alfredo's experiences do differ in important ways. There are three important and distinct groups of forced migrants: (1) asylum-seeker, (2) asylee and (3) refugee. According to the UNHCR, a refugee and an asylee each meet the same legal definition in that they have fled their country of origin due to a well-founded fear of persecution based on "race, religion, nationality, membership to a particular social group or political opinion."[5] Therefore, the only legal distinction between a refugee and an asylee is the location in which they are granted their legal status. A refugee obtains their legal status before entering the host country, either in their country of origin or in a refugee camp, while an asylee applies for and obtains asylum only after they have traveled outside of their host country.[6] Before a migrant becomes an "asylee" they are first recognized as an "asylum seeker" since they are actively applying for asylum.[7] In the United

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[4] Alfredo's story was first told on NPR (Peralta, Eyder. "Why a Single Question Decides the Fates of Central American Migrants." *National Public Radio*. NPR, 25 Feb. 2016. Web. 5 Apr. 2016. <http://www.npr.org/2016/02/25/467020627/why-a-single-question-decides-the-fates-of-central-american-migrants>.) I have adapted that story to highlight key issues of the asylee experience.

[5] "Refugees: Flowing Across Borders." *UNHCR: The UN Refugee Agency*. United Nations Human Rights, n.d. Web. 3 Mar. 2016. <http://www.unhcr.org/pages/49c3646c125.html>.

[6] Causevic, Samira. Newcomers Health Program, San Francisco. "Interview #1." Personal interview. 29 June 2015.

[7] Pantchenko, Marina. Bay Area Legal Aid, Oakland. "Interview #7." Personal interview. 13 July 2015.

States, and particularly within the Bay Area, asylum seekers either enter on temporary visas (such as a tourist, student or work visa), or they arrive as undocumented immigrants. Only once an asylum seeker has been granted legal status are they recognized as an "asylee" and deemed eligible for federally funded social benefits.

Since 1975, the United States has received and resettled approximately 3 million refugees and asylees.[8] On average the United States annually admits 75,000 refugees and 20,000 asylees.[9] While national attention has long been placed on refugees, current shifts in migrant populations arriving to the U.S. indicate an increasing asylee population. Data from the Department of Homeland Security, as seen in Figure 1, demonstrates that the annual rate of admitted refugees has dramatically declined from between 122,000 in 1990, to 78,000 in 2013.[10]

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[8] "History: Annual Refugee Arrival Data by Resettlement State and Country of Origin." *Office of Refugee Resettlement*. U.S. Department of Health & Human Services, n.d. Web. 2 Feb. 2016. <http://www.acf.hhs.gov/programs/orr/about/history>.

[9] Zong, Jie, and Jeanne Batalova. "Refugees and Asylees in the United States." *Migrationpolicy.org*. Migration Policy Institute, 27 Oct. 2015. Web. 15 Feb. 2016. <http://www.migrationpolicy.org/article/refugees-and-asylees-united-states>.

[10] Zong, Jie, and Jeanne Batalova. "Frequently Requested Statistics on Immigrants and Immigration in the United States." *MPI*. Migration Policy Institute, 26 Feb. 2016. Web. 2 Mar. 2016. <http://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states-4#Current%20and%20Historical>.

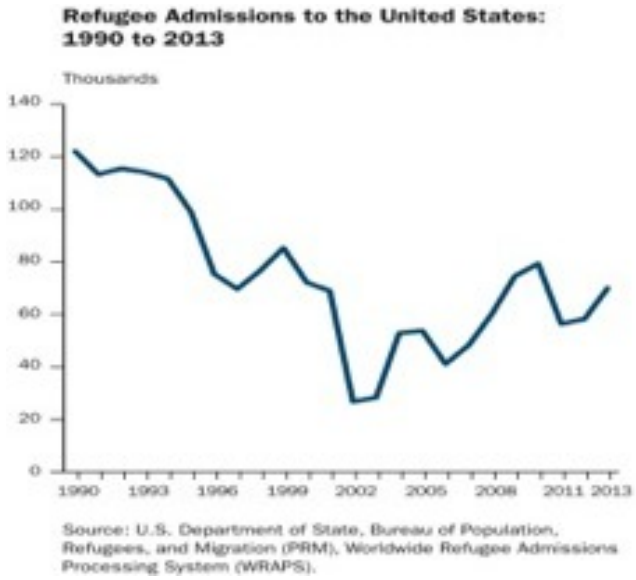

Figure 1: Flow of Refugees

During that same period the number of admitted asylees has increased more than threefold from 8,000 in 1990 to 27,000 in 2013, as shown in Figure 2.[11] As will become apparent, despite the shifting ratio between refugee and asylee populations, the resource distribution for each remains relatively static. That is to say, prioritization of assistance, specifically within the Bay Area in Northern California, is primarily given to refugee resettlement as opposed to asylee resettlement.[12]

Importantly, since the refugee and asylee populations reflect the ever-changing distribution of violent conflict throughout the world, the demographics and conditions of the

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[11] Zong, Jie, and Jeanne Batalova. "Refugees and Asylees in the United States." *Migrationpolicy.org*. Migration Policy Institute, 27 Oct. 2015. Web. 15 Feb. 2016. <http://www.migrationpolicy.org/article/refugees-and-asylees-united-states>.

[12] Causevic, Samira. Newcomers Health Program, San Francisco. "Interview #1." Personal interview. 29 June 2015.

refugee and asylee population who seek refuge in the United States are constantly changing. Data suggests that the national refugee and asylee demographic shifts every 3-5 years.[13]

As seen in Figure 2, refugee arrivals from 2003-2015 have changed over time. While refugees from countries in Africa and East Asia remain the most prevalent, the prevalence of refugees from Latin America and Europe has started to rise.[14] Figure 3 shows the specific country of origin of recent refugees. The most populous refugee populations in recent years are Burmese, Iraqi and Somali - making up about 57% of all refugee arrivals to the United States.[15] The Syrian war has also dramatically increased the number of Syrian refugees resettling in the United States from 31 in 2013 to 1,682 in 2015.[16]

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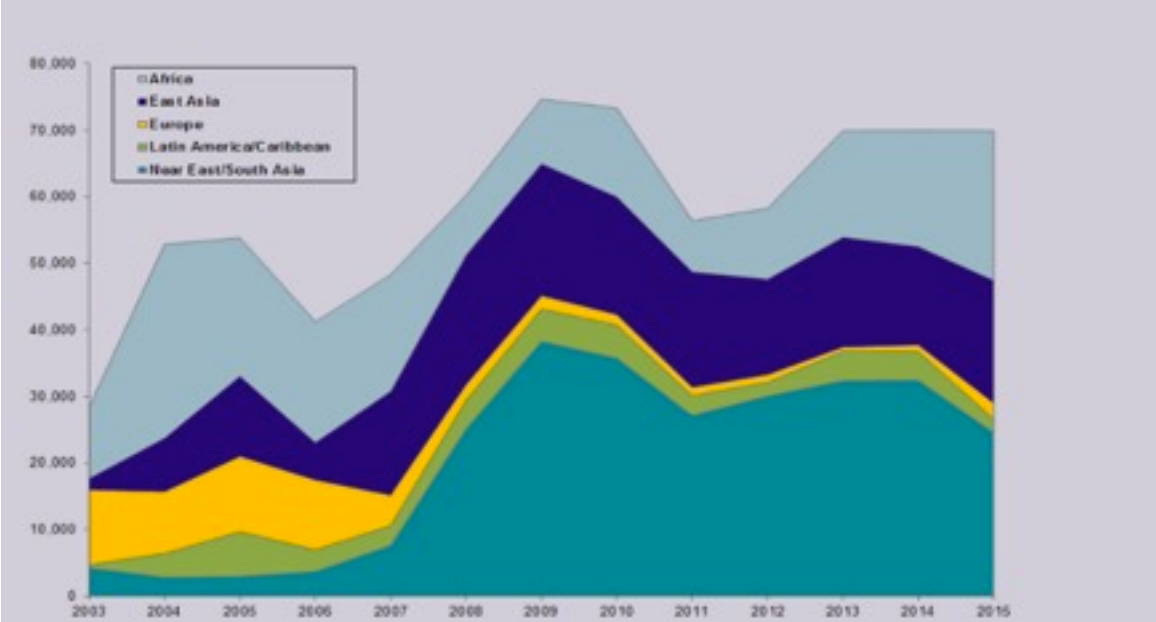
[13] Lahn, Deena. San Francisco Community Clinic Consortium, San Francisco. “Interview #5.” Personal interview. 9 July 2015.

[14] Zong, Jie, and Jeanne Batalova. "Refugees and Asylees in the United States." *Migrationpolicy.org*. Migration Policy Institute, 27 Oct. 2015. Web. 15 Feb. 2016. <http://www.migrationpolicy.org/article/refugees-and-asylees-united-states>.

[15] Ibid.

[16] Ibid.



Note: Data from the Department of State (DOS) Worldwide Refugee Admissions Processing System (WRAPS) on refugee arrivals differ slightly from the Department of Homeland Security's *Yearbook of Immigration Statistics* due to a different data counting approach.
Source: MPI analysis of WRAPS data from the DOS Bureau of Population, Refugees, and Migration, available online.

Figure 2: Refugee Arrivals by Region, 2003-2015

2015			2014			2013		
Country	**Number**	**Percent**	**Country**	**Number**	**Percent**	**Country**	**Number**	**Percent**
Burma	18,386	26.3	Iraq	19,769	28.2	Iraq	19,488	27.9
Iraq	12,676	18.1	Burma	14,598	20.9	Burma	16,299	23.3
Somalia	8,858	12.7	Somalia	9,000	12.9	Bhutan	9,134	13.1
Dem. Rep. Congo	7,876	11.3	Bhutan	8,434	12.1	Somalia	7,608	10.9
Bhutan	5,775	8.3	Dem. Rep. Congo	4,540	6.5	Cuba	4,205	6.0
Iran	3,109	4.4	Cuba	4,062	5.8	Iran	2,578	3.7
Syria	1,682	2.4	Iran	2,846	4.1	Dem. Rep. Congo	2,563	3.7
Eritrea	1,596	2.3	Eritrea	1,488	2.1	Sudan	2,160	3.1
Sudan	1,578	2.3	Sudan	1,315	1.9	Eritrea	1,824	2.6
Cuba	1,527	2.2	Afghanistan	753	1.1	Ethiopia	765	1.1
All other countries, including unknown	6,870	9.8	All other countries, including unknown	3,182	4.5	All other countries, including unknown	3,302	4.7
Total	**69,933**	**100.0**	**Total**	**69,987**	**100.0**	**Total**	**69,926**	**100.0**

Source: MPI analysis of WRAPS data.

Figure 3: Top Refugee Countries of Origin, 2013-2015

This thesis specifically analyzes the refugee and asylee situation in the California Bay Area. Importantly, the California refugee demographic is relatively similar to that of the United States. The most recent reports from the Office of Refugee Resettlement in 2014 indicate that of the 6,108 refugee resettled in the state that year, 247 were Burmese, 249 were Somalian and 3,049 were Iraqi.[17] Slightly distinct from the national profile, 1,668 refugees, about 27.3 percent of the annual refugee population in California in 2014, were Iranian.[18]

Alternatively the national asylee population in 2013 was 25,199, a 12 percent decrease from the asylee population in 2012. This population includes both affirmative and defensive asylees. Affirmative asylees apply for legal status upon entry to the United States, while defensive asylees seek asylum during a deportation hearing. A third manner of seeking asylum is the "following-to-join" status whereby a migrant must "demonstrate a relationship as the spouse or child of an admitted refugee and be admissible to the United States."[19] As seen in Figure 4, in 2013, the most prevalent countries of origin for both affirmative and defensive asylees resettling in the United States were China, Egypt, Ethiopia, Nepal and Syria.[20] However, the asylee population in California, and particularly the Bay Area, is noticeably different. While there is limited statistical data, service-providers throughout the Bay Area indicate that their primary

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[17] "Fiscal Year 2014 Refugee Arrivals." *Office of Refugee Resettlement*. U.S. Department of Health & Human Services, 11 Feb. 2015. Web. 18 Mar. 2016. <http://www.acf.hhs.gov/programs/orr/resource/fiscal-year-2014-refugee-arrivals>.

[18] Ibid.

[19] Pinnix, Jack. *Immigration News*. Allen & Pinnix, P.A. Immigration Law Specialists, 17 Sept. 2014. Web. 4 May 2016. <http://immigration-naturalization-law.com/immigration-news/refugee-and-asylum/>.

[20] Zong, Jie, and Jeanne Batalova. "Refugees and Asylees in the United States." *Migrationpolicy.org*. Migration Policy Institute, 27 Oct. 2015. Web. 15 Feb. 2016. <http://www.migrationpolicy.org/article/refugees-and-asylees-united-states>.

asylum-seeking and asylee populations are from Central America, particularly, Honduras, El Salvador, Nicaragua and Guatemala.[21]

Country of nationality	2013		2012		2011	
	Number	Percent	Number	Percent	Number	Percent
Total	25,199	100.0	29,367	100.0	24,904	100.0
China, People's Republic	8,604	34.1	10,121	34.5	8,592	34.5
Egypt	3,407	13.5	2,876	9.8	1,027	4.1
Ethiopia	893	3.5	1,121	3.8	1,071	4.3
Nepal	854	3.4	975	3.3	740	3.0
Syria	811	3.2	364	1.2	60	0.2
Venezuela	687	2.7	1,090	3.7	1,104	4.4
Iran	675	2.7	716	2.4	474	1.9
Russia	534	2.1	718	2.4	661	2.7
Haiti	496	2.0	681	2.3	872	3.5
Iraq	462	1.8	425	1.4	379	1.5
All other countries, including unknown	7,776	30.9	10,280	35.0	9,924	39.8

Figure 4: Affirmative and Defensive Asylee Population, 2011-2013[22]

As seen in Figures 5 and 6, California hosts an exceptionally large portion of the national refugee and asylee population. For instance, in 2013, California was the second most popular relocation state for refugees, hosting 6,379 refugees, or 9.1 percent of the total U.S. refugee population.[23] California's refugee population in 2013 was second only to Texas, which held 10.7 percent of the overall refugee population.[24] Further, California hosts the highest percentage of asylees in the United States. The most recent data from 2013 shows that California hosted 6,464

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[21] Pantchenko, Marina. Bay Area Legal Aid, Oakland. "Interview #7." Personal interview. 13 July 2015.

[22] Zong, Jie, and Jeanne Batalova. "Refugees and Asylees in the United States." *Migrationpolicy.org*. Migration Policy Institute, 27 Oct. 2015. Web. 15 Feb. 2016.

[23] *Arrivals by State and Nationality*. Rep. N.p.: Refugee Processing Center, 2016. Print.

[24] Ibid.

asylees or 42.3 percent of the entire annual asylee population.[25] In comparison, the second most asylee-populated state in the United States, New York, hosts only 13.0 percent of the entire asylee population. In recent years, service-providers believe that the number of asylees in California has further increased.[26]

State of residence	2013		2012		2011	
	Number	Percent	Number	Percent	Number	Percent
Total	69,909	100.0	58,179	100.0	56,384	100.0
Texas	7,466	10.7	5,905	10.1	5,627	10.0
California	6,379	9.1	5,167	8.9	4,987	8.8
Michigan	4,651	6.7	3,594	6.2	2,588	4.6
New York	3,965	5.7	3,525	6.1	3,529	6.3
Florida	3,613	5.2	2,244	3.9	2,906	5.2
Arizona	3,052	4.4	2,234	3.8	2,168	3.8
Ohio	2,788	4.0	2,245	3.9	1,691	3.0
Georgia	2,710	3.9	2,516	4.3	2,636	4.7
Pennsylvania	2,507	3.6	2,809	4.8	2,972	5.3
Illinois	2,452	3.5	2,082	3.6	1,937	3.4
Other	30,326	43.4	25,858	44.4	25,343	44.9

Source: U.S. Department of State, Bureau of Population, Refugees, and Migration (PRM), Worldwide Refugee Admissions Processing System (WRAPS).

Figure 5: Refugee Arrivals by State

[25] Zong, Jie, and Jeanne Batalova. "Refugees and Asylees in the United States." *Migrationpolicy.org*. Migration Policy Institute, 27 Oct. 2015. Web. 15 Feb. 2016. <http://www.migrationpolicy.org/article/refugees-and-asylees-united-states>.

[26] Causevic, Samira. Newcomers Health Program, San Francisco. "Interview #1." Personal interview. 29 June 2015.

State or territory of residence	2013		2012		2011	
	Number	Percent	Number	Percent	Number	Percent
Total	15,266	100.0	17,389	100.0	13,376	100.0
California	6,464	42.3	6,691	38.5	5,038	37.7
New York	1,988	13.0	2,407	13.8	2,020	15.1
Florida	1,886	12.4	2,600	15.0	2,225	16.6
Virginia	758	5.0	848	4.9	639	4.8
Maryland	544	3.6	707	4.1	522	3.9
Illinois	541	3.5	478	2.7	291	2.2
New Jersey	500	3.3	468	2.7	180	1.3
Texas	451	3.0	371	2.1	272	2.0
Michigan	189	1.2	160	0.9	123	0.9
Washington	185	1.2	317	1.8	330	2.5
Other	1,760	11.5	2,342	13.5	1,736	13.0

Note: Data exclude follow-to-join asylees.
Source: U.S. Department of Homeland Security, Refugee, Asylum, and Parole System (RAPS).

Figure 6: Asylee Arrivals by State

Legal History

Two pieces of legislation shape how the United States treats its refugee and asylee populations today. First, the UN's 1951 Convention relating to the Status of Refugees determines that a refugee is someone who "… is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail him- or herself of the protection of that country, or to return there, for fear of persecution."[27] This legal definition continues to the present day. Important principles within this Convention include (1) *non-refoulement*, or the prohibition against sending refugees back to their country of origin; (2) *non-discrimination* within their host country; and (3) *non-penalization* for migrating.

[27] "Refugees: Flowing Across Borders." *UNHCR: The UN Refugee Agency*. United Nations Human Rights, n.d. Web. 3 Mar. 2016. <http://www.unhcr.org/pages/49c3646c125.html>.

Second, and most pertinent to this research, the United States Refugee Act of 1980 standardizes resettlement procedures for refugee resettlement in the United States. Formally, the Refugee Act established the Federal Refugee Resettlement Program to "provide for the effective resettlement of refugees and to assist them in achieving economic self-sufficiency as quickly as possible after arrival in the United States."[28] The Refugee Act states that the U.S. Government will be responsible for providing the necessary health and mental health services and resources for refugees resettling in the United States.

Based on the Refugee Act of 1980, two major agencies are responsible for U.S. refugee resettlement in the United States: (1) the U.S. Department of State's Bureau of Population, Refugees, and Migration and (2) the Department of Health and Human Services' Office of Refugee Resettlement (ORR).[29] While the President establishes a ceiling on the number of refugees who can be resettled at the beginning of each Fiscal Year, the ORR is responsible for implementing the resettlement programing for refugees to the U.S. Primarily, the ORR aims to integrate refugee communities through *rapid self-sufficiency,* which essentially means economic self-sufficiency. Therefore, resettlement emphasizes employment, health, social services and cultural orientation.[30] By working through nine national resettlement agencies, known as Voluntary Agencies or VOLAGS, the ORR has developed a far-reaching integration approach. These key nine agencies include: Church World Service, Ethiopian Community Development

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[28] "The Refugee Act." *Office of Refugee Resettlement*. U.S. Department of Health and Human Services, 29 Aug. 2012. Web. 12 Mar. 2016. <http://www.acf.hhs.gov/programs/orr/resource/the-refugee-act>.

[29] Ibid.

[30] Halpern, Peggy. *Refugee Economic Self-Sufficiency: An Explanatory Study of Approaches Used in Office of Refugee Resettlement Programs*. Rep. U.S. Department of Health and Human Serices, Nov. 2008. Web. 4 May 2016. <https://aspe.hhs.gov/sites/default/files/pdf/75561/report.pdf>.

Council, Episcopal Migration Ministries, Hebrew Immigrant Aid Society, International Rescue Committee, U.S. Committee for Refugees and Immigrants, Lutheran Immigration and Refugee Services, United States Conference of Catholic Bishops, and World Relief Corporation.[31] Additionally, these agencies are complimented by smaller, local resettlement agencies in various refugee-impacted cities. In the Bay Area, Catholic Charities is one of the primary agencies. While ORR's resettlement model is widely regarded as innovative, it also has many recognized short-comings. Most importantly, their integration methods are not tailored for the specific city, refugee group or circumstances. Since the resettlement programs have limited funds and resources and emphasize rapid self-sufficiency, they tend not to prioritize the local needs of specific refugee populations.

Alternatively, resettlement processes for asylees are much more ambiguous and unorganized. As will be highlighted throughout this thesis, resettlement for asylees is hindered by minimal federal support and guidance. Asylees are eligible for most of the same social benefits as refugees, yet because there is no equivalent federally funded resettlement program for asylees as there is for refugees, asylees face major challenges in accessing the benefits and resources for which they are eligible.[32]

Contextual Background

The refugee and asylee experience can be separated into three categories: (1) pre-migration, (2) migration and (3) resettlement. In this paper, I describe and interrogate the ways in

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[31] "Voluntary Agencies." *Office of Refugee Resettlement*. U.S. Department of Health & Human Services, 17 July 2012. Web. 3 Apr. 2016. <http://www.acf.hhs.gov/programs/orr/resource/voluntary-agencies>.

[32] Dieterich, Cristy. Newcomers Health Program, San Francisco. "Interview #3." Personal interview. 2 July 2015.

which trauma and stress occur during each of these stages, with a specific emphasis on resettlement. These three stages are crucial to understanding the story of trauma suffered by the asylee and refugee populations in the United States and form a key conceptual component of this thesis.

Conclusive research shows that refugees and asylees have a heightened risk of mental health problems such as PTSD, anxiety and major depressive disorders.[33] A large body of research argues that the first two stages of the forced migrant experience, pre-migration and migration, are characterized by trauma and cause the refugee and asylee's heightened rate of mental health needs.[34] For example, during the first stage, pre-migration, forced migrants face severe mental health stressors due to persecution, or threat thereof. As seen in the stories of Tanvi and Alfredo, persecution can cause both emotional and physical trauma. Persecution often involves torture, mental and physical abuse, discrimination, extreme violence, and/or the loss of immediate family members.[35]

The second stage, migration, can also be detrimental to mental health and well-being of refugees and asylees. Research explains that the extreme danger and fear for life en route can cause transitory trauma.[36] Importantly, the degree of trauma during migration depends in part on the particular migrant population and their means of transportation. For instance, Central

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[33] Shawyer, Frances et al. "A Cross-Sectional Survey of the Mental Health Needs of Refugees and Asylum Seekers Attending a Refugee Health Clinic: A Study Protocol for Using Research to Inform Local Service Delivery." *BMC Psychiatry* 14 (2014): 356. *PMC*. Web. 5 May 2016.

[34] Silove, D., I. Sinnerbrink, A. Field, V. Manicavasagar, and Z. Steel. "Anxiety, Depression and PTSD in Asylum-seekers: Assocations with Pre- Migration Trauma and Post-migration Stressors." *The British Journal of Psychiatry* 170.4 (1997): 351-57. Web.

[35] Biasetto, Cristina. Survivors International, San Francisco. "Interview #14." Personal interview. 28 July 2015.

[36] *Displacement and Transit: Traumatic Stress in the Lives of Refugees*. Rep. Vol. Bosnian Refugees in America. N.p.: Springer US, n.d. Print. Clinical Sociology: Research and Practice.

American asylees who travel to the United States on land often encounter extraordinary rates of violence, sexual assault and fear en route.[37] Alternatively, refugees generally experience migration trauma when traveling from their country of origin to a refugee camp, and whilst living in a refugee camp (if this is their migration pattern). However, the actual transit to the United States generally occurs via plane.[38] I will revisit the distinction between the asylee's migration and the refugee's migration experience later in the thesis.

Beyond the trauma that occurs during the first two stages of the refugee and asylee experience, a smaller body of research identifies the third stage, resettlement, as a traumatic experience. Mental health stressors such as job insecurity, housing insecurity, isolation, loss of family connections, lack of cultural understanding, difficulty in obtaining social benefits, and adjusting legal status exacerbate the mental health needs of refugees, asylum seekers and asylees alike.[39] Other research suggests that resettlement impacts the mental health of refugees and asylum seekers differently. While asylum seekers and refugees often face similar forms of persecution and trauma in the pre-migration and migration stages, and therefore often arrive with similar mental health needs, new literature contends that resettlement stressors impact asylum seekers more severely than refugees in the United States.[40] Two contending theories attempt to

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[37] Lopez, Lydia. Lawyers' Committee for Civil Rights, San Francisco. "Interview #20." Personal interview. 10 August 2015.

[38] Rafael, Blythe. East Bay Refugee Forum, Oakland. "Interview #18." Personal interview. 6 August 2015.

[39] Shawyer, Frances et al. "A Cross-Sectional Survey of the Mental Health Needs of Refugees and Asylum Seekers Attending a Refugee Health Clinic: A Study Protocol for Using Research to Inform Local Service Delivery." *BMC Psychiatry* 14 (2014): 356. *PMC*. Web. 5 May 2016.

[40] Hocking, DC, GA Kennedy, and S. Sundram. "Mental Disorders in Asylum Seekers: The Role of the Refugee Determination Process and Employment. Mental Disorders in Asylum Seekers: The Role of the Refugee Determination Process and Employment." *US National Library of Medicine National Institutes of HEalth*. NCBI, n.d. Web. 2 Jan. 2016. <http://www.ncbi.nlm.nih.gov/pubmed/25503784>.

explain this discrepancy. One theory holds that the asylum seeking process is to blame, as it can last up to two years, and the uncertainty can cause severe mental stress for the applicant, a stressor that refugees avoid. Seeking asylum also requires the telling and retelling of the asylee's traumatic story, and asylees live under a constant threat of deportation.[41] A second proposed theory suggests that it is the lack of formal resettlement processes that is at fault; unlike refugees, asylees do not have a formal resettlement program and therefore struggle to integrate without the guidance of a resettlement caseworker/program.[42]

The question is unresolved and requires more in-depth study. In this thesis I test the hypothesis that there is a discrepancy in the trauma undergone by refugees and asylees during the resettlement process by looking at the specific case study of the Bay Area. In particular, the thesis asks: *What are the circumstances of resettlement for refugees and asylees in the Bay Area? And, in what ways is resettlement perceived as a traumatic experience for refugees and asylees by service providers?*

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[41] Schock, Katrin, Rita Rosner, and Christine Knaevelsrud. "Impact of Asylum Interviews on the Mental Health of Traumatized Asylum Seekers." *European Journal of Psychotraumatology* 6 (2015): 10.3402/ejpt.v6.26286. *PMC*. Web. 5 May 2016.

[42] Causevic, Samira. Newcomers Health Program, San Francisco. "Interview #1." Personal interview. 29 June 2015.

Chapter II. Methods

In order to explore the relationship between resettlement trauma and mental health needs in the Bay Area, my thesis uses community-based participatory qualitative research. This method seeks "to clarify a particular local problem through participatory engagement"[43] and serves my research purpose by drawing on the contextual knowledge of Bay Area based community organizations to provide their understanding of the refugee and asylee populations of the area. This chapter will expand on both the research methods and qualitative analysis methods used to reach the findings of my research.

Methods Overview

My data consists of 34 semi-structured qualitative interviews with service providers in Santa Clara, Alameda, San Mateo and San Francisco counties. The "service providers" are health providers, legal professionals, community organizers, and social workers who I chose because of their consistent and prolonged involvement with migrants. Seventeen of the interviews were recorded and have been transcribed verbatim. The remaining seventeen interviews were not audio recorded due to legal and/or confidentiality restraints, but were instead recorded through extensive field notes. This study was conducted as a community based research project and therefore the research methods, design, and participants were jointly established with my community partner, Newcomers Health Program, a refugee/asylee health clinic at San Francisco General Hospital. I analyzed the the qualitative data in three rounds of coding using Dedoose coding software. The findings of this research suggest that from the service provider perspective

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[43] Miles, B. Mathew, A. Michael Huberman, and Johnny Saldaña. *Qualitative Data Analysis: A Methods Sourcebook*. Los Angeles, CA: SAGE Publications Ltd. 2014.

the mental health of asylum seekers and asylees is significantly more impacted by the process of resettlement than the mental health of refugees in the Bay Area. Furthermore, the findings indicate that there are insufficient resources for asylum seekers and asylees in each of the four studied counties.

Justification of Methodologies Chosen

Qualitative studies that explore the mental health needs of recently arrived migrants have called for the perspective of community service providers across health and law professions who work directly with the population of interest.[44] Therefore, qualitative interviews with service providers in the Bay Area address this research gap. Additionally, current research hypothesizes that there is a distinction between the impact of resettlement on the mental health needs of refugees vs. asylum seekers. In order to most accurately analyze and expand upon this existing theory, this explanatory research relies on the expertise of community organizations during the research design, data collection and data analysis processes.

Population Sample and Selection

My thesis uses a purposive population sample that allows the population to evolve throughout the data collection process.[45] My community partner helped establish contact with the first 15 potential participants. Ten of these participants completed the interview process. Following initial outreach, potential participants were identified and contacted via snowball

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[44] Pottie, Kevin et al. "Access to Healthcare for the Most Vulnerable Migrants: A Humanitarian Crisis." *Conflict and Health* 9 (2015): 16. *PMC*. Web. 5 Nov. 2015.

[45] Miles, B. Mathew, A. Michael Huberman, and Johnny Saldaña. *Qualitative Data Analysis: A Methods Sourcebook*. Los Angeles, CA: SAGE Publications Ltd. 2014.

sampling from previous participants.[46] Ultimately, the population sample was selected to represent the refugee/asylee service provider population in the Bay Area. To qualify for an interview, each potential participant met the following requirements: (a) is a service provider for refugee, asylum seeker or asylee populations and (b) works within San Francisco, Alameda, San Mateo and Santa Clara counties. Factors such as age, gender, or personal migration experience were not considered in the selection process since this research seeks to identify a diverse group of service providers. For the purposes of this study, "service providers" can be separated into ten categories: program manager, health coordinator, policy advocate, lawyer, caseworker, counselor, political organizer, health provider, psychologist, and researcher (See Appendix A). These categories were not pre-determined, but were instead selected based on convenience sampling.[47] By creating a multi-county study, the research findings will be a useful tool to compare the needs and assets across county borders. The sample population was intentionally diverse to increase the validity of claims made about the needs of the Bay Area migrant population.

In the nature of community based participatory research, I worked concurrently as a health-worker and as a researcher at a refugee health clinic. The role of health-worker gave me greater access to service providers in the Bay Area. Overall, approximately 60 potential participants were contacted, and 34 were willing and able to complete the interview process. The data set of each population includes a 15 to 90 minute interview. Recorded interviews are accompanied by a verbatim transcription. Non-recorded interviews are accompanied by extensive field notes, written by hand or typed. In order to conduct this research, I obtained IRB

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[46] Miles, B. Mathew, A. Michael Huberman, and Johnny Saldaña. *Qualitative Data Analysis: A Methods Sourcebook*. Los Angeles, CA: SAGE Publications Ltd. 2014.

[47] Ibid.

approval to interview both service providers and migrants in a medical or non-medical setting. Despite institutional approval, I only collected data from service providers. Accessing the service provider population in the Bay Area was straightforward due to the pre-established connections and network available to Newcomers Health Program. In the end, there was a surplus of service providers who were interested in being interviewed for this research.

Alternatively, due to limitations in my language ability and sensitivity trainings, I chose to not conduct interviews with migrants and instead focus on the unique voice of the service providers. In the Conclusion of this thesis I suggest that further research should interview migrants directly to collect and analyze their valuable perspectives.

Data Collection

I conducted data through two primary methods. First, 20 interviews were conducted in person. I conducted each of these interviews in the participant's office building. Each office building was in one of the four studied counties. The interviews were conducted in either the participant's office, or in a separate conference room. Each interview was conducted privately so as to encourage the participant to speak as honestly as possible. Second, due to time and distance restrictions, I conducted some interviews over the phone. These calls were conducted in a private conference room. I contacted participants at their work number during the work day. However, three participants asked to be contacted via their cell phone as they commuted to or from work. Due to limitations in data collection, participant observation is not used as a form of data in this study.

I scheduled interviews either directly with the participant or through their assistant. All scheduling was completed over private email correspondence. I conducted all interviews

between July 1 and August 31, 2015. In each instance the participant chose the meeting time. Only two or three participants required rescheduling due to conflicts. In the introductory email, I asked for 30 minutes from each participant. However, depending on the availability of participants, interviews varied in time. In person interviews lasted approximately 45-90 minutes, and phone interviews lasted approximately 15-40 minutes.

I sent detailed information about the study to each interviewee in the introductory email, the participant was given the opportunity to ask questions prior to the interview, and I gave a description of the intent and implications of the study in person or via phone when the interview began. In order to minimize the harm and risk of data collection, I asked each participant for informed consent, I informed them that they were not required to answer each question, and I told them that they could stop the interview at any time.[48] I asked each participant if they were willing to be recorded to minimize biases and increase accuracy during the data analysis process. In this process, I promised each participant that they would have privacy, confidentiality and anonymity.[49] However, due to legality and important sensitivity issues, only 17 participants agreed to be recorded.

Interviews were conducted using a list of semi-structured questions. The list of semi-structured question includes 8-10 general questions that I asked every participant, and 5-7 specific questions depending on the "type" of service provider. The general questions cover two important themes: (1) the experience of resettlement for the relevant migration population, and (2) the service providers perceived trauma of this population. Specific questions are tailored to the service provider so as to gauge their unique perspective. For instance, if the participant is

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[48] Ibid.

[49] Ibid.

categorized as a "lawyer" I would ask: "How does the asylum seeking process seem to impact the well-being of your clients?" While if a participant is categorized as a "psychologist" they were asked: "What are the most common psychological diagnoses for asylum seekers?" (See Appendix C).

Thirty-three of the thirty-four interviews were completed. One interview with a government worker was cut short because the interviewee was uncomfortable divulging information due to legal constraints. I have chosen to include this interview because it provides interesting perspective of the responsibility of the U.S. government. When interviews were recorded, I recorded them using the voice memo device on the iPhone 4. Further, I conducted each interview in English, and therefore did not require translation assistance. I conducted, wrote field notes, and transcribed each recorded interview. As a trained employee at the Department of Public Health within the refugee health clinic, I was uniquely qualified to interview service providers about migrant health. The final data set consists of 17 transcriptions from recorded interviews, and 17 extensive field notes from non-recorded interviews.

All participant involvement was voluntary and therefore I provided no incentive or compensation to the participants. Overall, this increased the validity of this study.[50] In general, most participants expressed an interest in the findings of this study, and I will therefore send them each an abstract of the research findings following the completion of this study.

Data Organization and Analysis

I completed data analysis between November 2015 - March 2016. I analyzed the data using Dedoose coding software. I used approximately 115 external and internal codes in the

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[50] Wolf, Jennifer. Lecture. Course on Advanced Qualitative Data Analysis, Stanford University, California. October, 2015.

coding process (See Appendix D). I created external codes based on current literature characterizing the relationship between immigration and mental health, conversations with service providers and immigration academics, and pre-established research questions. Additionally, I utilized internal codes such as inductive and in vivo codes to reflect the themes and trends which participants identified.[51] I analyzed the data using two coding passes. The first cycle codes are primarily categorical codes that identify "attributes, emotions and themes" in the data sets.[52] Twenty categorical codes are used, and the majority are either descriptive or in vivo codes.[53] Example categorical codes include, "mental health need," "resettlement stressor," and "community." Second cycle codes are sub-categorical codes which draw out more specific themes and patterns in the data.[54] Second cycle codes are generally interpretive. For example, "vulnerability," "migration trauma," and "culturally sensitive" are all sub-categorical, interpretive codes. I organized codes in a coding chart and I assigned a specific definition to each code prior to the coding process. After each coding pass, I wrote analytic memos to help draw conclusions from the specific data set by identifying current propositions based on the data[55] (See Appendix E). Throughout the coding process I commonly employed descriptive, in vivo, process, emotion, and versus coding methods.[56] Throughout the coding process, co-coding was

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[51] Miles, B. Mathew, A. Michael Huberman, and Johnny Saldaña. *Qualitative Data Analysis: A Methods Sourcebook*. Los Angeles, CA: SAGE Publications Ltd. 2014.

[52] Evered, J. (2014). "The Normal School Thing." Exploring the Educational Experiences of Youth

[53] Miles, B. Mathew, A. Michael Huberman, and Johnny Saldaña. *Qualitative Data Analysis: A Methods Sourcebook*. Los Angeles, CA: SAGE Publications Ltd. 2014.

[54] Ibid.

[55] Saldaña, Johnny. *The Coding Manual for Qualitative Researchers*. Los Angeles, CA: SAGE Publications Ltd. 2013.

[56] Ibid.

conducted with fellow trained qualitative data analysts to confirm the utilization of codes and coding definitions.[57]

I used matrices as the primary post-coding tool to systematically draw conclusions about the data from the coding process (See Appendix F). Matrices helped to situate the coding findings into an organized and readable map.

Limitations and Validity Issues

Through verbatim transcripts and detailed field notes, analytic memos following coding, and thoughtful matrix building, this research has descriptive validity as it represents a strong "degree of factual accuracy."[58] Additionally, this study employed multiple strategies to ensure the validity of these findings, including, "checking for researcher effects" and "triangulating."[59] Additionally, as mentioned, this study was limited to data collection from the service provider population.

Overall, the methods used in this research seek to create a community-informed opinion about the realities of refugee and asylee resettlement in the Bay Area. By focusing on the voices of these 34 service providers, I strive to value the perspective of this population. The findings similarly call attention to the unique point of view of service providers and their perception of resettlement for the local refugee and asylee population.

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[57] Miles, B. Mathew, A. Michael Huberman, and Johnny Saldaña. *Qualitative Data Analysis: A Methods Sourcebook*. Los Angeles, CA: SAGE Publications Ltd. 2014.

[58] Wolf, Jennifer. Lecture. Course on Advanced Qualitative Data Analysis, Stanford University, California. October, 2015.

[59] Miles, B. Mathew, A. Michael Huberman, and Johnny Saldaña. *Qualitative Data Analysis: A Methods Sourcebook*. Los Angeles, CA: SAGE Publications Ltd. 2014.

Chapter III. Findings

The findings of this research largely indicate that resettlement in the Bay Area is a traumatic experience for the refugee and asylee population. Due to a variety of barriers to resources, a lack of guidance, and differences in the asylee and refugee resettlement experience, service providers indicate that during resettlement asylees face a heightened risk of trauma than refugees. This section describes the exact findings of this thesis, including both the circumstances of resettlement, and the perceived mental health impact from the service provider perspective.

Circumstances of Trauma Prior to Resettlement

In order to contextualize and infer correlation between resettlement and emotional well-being of migrants, it is important to first analyze the circumstances of refugees and asylees prior to resettlement during the stages of (1) pre-migration and (2) migration. The "refugee and asylee experience" is incredibly nuanced for each individual depending on gender, age, country of origin, story of persecution, migration experience. Therefore, by drawing upon existing literature and interview data, I will highlight the predominant trends of pre-migration and migration for refugees and asylees who resettle in the Bay Area. There is clear evidence from existing literature that by the time refugees and asylees arrive in the United States, they have faced extreme trauma and suffer from poor mental health outcomes. While the information presented in this section is not specific to the Bay Area population, it can be reasonably applied to this specific refugee/asylee demographic.

Pre-migration

According to legal definition, refugees and asylees encounter persecution, or threat thereof, based on "race, religion, nationality, membership to a particular social group or political opinion."[60] Persecution can manifest in many forms. Refugee and asylee service-providers in the Bay Area most commonly describe instances of physical abuse, rape, other forms of sexual assault, torture, forced conscription, other forms of violence, murder of family members, or fear for life.[61] While traditionally refugee status was designed to support migrants fleeing persecution of communist governments, the cause of persecution has spread with the current climate of violence and instability. One example is asylees who migrate from El Salvador, fleeing severe gang violence and "… murder rates 20 times that of the United States."[62] Alternatively, Somalian refugees are fleeing their country of origin due to an environment of conflict and violence caused by several groups of insurgents.**[63]** Regardless of the root cause of persecution, refugees and asylees generally face similar trauma, unrest, and overall persecution in their countries of origin.

Overall, approximately 60 percent of refugees suffer from mental health disorders such as PTSD, depressive disorders, and anxiety. Those who were tortured are especially susceptible to depression, anxiety and post-traumatic stress disorder. Mental health disorders remain particularly prevalent in refugees and asylees who lived in war torn regions for multiple years.[64]

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[60] "Refugees: Flowing Across Borders." *UNHCR: The UN Refugee Agency*. United Nations Human Rights, n.d. Web. 3 Mar. 2016. <http://www.unhcr.org/pages/49c3646c125.html>.

[61] Biasetto, Cristina. Survivors International, San Francisco. "Interview #14." Personal interview. 28 July 2015.

[62] "Violence in El Salvador: Rivers of Blood." *The Economist*. N.p., 10 Oct. 2015. Web. 14 Apr. 2016. <http://www.economist.com/news/americas/21672337-crackdown-gangs-has-so-far-made-things-worse-rivers-blood>.

[63] "Somalia: Overview." *UNHCR: The UN Refugee Agency*. UNHCR, n.d. Web. 4 May 2016. <http://www.unhcr.org/pages/49e483ad6.html>.

[64] Biasetto, Cristina. Survivors International, San Francisco. "Interview #14." Personal interview. 28 July 2015.

Refugees and asylees who have experienced political imprisonment have a 20 percent rate of PTSD as determined by the *Harvard Trauma Questionnaire*[65] but have similar rates of depression as those who were not imprisoned. Overall, the experience of pre-migration, whether it explicitly includes torture, political imprisonment, or exposure to warfare, is highly traumatic for refugees and asylees. Figure 7 identifies the specific factors that influence the mental health outcomes of both adult and child refugees and asylees in both the pre-migration and migration stages.

Premigration	**Migration**
Adult	
Economic, educational and occupational status in country of origin	Trajectory (route, duration)
Disruption of social support, roles and network	Exposure to harsh living conditions (e.g., refugee camps)
Trauma (type, severity, perceived level of threat, number of episodes)	Exposure to violence
Political involvement (commitment to a cause)	Disruption of family and community networks
	Uncertainty about outcome of migration
Child	
Age and developmental stage at migration	Separation from caregiver
Disruption of education	Exposure to violence
Separation from extended family and peer networks	Exposure to harsh living conditions (e.g., refugee camps)
	Poor nutrition
	Uncertainty about future

Figure 7: Factors Influencing Mental Health in Pre-migration and Migration

[65] Mills, Edward J et al. "Prevalence of Mental Disorders and Torture among Tibetan Refugees: A Systematic Review." *BMC International Health and Human Rights* 5 (2005): 7. *PMC*. Web. 5 May 2016.

Migration

The second stage of the refugee and asylee experience, migration, is far more distinct among these two migrant populations then pre-migration. For refugees migration involves, (1) their initial fleeing from their home across the border, sometimes to a refugee camp, and (2) their travel from a refugee camp or temporary settlement to the United States. The first stage of the refugee migration experience is not internationally supported, and is similar to the migration of the asylee population. However, the second stage of the refugee migration experience is internationally supported.

Officially, the migration, or "in transit," period for refugees begins once they leave their home.[66] According to 2015 data, two-thirds of the international refugee population "live in protracted refugee situations," or, refugee camps. This amounts to over 10 million people. This period of time, while considered a place of refuge and escape from persecution, also creates many stressors and can serve as a place of trauma. Research indicates that refugee camps are often dangerous and "may have higher mortality rates than countries of origin due to 'interethnic strife, sexual violence, and disease epidemics.'"[67] This period of time is often riddled with uncertainty and fear for refugees.[68] According to the U.S. State Department, in 1993, the average length of stay in a refugee camp was nine years**.** In 2003, this number jumped significantly to seventeen years.[69] Overall, this experience induces trauma and stress to varying degrees for refugees.

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[66] Wessels, Whitney Keltner, "The Refugee Experience: Involving Pre-migration, In Transit, and Post Migration Issues in Social Services" (2014). Master of Social Work Clinical Research Papers. Paper 409. http://sophia.stkate.edu/msw_papers/409.

[67] Ibid.

[68] Ibid.

[69] "Protracted Refugee Situations." *Diplomacy in Action*. U.S. Department of State, n.d. Web. 4 May 2016.

While refugees most likely face a degree of trauma while fleeing their home, either relocating elsewhere in their home country or traveling to a refugee camp, their migration to the U.S. is relatively smooth. A refugee's migration to the United States is systematic and structured. The International Organization for Migration (IOM), created following World War II, with the direct purpose of managing the migration of refugees, is primarily responsible for their migration preparation and processes. The IOM works closely with other international organizations such as the United Nations High Commission for Refugees (UNHCR) and local agencies to perform its duties. Once refugees are identified by the UNHCR, the refugees will work primarily with the IOM prior to their departure.[70] Their pre-migration program includes: "Case Processing, Health Assessments, Travel Health Assistance and Pre-Departure Orientation/Integration."[71] The IOM manages the transportation of refugees from either their country of origin or refugee camp to the United States. Refugees are not asked to cover the cost of their travel. Instead, IOM initially pays the transportation costs and refugees are expected to repay the fee following their resettlement in the United States. The majority of refugees travel via aircraft as they are departing from overseas.[72] Regardless of whether they are traveling from their country of origin or from a refugee camp, refugees depart with the guidance of aid workers, and are received in the United States by a resettlement caseworker.

Alternatively, asylees traveling to the United States experience an unstructured, independent, and often life-threatening migration journey.[73] Since they have not yet been granted

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[70] "Resettlement Assistance." *International Organization for Migration*. N.p., 2015. Web. 4 May 2016. <https://www.iom.int/resettlement-assistance>.

[71] Ibid.

[72] Ibid.

[73] Rafael, Blythe. East Bay Refugee Forum, Oakland. "Interview #18." Personal interview. 6 August 2015.

asylum status, they are not the responsibility of the U.S. government or other international agencies. During this stage they are commonly referred to as "asylum seekers." As discussed earlier, in the Bay Area, asylum seekers usually arrive in the United States from Central America through Mexico.[74] Without assistance from the UNHCR, the IOM, or other local agencies, asylum seekers must run this gauntlet alone. It is almost always traumatizing. One asylee health provider explains: "People who experience border crossings, if you come by land, are incredibly traumatized and usually involve some period of time where people think they are going to die. Or, they have to hide for extended periods of time, or they may have been detained at some point. (Sometimes) they have been shot at or members of their family have been killed."[75]

Most commonly, Central Americans travel by illegally boarding freight trains, which carry them north on a route displayed in Figure 8.[76]

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[74] Lopez, Lydia. Lawyers' Committee for Civil Rights, San Francisco. "Interview #20." Personal interview. 10 August 2015.

[75] Schoenfeld, Naomi. University of California San Francisco, San Francisco. "Interview #27." Personal interview. 19 August 2015.

[76] Villegas, Rodrigo Dominguez. "Central American Migrants and." *Migrationpolicy.org*. Migration Policy Institute, 10 Sept. 2014. Web. 04 May 2016. <http://www.migrationpolicy.org/article/central-american-migrants-and-la-bestia-route-dangers-and-government-responses>.

Figure 8: "La Bestia" Migration Route for Asylum Seekers[77]

These trains, known as "La Bestia" or "The Beast," pose significant danger to asylum seekers. The routes of asylum seekers are well known to Mexican crime organizations who often exploit the migrants en route. The Migration Policy Institute explains: "At each stage of the journey, migrants are subject to extortion, theft, rape, and even murder if they fail to pay 'protection' and other fees established by these groups."[78] The occurrence of violence and abuse during this route is staggering. Twelve of every thirteen women who travel this route will be subject to sexual abuse.[79]

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[77] Ibid.

[78] Ibid.

[79] Minian, Ana. "Mexican Migration." Stanford University, Stanford, CA. Dec. 2015. Lecture.

Once asylum seekers are close to the U.S.-Mexico border, they often enlist the help of "coyotes" to help them successfully cross the border and avoid run-ins with the U.S. Border Patrol. These "human smugglers" charge significant fees to each of their "clients." However, if caught, asylum seekers can be detained at the border for extended periods of time, and often suffer inhumane treatment and abuse in detention centers.[80] Overall, asylum seekers face severe trauma during the process of migration from Central America.

The Resettlement Experience within the Bay Area

The County Specific Context. Resources and refugee/asylee populations differ dramatically by county in the Bay Area.[81] Historically, the Bay Area has been a host to many refugees. One provider explains, "California has always focused on refugees. When it was just refugees (and not asylees) it was not a challenge."[82] However, with a dramatic rise in the cost of living in San Francisco in the past decade, refugee resettlement agencies have lost their funding.[83] Consequently, the current spread of refugees vs. asylees throughout the Bay Area correlates with the cost of living. Therefore, refugees resettling to the Bay Area are now redirected towards nearby cities to San Francisco such as Oakland and San Jose to find more affordable living arrangements.[84] Now, San Francisco serves a primarily asylee population. Of the ten counties in California that provide services to refugees, San Francisco is the only county

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[80] Burnett, John. "Who Is Smuggling Immigrant Children Across The Border?" *National Public Radio*. NPR, 15 July 2014. Web. 3 Feb. 2016. <http://www.npr.org/sections/parallels/2014/07/15/331477447/who-is-smuggling-immigrant-children-across-the-border>.

[81] Martinez, Christopher. Catholic Charities, Oakland. "Interview #13." Personal interview. 23 July 2015.

[82] Causevic, Samira. Newcomers Health Program, San Francisco. "Interview #1." Personal interview. 29 June 2015.

[83] Martinez, Christopher. Catholic Charities, Oakland. "Interview #13." Personal interview. 23 July 2015.

[84] Ibid.

which serves a majority asylee population.[85] The asylee population in San Francisco County is primarily from Central America. Most commonly, service-providers work with asylees from Nicaragua, Guatemala, El Salvador and Honduras. These asylees speak Spanish or indigenous languages such as Mam. Many of them are monolingual and do not speak English.[86]

Within the Bay Area, one specific group of asylees, many of whom are resettled in San Francisco, has received extensive media coverage in recent years: Unaccompanied Alien Children (UAC). UACs are children under 18 who have traveled to the United States to obtain legal status without accompanying adults. During the summer of 2014, UACs arrived in the Bay Area in unprecedented numbers.[87] Bay Area agencies responded quickly and effectively. Two years later, there are a variety of unique resources available to UACs such as special health and legal benefits.[88]

The refugee population in the Bay Area primarily resides outside of San Francisco in Santa Clara, San Mateo and Alameda Counties. Two primary agencies help resettle refugees in the Bay Area: the International Rescue Committee (IRC), and Catholic Charities. The IRC has offices in both Santa Clara and Alameda Counties, and Catholic Charities works primarily in

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[85] Causevic, Samira. Newcomers Health Program, San Francisco. "Interview #1." Personal interview. 29 June 2015.

[86] Dieterich, Cristy. Newcomers Health Program, San Francisco. “Interview #3.” Personal interview. 2 July 2015.

[87] Lopez, Lydia. Lawyers’ Committee for Civil Rights, San Francisco. “Interview #20.” Personal interview. 10 August 2015.

[88] Following this surge of UACs there has been significant research and writing about this population. Therefore, while I recognize that there is still much advocacy, research and policy needed to improve the current situation of this specific migrant population, they will not be the focus of this paper.

Alameda County. Other small local agencies provide support to refugees and asylees throughout the Bay Area.[89]

Resettlement and Seeking Asylum. Asylum seekers can either apply affirmatively or defensively to become an asylee. If affirmatively, the asylum seeker applies before official entry into the host country, generally at the border. In defensive proceedings, the asylum seeker applies during a deportation trial. With few exceptions, most migrants who seek asylum while in the Bay Area are applying for asylum defensively.[90]

In the Bay Area, the asylum seeking process can last up to two years.[91] To obtain status, asylum seekers work closely with pro-bono legal clinics.[92] While they face deportation due to their undocumented status, their court appearances are a chance to prove that they fled their country of origin due to a well-founded fear of persecution. To do this, asylum seekers are asked to tell their story of persecution in court.[93] Often, they will be asked to tell this story multiple times, including recounting to a lawyer, psychiatrist and court officials. Seeking asylum is a long and bureaucratic process.[94] For example, in the summer of 2015, when this research was

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[89] Many of the service providers and agencies within the four analyzed counties also work closely with other migrant populations such as undocumented immigrants, Survivors of Domestic Violence, Victims of Trafficking, and Special Immigrant Visa Holders (SIV). Similar to the UAC migrants, these populations require significant and specific attention. However, due to limitations in research capacity, this research will avoid looking at the specific needs of other groups of migrants who each face their own specific set of vulnerabilities.

[90] Kelly, Mariam. Community Legal Services of East Palo Alto, East Palo Alto. "Interview #15." Personal interview. 30 July 2015.

[91] Lopez, Lydia. Lawyers' Committee for Civil Rights, San Francisco. "Interview #20." Personal interview. 10 August 2015.

[92] Ibid.

[93] Nelson, Nick. Bay Area Legal Aid, Oakland. "Interview #12." Phone interview. 23 July 2015.

[94] Kelly, Mariam. Community Legal Services of East Palo Alto, East Palo Alto. "Interview #15." Personal interview. 30 July 2015.

conducted, San Francisco defensive asylum cases were backlogged to cases that were filed in August of 2013.[95]

As a part of the asylum seeking process, the migrant will often undergo a thorough forensic evaluation to help prove the physical and mental trauma that they claim in their asylum case. These evaluations are completed upon the request of an asylum attorney. The few physicians who conduct this forensic evaluation in the Bay Area explain that they primarily look for physical evidence of abuse, or prevalence of Post-Traumatic Stress Disorder to help support the asylum cases.[96]

Asylum seekers do not receive housing assistance, cash assistance, food stamps, ESL training, or employment training. This lack of resources only adds to existing mental stress. And, perhaps most importantly, there are limited emotional support services during this time.[97] Consequently, the mental health burden falls to the asylum seeker's lawyer, the only consistent service provider for the asylum seeker during this two year period, a provider who is not formally trained to offer mental health support and guidance.[98] Moving forward, it is important to consistently consider the added stress and trauma that comes with the asylum seeking process for asylees during the resettlement period.

Resettlement Resources. Outside of health resources (which will be looked at separately in the following section), refugees and asylees are similarly eligible for certain federally-funded social benefits. These benefits include: Refugee Cash Assistance (RCA), California Work

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[95] Smith, Michael. East Bay Sanctuary Covenant, Oakland. "Interview #22." Phone interview. 12 August 2015.

[96] Nelson, Nick. Bay Area Legal Aid, Oakland. "Interview #12." Phone interview. 23 July 2015.

[97] Madrid, Mylene. Refugee Health Assessment Program, San Jose. "Interview #4." Personal interview. 8 July 2015.

[98] Lopez, Lydia. Lawyers' Committee for Civil Rights, San Francisco. "Interview #20." Personal interview. 10 August 2015.

Opportunity and Responsibility to Kids (CalWORKs), Refugee Medical Assistance (RMA), Temporary Assistance for Needy Families (TANF), among others.[99] Overall, the benefits available to refugees and asylees upon resettlement are relatively similar. Yet, refugees and asylees in the Bay Area receive differing levels of guidance in obtaining these resources.

Overall, the refugee and asylee resettlement experience in the United States is driven by the concept of "rapid self-sufficiency."[100] The U.S. Department of State agreed to fund resettlement assistance in 1975 to lessen the burden on individual host states. Rapid self-sufficiency is measured in terms of economic self-sufficiency, which, according to the Act of 1980, is defined by: "earning a total family income at a level that enables a family unit to support itself without receipt of a cash assistance grant."[101] Therefore, theoretically the national priority of refugee resettlement, which includes asylee resettlement, is ensuring economic self-sufficiency.[102] This priority is most explicitly enforced through refugee resettlement, however, it also trickles into asylee resettlement through less direct means.

Overall, the policy of rapid self-sufficiency is enforced by providing resettlement agencies with minimal funding to assist refugees within their first ninety days of arrival. This quickly puts a burden on the refugees to achieve economic self-sufficiency. When asked: "What is prioritized in the refugee and asylee resettlement process?" service providers in the Bay Area consistently confirmed that employment and economic independence were the primary concern,

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[99] Causevic, Samira. Newcomers Health Program, San Francisco. "Interview #1." Personal interview. 29 June 2015.

[100] Halpern, Peggy. *Refugee Economic Self-Sufficiency: An Explanatory Study of Approaches Used in Office of Refugee Resettlement Programs*. Rep. U.S. Department of Health and Human Serices, Nov. 2008. Web. 4 May 2016. <https://aspe.hhs.gov/sites/default/files/pdf/75561/report.pdf>.

[101] Harris, Lindsay M. ***Draft Only*** *From Surviving to Thriving? An Investigation of Asylee Integration in the United States*. Forthcoming in the New York University Review of Law and Social Change, 2016. Web. Mar. 2016.

[102] Ibid.

with factors such as health, education, and family reunification coming only after economic self-sufficiency was achieved.[103] Concretely, two-thirds of the thirty-four interviewed service providers indicated that employment was their primary concern. This priority has been historically criticized by refugee resettlement workers. Research suggests that employment services supported by the Office of Refugee Resettlement too narrowly focus on "immediate employment at the expense of obtaining better job matches, especially for highly educated refugees."[104]

Turning to health benefits, the Bay Area provides reliable and consistent physical health resources for refugees/asylees, however, mental health services are generally lacking.[105] Overall, the Affordable Care Act (ACA), signed in 2010, commonly known as "Obamacare," has dramatically improved access to healthcare for refugees and asylees since they gained access to Medi-Cal (California's Medicaid program). Prior to the ACA, subsidized health care was limited to a small population in the United States, primarily based on disability, pregnancy, or number of children in a family.[106] Under this healthcare system, the refugee and asylee population were forced to rely on Refugee Medical Assistance (RMA), which is inferior to the healthcare they can now access. RMA awarded healthcare to both refugees and asylees for up to 8 months.[107] The major problem with this program is that it is unrealistic for refugees and asylees to have the

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[103] Hummer, Karita and Genet Wadajo. Factr, San Jose. "Interview #6." Personal interview. 9 July 2015.

[104] Capps, Randy, and Kathleen Newland. *The Integration Outcomes of U.S. Refugee: Successes and Challenges*. Rep. N.p.: Migration Policy Institute, n.d. Print.

[105] Schoenfeld, Naomi. University of California San Francisco, San Francisco. "Interview #27." Personal interview. 19 August 2015.

[106] Madrid, Mylene. Refugee Health Assessment Program, San Jose. "Interview #4." Personal interview. 8 July 2015.

[107] Causevic, Samira. Newcomers Health Program, San Francisco. "Interview #1." Personal interview. 29 June 2015.

economic ability to independently fund healthcare for themselves and their families after only 8 months. However, with the implementation of the ACA, subsidized healthcare coverage was expanded to millions of people - this expansion included refugees and asylees.[108]

The majority of service-providers agree that the ACA has successfully expanded access to health for refugees and asylees in the Bay Area. However, Medi-Cal is not available to all refugees and asylees.[109] ACA eligibility standards are based on both immigration status (asylee, refugee) and income. Therefore, those refugees/asylees who fall above 138 percent of the federal poverty line are not eligible for Medi-Cal. Instead, they are transitioned onto certain Managed Care plans such as Covered California. Without Medi-Cal, refugees and must pay a premium for healthcare.[110] Health providers unanimously indicate that the 138 percent line unfairly hinders migrant's income. One interviewee, a public health advocate in San Francisco County, explains, "The federal poverty level is a *ridiculous* measure, particularly in a place like San Francisco…"[111] Further, those who fall under 138 percent of the poverty line are still occasionally enrolled in RMA or not transitioned to Medi-Cal due to infrastructural constraints and confusions.[112]

Refugees and asylees who are enrolled in the ACA participate in an extensive medical screening led by the Refugee Health Assessment Program (RHAP) immediately after they are

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[108] Ibid.

[109] Madrid, Mylene. Refugee Health Assessment Program, San Jose. "Interview #4." Personal interview. 8 July 2015.

[110] Cassidy, Amanda. *Health Policy Brief: Basic Health Program*. Rep. N.p.: Robert Wood Johnson Foundation, n.d. Print. 2012.

[111] Lahn, Deena. San Francisco Community Clinic Consortium, San Francisco. "Interview #5." Personal interview. 9 July 2015.

[112] Madrid, Mylene. Refugee Health Assessment Program, San Jose. "Interview #4." Personal interview. 8 July 2015.

enrolled in full-scope Medi-Cal. The RHAP evaluation creates a full medical record of each migrant patient by collecting their medical history, family's medical history, conducting a routine checkup by a health-worker, a thorough checkup by a physician or physician's assistant, urinary and stool tests, and blood tests. The entire assessment costs upwards of $3,000, however, this cost is covered by Medi-Cal for refugees and asylees. In speaking to service providers who run RHAP in both Santa Clara and San Francisco Counties, this program is an essential entry point into the healthcare system for refugees and asylees.[113] Following RHAP, which can be completed in two to four visits depending on the county, health-workers help direct refugees and asylees to a medical home (if not already acquired), and additional health resources.[114]

In addition to the existing preventive care resources available to these migrants, refugees and asylees have access to a variety of safety net services.[115] These are not commonly utilized by refugees and asylees, since they have alternative options, but occasionally they will continue to use these resources in place of more consistent and comprehensive health care. Most commonly, these resources are utilized by asylum seekers when they are still undocumented immigrants.[116] While the RHAP, and services provided by the ACA are relatively similar across the four considered counties in the Bay Area, safety net services vary dramatically by County. San Francisco clearly stands out as the most well-endowed with safety net services. The San Francisco Community Clinic Consortium, a series of ten community clinics which are specifically tailored to serve marginalized communities, such as ethnic minorities, the homeless

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[113] Dieterich, Cristy. Newcomers Health Program, San Francisco. "Interview #3." Personal interview. 2 July 2015.

[114] Rivera, Annie. Newcomers Health Program, San Francisco. "Interview #2." Personal interview. 2 July 2015.

[115] Lahn, Deena. San Francisco Community Clinic Consortium, San Francisco. "Interview #5." Personal interview. 9 July 2015.

[116] Kurniadi, Alice. San Francisco Department of Public Health. "Interview #8." Personal interview. 16 July 2015.

population, and the LGBTQ community, make San Francisco an outstanding source of safety-net services.[117] Additionally, programs such as Healthy San Francisco, who serve a primarily undocumented population, provide quality healthcare for no cost. A final option, beyond Medi-Cal provided services and safety-net services, is the Emergency Room. This resource is often utilized inappropriately for non-emergent situations, and contributes to significant costs for American taxpayers.[118]

Importantly, mental health care is limited for refugees and asylees in the Bay Area. Unlike general health resources, mental health resources are more difficult to access and less systematically provided. Each of the mental health providers interviewed indicated that mental health resources, and funding for mental health services, are particularly lacking for refugees and asylees in the Bay Area. Further, more than fifty percent other service providers questioned about mental health care explained that mental health support for these migrants was not sufficient. Despite research that indicates that the majority of refugee and asylee populations should undergo some form of therapy, only a small portion of the refugee and asylee population participate in therapy during the period of resettlement in the Bay Area.[119] Medi-Cal technically includes coverage for mental health resources, however, access to these resources is inconsistent in the Bay Area. Overall, the most systematic way to receive mental health resources is through the RHAP. Once refugees and asylees have completed the RHAP, if they implied or indicated a need for mental health resources, they are referred to existing services. Certain counties provide exceptional care for these populations. For instance, at San Francisco General Hospital,

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[117] Lahn, Deena. San Francisco Community Clinic Consortium, San Francisco. “Interview #5.” Personal interview. 9 July 2015.

[118] Causevic, Samira. Newcomers Health Program, San Francisco. "Interview #1." Personal interview. 29 June 2015.

[119] Radke, Meredith. International Rescue Committee. “Interview #24.” Personal interview. 17 August 2015.

Newcomers Health Program (NHP) conducts the RHAP.[120] If an asylee demonstrates a need for mental health services, NHP conducts a "warm hand-off" to the Behavioral Health Team, a team of mental health specialists who are located on the same floor as NHP.[121] This easy transition lessens the small barriers that might prevent a refugee or asylee from enrolling in mental health assistance.

There are only a few other mental health providers in the Bay Area who provide high quality mental health resources for refugees and asylees. First, the International Rescue Committee (IRC) in Oakland, one of the key resettlement agencies for refugees in the Bay Area, has uniquely designed a Center for Well-Being (CWB) in the same building as their central office. One caseworker at the IRC indicates, "… all of my mental health clients go to the CWB for therapy sessions and counseling."[122] This program is funded through an Alameda County grant, and while there is only one full-time staff member, CWB is able to consistently see twenty-five to thirty clients on an annual basis. Additionally, Factr, an organization in Santa Clara County, creatively addresses the mental health needs of the refugee and asylee population through art therapy and community psychology strategies.[123] Finally, Survivors International, is one of the only organizations in the Bay Area specifically designed to provide mental health assistance to victims of torture. By using trauma-informed strategies, Survivors International takes referrals from throughout San Francisco County to help serve the refugee and asylee population affected by torture, detention and abuse. However, due to limited funding, they now

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[120] Dieterich, Cristy. Newcomers Health Program, San Francisco. "Interview #3." Personal interview. 2 July 2015.

[121] Ibid.

[122] Radke, Meredith. International Rescue Committee. "Interview #24." Personal interview. 17 August 2015.

[123] Hummer, Karita and Genet Wadajo. Factr, San Jose. "Interview #6." Personal interview. 9 July 2015.

serve only San Francisco County, and cannot extend their services to residents outside of this county.[124] While there are clearly existing options for refugees and asylees to provide direct assistance for their mental health and emotional needs, these resources reach only a very small portion of the population in need.

Guidance in Obtaining Social Benefits. In general, both refugees and asylees are similarly eligible for the resources and social benefits provided throughout the Bay Area. However, despite matching eligibility, refugees tend to enroll and utilize these programs and services much more frequently than asylees.[125] There are a series of possible explanations for this discrepancy. One of the most clear and consistently highlighted explanations is the role of formal guidance, or lack thereof, for refugees and asylees in obtaining these benefits.[126] The support in obtaining existing social benefits/services/resources is a crucial point of divergence in the refugee and asylee resettlement experience.

The distinction between the refugee and asylee resettlement experience starts from the very beginning. Refugees are eligible for the Resettlement and Placement program, commonly known as "R and P" among refugee service providers. Through this program: "primary services are given to every individual refugee that arrives on U.S. soil."[127] The Bureau of Population, Refugees and Migration (PRM) controls the R and P program and dispenses resettlement responsibility and funding to a series of national nonprofit organizations who meet a specific set of guidelines. These organizations are known as "resettlement agencies" and provide the primary

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[124] Martinez, Christopher. Catholic Charities, Oakland. "Interview #13." Personal interview. 23 July 2015.

[125] Dieterich, Cristy. Newcomers Health Program, San Francisco. "Interview #3." Personal interview. 2 July 2015.

[126] Causevic, Samira. Newcomers Health Program, San Francisco. "Interview #1." Personal interview. 29 June 2015.

[127] "Our Services - Resettlement and Placement." *U.S. Together*. N.p., n.d. Web. 4 May 2016.

source of guidance for refugees in their initial thirty to ninety days of resettlement. For instance, in the Bay Area, Catholic Charities and the International Rescue Committee (IRC) generally support refugees up through their first ninety days in the United States.[128]

Resettlement agencies responsible for R and P programs are expected to provide "basic services" which includes an extensive list of approximately 25 items.[129] These include, but are not limited to: "(1) decent, safe and affordable housing, (3) appropriate food and food allowances, (4) assistance in applying for social security cards, (7) transportation to job interviews and job training, (10) assistance in obtaining health screening and mental health services, (14) enrollment in English as a Second Language instruction, (16) airport pick-up, (18) general case management, (19) development and implementation of a resettlement plan."[130] The exact provision of these services varies based on the norms of the state, county, and resettlement agency. And, resettlement agencies, specifically within the Bay Area, face enormous funding constraints. Regardless of the geographic location and cost of living, each national refugee case is allocated $1,125 for their 30-90 day period.[131] Two resettlement caseworkers who work in Oakland adamantly explained that this allowance is insufficient. One explains, "… by the time you have paid rent and the deposit, you have already overspent on your per capita for a client. And then, you need to help them pay for food, household supplies, transportation, to have some sort of cash before public benefits are approved. So, before clients even arrive they are already in negative money."[132]

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[128] Martinez, Christopher. Catholic Charities, Oakland. "Interview #13." Personal interview. 23 July 2015.

[129] "Our Services - Resettlement and Placement." *U.S. Together*. N.p., n.d. Web. 4 May 2016.

[130] Ibid.

[131] Radke, Meredith. International Rescue Committee. "Interview #24." Personal interview. 17 August 2015.

[132] Ibid.

Despite these financial limitations, resettlement agencies in the Bay Area provide comprehensive guidance and care for each resettled refugee. And, with severe cases, refugees are referred to an Intensive Case Manager, who works primarily with refugees with "severe medical conditions, mental health/behavioral health conditions, identify as LGBT, are single parents, or are unaccompanied minors."[133]

While there are remaining challenges to the R and P program in the United States, refugees clearly benefit from the guidance of this program as it is their primary platform to enroll in public benefits and access social services. On the other hand, there is no existing federal resettlement program for asylees in the United States. When asylum seekers are granted asylee status, they do not receive similar assistance to the R and P program to help them resettle and obtain social benefits. The reality, however, pales in comparison to the R and P program for refugees. Rather, when asylum seekers are officially granted asylum in the Bay Area, they are invited to a one time event known as the "Asylum Orientation" through a flyer distributed by the court. This orientation takes place once a month in the Federal Building in San Francisco, and lasts two to four hours. The Asylum Orientation is primarily for asylees who have been granted their status in San Francisco County, however, it is also applicable and accessible to asylees in the surrounding counties, if they are aware of the event.

The Asylum Orientation is co-led by the International Rescue Committee and Newcomers Health Program. The Orientation provides information about public benefits, education, employment, health, immigration status, etc. The Orientation also serves as a way to recruit patients for the Refugee Health Assessment Program. The information provided at the Asylum

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[133] Ibid.

Orientation is crucial for asylees to understand how to access the public benefits they are eligible for such as food stamps and CalWorks programs. However, the delivery of this information hinders the Orientation's effectiveness. Information is delivered primarily in English, while the majority of attendees are generally monolingual Spanish-speaking. Further, the information is delivered quickly, and is confusing to follow. While the directors of the Asylum Orientation agree that it is a step in the right direction, they express consistent frustration and dissatisfaction with the impact of the event.[134]

Barriers to Resources. While there are plentiful resources available for both refugees and asylees, service-providers indicate that only a portion of these migrants actually access the benefits for which they are eligible. Service-providers estimate that asylees enroll in social benefits less frequently than refugees in the Bay Area.[135] This applies to both general benefits, such as employment and housing, in addition to healthcare resources. I asked each interviewee, "What do you see as some of the most prominent challenges for your patient/client population to receive quality and consistent healthcare access?" Collectively, service-providers most commonly cited the following barriers: linguistic sensitivity, overburdened system, lack of mental health services, information gaps, accessibility, other resettlement priorities and cultural stigma.

Service providers indicate that some factors reduce healthcare access for *both* asylees and refugees. These include: the overburdened system, linguistic sensitivity, resettlement priorities, the overall lack of mental health care services and cultural stigma. The healthcare system in the Bay Area is clearly overburdened. With the implementation of the Affordable Care Act in 2010,

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[134] Dieterich, Cristy. Newcomers Health Program, San Francisco. "Interview #3." Personal interview. 2 July 2015.

[135] Causevic, Samira. Newcomers Health Program, San Francisco. "Interview #1." Personal interview. 29 June 2015.

the Bay Area Medi-Cal system has acquired thousands of new patients. The refugee and asylee population, previously enrolled in Refugee Medical Assistance, have similarly transferred to Medi-Cal. Therefore, those migrants who have recently arrived should be automatically enrolled in Medi-Cal. Unfortunately, healthcare providers explain that the logistical process of enrolling migrants in Medi-Cal or other managed care plans has been challenging. One provider from Santa Clara County emphasizes, "…social service agencies are experiencing such a heavy increase in the volume of applications… so some of our clients are getting lost in the shuffle. People who normally go quickly and apply for Medi-Cal and then are all eligible for full-scope coverage… well, all of a sudden they are getting all of these complications and somebody is getting denied."[136]

Once asylees and refugees enroll in Medi-Cal, the problems of an overburdened healthcare system manifest in subsequent challenges. For instance, four service providers indicate that there are simply not enough healthcare providers. Consequently, refugees and asylees face extended wait times at their medical home and sometimes a lower quality of care. Additionally, health clinics often do not meet the language needs of refugees/asylees and providers generally need to utilize third party interpretive services, often a phone-interpreter. Overall, with such an overburdened system, it is difficult for refugees and asylees to access healthcare in both a quick and linguistically sensitive manner.

Further, the resettlement priorities for refugees and asylees only minimally emphasizes the importance of preventive healthcare, and does not prioritize mental healthcare. With a focus on economic self-sufficiency, as previously explained, refugee caseworkers prioritize secure

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[136] Madrid, Mylene. Refugee Health Assessment Program, San Jose. "Interview #4." Personal interview. 8 July 2015.

employment and housing before healthcare. While they ensure that refugees undergo the necessary Refugee Health Assessment, they do not offer further assistance regarding healthcare unless there is a glaring need. There is an even more dramatic lack of mental healthcare prioritization on the part of caseworkers. One provider explained, "The focus should be on meeting the basic material needs for immigrants, such as helping them get settled with food and housing and employment. If we do that first, then the mental health problems and stressors will slowly disappear."[137] When one service provider was directly asked if they thought prioritizing mental health assistance for refugees was important they explained: "Not really, the first steps should be finding housing and a job."[138]

These resettlement priorities primarily affect refugees who work closely with resettlement caseworkers. Alternatively, asylees, as mentioned, do not have resettlement caseworkers. Therefore, their formal resettlement priorities are determined either by their asylum attorney, or by the Asylum Orientation. Two lawyers who work with the asylum seeking population in the Bay Area explain that once their client obtains legal status, they direct them to employment and housing services.[139],[140] However, they do not direct them to healthcare resources, and certainly not mental healthcare services.[141] The Asylum Orientation, alternatively, equally emphasizes public benefits, healthcare, education and employment. But, importantly, the

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[137] Gottlieb, Laura. San Francisco General Hospital, San Francisco. "Interview #25." Phone interview. 17 August 2015.

[138] Ramos, Marisa. Office of Refugee Health. "Interview #17." Phone interview. 5 August 2015.

[139] Lopez, Lydia. Lawyers' Committee for Civil Rights, San Francisco. "Interview #20." Personal interview. 10 August 2015.

[140] Pantchenko, Marina. Bay Area Legal Aid, Oakland. "Interview #7." Personal interview. 13 July 2015.

[141] Lopez, Lydia. Lawyers' Committee for Civil Rights, San Francisco. "Interview #20." Personal interview. 10 August 2015.

healthcare portion of this presentation focuses on the Refugee Health Assessment Program, and does little to direct asylees to long-term healthcare assistance.[142]

A further barrier to resources for both refugees and asylees is the overall the lack of mental health services. Similar to national mental health resources, the Bay Area is limited in quality mental healthcare services. Overall, in San Francisco, Santa Clara, Alameda, and San Mateo counties, mental healthcare resources are limited for the entire population, not just refugees and asylees. One physician located in Alameda County explains that the mental health services are "abysmal."[143] Resources that particularly address the needs of refugees and asylees are both fragmented and fractured, and migrants are forced to rely on pro-bono therapists.[144] However, obtaining even these resources is difficult since they are often distant from the migrant's central health care location. Refugees and asylees are usually referred to mental health resources through the Refugee Health Assessment Program. The few agencies in the Bay Area that focus solely on mental health care for refugees and asylees often have limitations regarding the age and county of residence for the patient, and the number of eligible visits - all of which act as further limitations and disincentives to receiving mental health care. A final challenge which serves as a barrier to resources for refugees and asylees is the cultural stigma associated with mental health needs.

An additional significant barrier that affects access to physical and mental healthcare for refugees and asylees in the Bay Area is commonly known as "information gaps." As previously indicated, refugees and asylees receive drastically different guidance in receiving social benefits

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[142] Dieterich, Cristy. Newcomers Health Program, San Francisco. "Interview #3." Personal interview. 2 July 2015.

[143] Nelson, Nick. Bay Area Legal Aid, Oakland. "Interview #12." Phone interview. 23 July 2015.

[144] Schoenfeld, Naomi. University of California San Francisco, San Francisco. "Interview #27." Personal interview. 19 August 2015.

since refugees have an individual caseworker and asylees are essentially on their own. This barrier clearly impacts their utilization of healthcare resources.

Information gaps manifest in a variety of ways. For instance, agencies often have a difficult time connecting with asylees. Six agencies voluntarily explained the challenge of keeping up to date contact information with asylees, since they are not formally their clients. If an asylee moves addresses or changes cell phone numbers, there is no central database system in which asylee agencies and clinics can see this change.[145] Therefore, agencies often lose track of asylees. In another example, asylee service-providers face information gaps amongst themselves. For example, while the Asylum Orientation is the primary form of resettlement assistance for asylees, several asylee service-providers in San Francisco had never heard of the Asylum Orientation, and therefore have never sent their clients to this important resource.[146] Further, there is no central database that maps out the existing resources available to asylees in the Bay Area. Therefore, asylee service-providers will often "just google" the resources they need, since they do not have a formalized and systematic method of referrals.[147] Similarly, there appear to be few structured referral systems between agencies assisting asylees. Therefore, the responsibility to obtain different resources falls on the asylee and not on the service-provider to make connections. As emphasized in many interviews, giving the asylee the responsibility of obtaining social benefits independently is generally unsuccessful. One service-provider explained the dozens of small barriers that asylees are confronted with: "The things we take for granted, like calling a phone number, and leaving a message… some asylees do not know how to leave a

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[145] Dieterich, Cristy. Newcomers Health Program, San Francisco. "Interview #3." Personal interview. 2 July 2015.

[146] Martinez, Christopher. Catholic Charities, Oakland. "Interview #13." Personal interview. 23 July 2015.

[147] Lopez, Lydia. Lawyers' Committee for Civil Rights, San Francisco. "Interview #20." Personal interview. 10 August 2015.

message!"[148] Overall, information gaps between different agencies, and gaps between service providers and asylees significantly lessen asylee access to local healthcare benefits, and other social benefits.

Perceived Trauma and Mental Health Needs of Resettlement

So far this analysis has answered the first of two research questions: *What are the circumstances of resettlement for refugees and asylees in the Bay Area?* According to the results and analysis of this first question, I will now answer the second question: *In what ways is resettlement perceived as a traumatic experience for refugees and asylees by service providers?* This question heavily relies on the expertise of service providers within the Bay Area, their subjective interpretation of trauma, and their identification of mental health needs within their patient/client population.

Importantly, this section covers the *perceived* trauma and mental health needs of the resettled refugee/asylee population in the Bay Area. Instead of relying on quantitative data, each of these service providers shared their observations and experiences with their patient/client population regarding their mental health. Depending on the background of the service provider, for instance, whether or not they have medical training, each opinion might use a different definition of "mental health" or "trauma." For example, "trauma" in this instance is not always scientifically sound. Trauma in the psychological sense refers to: "… an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea."[149] However, this section

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[148] Ibid.

[149] "Trauma." *American Psychological Association*. N.p., 2016. Web. 01 May 2016.

uses trauma as it is interpreted by refugee and asylee service providers throughout the Bay Area. Therefore, it can be assumed that "trauma" is often conflated with mental/emotional stress or other interpretations of trauma. I chose to use "trauma" to remain consistent with the perspective of the interviewed population since this word was used by more than fifty percent of the thirty-four service providers to describe the refugee/asylee resettlement experience. Similarly, the identified mental health conditions and needs are perceived from service providers with varying degrees of mental health training.

Existing Trauma. The very definition of a "refugee" or "asylee" is inherently linked with trauma. First, as indicated in previous sections, the pre-migration circumstances of refugees and asylees is traumatic. My second research question asks service-providers to consider how the third stage of the refugee and asylee experience, resettlement, creates trauma for these migrants. Importantly, it is extraordinarily difficult to parse out in which stage of the refugee/asylee experience trauma occurs. For instance, while a refugee service provider in the U.S. might witness emotional swings in their client during a stressful resettlement process, their behavior might be a result of pre-existing trauma from their pre-migration and migration experiences. However, the service provider, especially if they are not a mental health provider, might assume that these emotional outbursts are the result of the stressful resettlement period and subsequently classify resettlement as "traumatic" for their client or patient. Therefore, the connections drawn by service providers between the resettlement experience and perceived trauma should be considered as important observations and interpretations, but not as scientific fact.

Stressors of Resettlement. Each interviewee was asked to describe the most prevalent resettlement stressors for their asylee and refugee population. "Resettlement stressor" in this

instance refers to a factor which the service provider believes significantly contributes to stress throughout the resettlement experience. While refugees and asylees suffer some similar resettlement stressors, the interview data implies that asylees suffer more pervasive and extreme resettlement stressors in the Bay Area than refugees. These stressors are inherently linked with the differences of the resettlement experience for refugees and asylees in the Bay Area.

To begin, the primary resettlement stressors which apply to both refugees and asylees in the Bay Area include: cultural adjustment, displacement, employment security, family reunification, lack of a social network, housing, feelings of isolation, language, cost of living and health. The two most commonly cited overlapping stressors (for both refugees and asylees) are housing and feelings of isolation.

First, housing within the Bay Area is a stressor for the average citizen. However, for the refugee or asylee who has recently moved to the United States, has no employment security, and is relying on minimal federal cash assistance, housing insecurity can lead to an immense degree of stress. Over sixty percent of the service providers indicated that housing perpetuates stress and frustration for refugees and asylees. This stress is the result of either a lack of housing, too many family members in a single housing unit, unsafe housing or fear of eviction.[150]

In addition to housing stress, service providers observe that the process of resettling in a new country often leads to severe feelings of isolation. Legal, health and mental health service providers each explained the visible impact of isolation on their clients and patients. Specifically, refugees and asylees who migrate to the Bay Area have often left family members behind and feel emotionally isolated. One provider says, "… being uprooted from your family causes severe

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[150] Mondragon, Aracely. San Francisco Organizing Project, San Mateo. "Interview #11." Personal interview. 22 July 2015.

isolation."[151] Providers indicate that either as an adult or a child this can create trauma. For instance, "… women who are leaving their children behind causes PTSD and leads to tons of somatic complaints."[152] Or, children who have traveled to meet their parents, "… because a lot of their kids did not grow up with their parents, they are dealing with the fact that they don't know this person."[153] Further, migrants also feel culturally and linguistically isolated. Service providers indicate that tasks regarded as extraordinarily simple to the average citizen can cause insurmountable stress for refugees and asylees. One interviewee explains, "…. Health insurance is very foreign! Receipt of bills is astonishing. The "basic" things are so foreign."[154] Similarly, refugees and asylees often do not know how to navigate their new host city. One health provider from San Francisco indicates that the largest stressor is often dealing with public transportation.[155] Overall, service providers repeatedly observe that these factors contribute to the overwhelming sadness, fear and loneliness that their clients experience on a daily basis. For this reason, service providers prioritize connecting asylees and refugees with cultural community centers whenever possible.[156]

Beyond resettlement stressors that affect *both* refugees and asylees, asylees have three additional factors that contribute to their overall resettlement stress. These include: (1) adjusting legal status, (2) fear of deportation and (3) obtaining social benefits without guidance/individual

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[151] Fraimow-Wong, Leah. Street Level Health, Oakland. "Interview #29." Phone interview. 24 August 2015.

[152] Mittal, Pooja. San Francisco General Hospital, San Francisco. "Interview #28." Personal interview. 19 August 2015.

[153] Lopez, Lydia. Lawyers' Committee for Civil Rights, San Francisco. "Interview #20." Personal interview. 10 August 2015.

[154] Rafael, Blythe. East Bay Refugee Forum, Oakland. "Interview #18." Personal interview. 6 August 2015.

[155] Rivera, Annie. Newcomers Health Program, San Francisco. "Interview #2." Personal interview. 2 July 2015.

[156] Lama, Chad. International Rescue Committee, Oakland. "Interview #9." Phone interview. 16 July 2015.

caseworker support. Each of these stressors builds upon the constant uncertainty that asylees face, an uncertainty far greater than that of refugees during resettlement.

To begin, the process of adjusting their legal status is extensive. During this two year time frame in the Bay Area, asylum seekers face a series of challenges. As explained, they are asked to re-tell their story of trauma multiple times throughout the process. One resettlement caseworker explains, "One of the documents that is the most important is their story, the story of their trauma. We tell them, one of the goals in writing their personal statement is to reader emotional, and maybe even cry a little… you have to show that you were a victim of a crime."[157] With such specificity and emotion required in the retelling of their story, this process often causes asylum seekers emotional distress. One mental health provider, who often conducts forensic evaluations for asylum seeking patients, explains the stress that this process can cause, "… for PTSD the worst thing you can do is repeatedly think/talk about it (past trauma)… and this is what they are *required* to do when they are seeking asylum."[158] Interestingly, one service provider felt that the telling and retelling of their story is instead "therapeutic"[159] for the asylum seekers, however, they were in the minority opinion.

Further, during this period, asylum seekers face the constant threat of deportation since they are formally undocumented. While asylum seekers generally suffer a constant fear of authority,[160] they are asked to interact with lawyers, judges and the court on a semi-regular basis during this process, only increasing their level of stress and fear. Overall, asylum seekers face a

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[157] Martinez, Christopher. Catholic Charities, Oakland. "Interview #13." Personal interview. 23 July 2015.

[158] Nelson, Nick. Bay Area Legal Aid, Oakland. "Interview #12." Phone interview. 23 July 2015.

[159] Lopez, Lydia. Lawyers' Committee for Civil Rights, San Francisco. "Interview #20." Personal interview. 10 August 2015.

[160] Kelly, Mariam. Community Legal Services of East Palo Alto, East Palo Alto. "Interview #15." Personal interview. 30 July 2015.

magnified degree of uncertainty during this time. They are uncertain as to whether they can stay with their families in the United States, be deported back to Mexico, obtain legal recognition and social benefits from the U.S. Government. One provider in San Mateo explained: "… there is the constant threat of displacement, this is very relevant to the issue of mental health."[161] To complement this trauma, there is the fact that asylum seekers are wholly unsupported during this trying period. Service providers continuously indicate that the lack of services and guidance available for asylum seekers during their asylum seeking period appears to lead to significant mental stress.[162]

Finally, as referenced in earlier sections, once asylum seekers are eventually granted their legal status, they face significantly more stress than refugees in obtaining their social benefits since they do not have a resettlement caseworker to guide them. "Asylees never benefit from a resettlement agency,"[163] and are instead expected to champion the logistical, language, cultural and systematic barriers they face to enroll in programs such as Medi-Cal, ESL training, housing assistance, CalWorks, food stamps, etc. Asylee service providers explain that this lack of support only further isolates, challenges, and perpetuates conditions of depression and anxiety for asylees.[164]

Clearly, refugees and asylees suffer significant resettlement stressors during this challenging period of their migration experience. The overwhelming consensus from service providers indicates that asylees face more severe and lasting resettlement stressors than refugees.

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[161] "Interview #26." Phone interview. 17 August 2015.

[162] Nelson, Nick. Bay Area Legal Aid, Oakland. "Interview #12." Phone interview. 23 July 2015.

[163] Rafael, Blythe. East Bay Refugee Forum, Oakland. "Interview #18." Personal interview. 6 August 2015.

[164] Smith, Michael. East Bay Sanctuary Covenant, Oakland. "Interview #22." Phone interview. 12 August 2015.

While this should not undermine the overall stress that accompanies the refugee resettlement experience, it should raise question to the disproportionate number of services and resources available to refugees, rather than asylees, upon resettlement in the Bay Area.

Perceived Mental Health Needs

Perceived Mental Health Needs. During the data collection period of this research, interviewees were asked about the health needs of their client/patient population. The results overwhelmingly indicate that mental health needs are both prevalent and rampant within the resettling refugee and asylee community. Of the thirty-four service providers interviewed, twenty-one interviewees were asked: "What are the major health needs your patient/client population faces?" Of these twenty-one people, twenty indicated that mental health is one of the most pressing health concerns. Similarly, of these twenty-one service providers, twenty participants believe that mental health attention should be made more of a priority during the resettlement process. When asked what percentage of their patient/client asylee and refugee population exhibits a need for mental health attention or support, the most common response was ninety percent or higher.

Interestingly, the interviewees who responded most confidently about the mental health needs of the refugee/asylee population, were often not health or mental health providers, rather they were lawyers and resettlement caseworkers. One lawyer explained, "… the overwhelming majority of them have mental health needs. And those needs go unaddressed. So I think it is absolutely critical. I think mental health is so important for this population by virtue of where they have come from and experiencing what they have."[165] Similar to lawyers, caseworkers are

[165] Pantchenko, Marina. Bay Area Legal Aid, Oakland. "Interview #7." Personal interview. 13 July 2015.

concerned about addressing the mental health needs of their client population. One resettlement worker explained, "… they are more likely than not to have some trauma, or post traumatic stress to some degree."[166] Similarly, a caseworker from a differing country explains, "… many of them, I believe, are re-traumatized. This system has set them up for failure. It all goes back to that trauma thing…"[167] These service providers explain that they evaluate the mental health needs of their clients often by their swinging emotions, physical manifestations of stress, deep and obvious sadness, and other behavioral observations.

Health and mental health service providers also consistently stressed the existing mental health needs of the asylee and refugee patient population. One health provider explained that the "… main health needs are the mental health needs"[168] and, "… the impact of immigration on health is totally catastrophic. Every stage induces trauma."[169] A different physician went on to critique some existing misunderstandings within refugee/asylee healthcare, "… people are well-versed in the fact that immigrants have mental health needs, but they do not necessarily do much about the social determinants of those needs."[170] Other health providers confirm that both the overall refugee/asylee experience and particularly the resettlement experience clearly creates trauma for their patients. Most commonly, service providers indicate high rates of PTSD, depressive disorders and anxiety. Only two service providers indicated that more severe

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[166] Lama, Chad. International Rescue Committee, Oakland. "Interview #9." Phone interview. 16 July 2015.

[167] Martinez, Christopher. Catholic Charities, Oakland. "Interview #13." Personal interview. 23 July 2015.

[168] Nelson, Nick. Bay Area Legal Aid, Oakland. "Interview #12." Phone interview. 23 July 2015.

[169] Ibid.

[170] Gottlieb, Laura. San Francisco General Hospital, San Francisco. "Interview #25." Phone interview. 17 August 2015.

psychiatric disorders, such as schizophrenia, are occasionally seen among their patient/client populations.[171],[172]

Overall, the findings indicate that the mental health of both refugees and asylees, from the service provider perspective, is affected during the process of resettlement. The trauma endured during resettlement is a consequence to a variety of factors, namely barriers to resources, and stressors of resettlement. These findings have a series of crucial implications discussed in the following chapter.

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[171] Pantchenko, Marina. Bay Area Legal Aid, Oakland. "Interview #7." Personal interview. 13 July 2015.

[172] Nelson, Nick. Bay Area Legal Aid, Oakland. "Interview #12." Phone interview. 23 July 2015.

Chapter IV. Implications

Overall, the data collected for this research provide important insights into the real-world processes of resettlement for refugees and asylees in the Bay Area. The insights of service providers in this field reveals a deep understanding of both the challenges and resources of the resettlement experience. These service providers make abundantly clear that barriers remain to making the resettlement experience a positive one. Stress and trauma continue to afflict refugees and asylees in the Bay Area. Therefore, in this concluding chapter I draw on the unique knowledge of service providers in order to propose improvements for the resettlement system in the Bay Area.

Service Provider Proposed Solutions

During the interviewing process I asked each service provider to suggest potential improvements: "How might you improve the resettlement process in the Bay Area to lessen the trauma it causes?" "In what ways do you think the resettlement process could be improved for the well-being of refugees and asylees?" Respondents provided nuanced and varied proposals, which I have divided into three broad categories: (1) increase healthcare capacity, (2) create high-level policy change and (3) use community as a tool for healing.

First, most everyone agreed that the existing healthcare system in the Bay Area should be strengthened to better fit the needs of refugees and asylees. Overall capacity of refugee and asylee health services should be improved. Since Medi-Cal systems have been recently overburdened with the expansion of eligibility due to the ACA, there must be more healthcare providers who are qualified to work with the refugee and asylee patient population. Similarly, there should be an increase in linguistically and culturally appropriate healthcare services for

refugees and asylees. Further, service providers indicate that mental health care, specifically, must be improved to meet the glaring needs of the refugee and asylee population resettling in the Bay Area. From the service provider perspective, improving the existing mental health care system requires prioritizing mental health throughout the resettlement process, conducting thorough mental health evaluations upon arrival, and improving the hand off system between health and mental health providers to decrease stigma and encourage the likelihood that migrant patients will follow through with mental health care. Similarly, trauma-informed care should be made more accessible to refugees and asylees, specifically those who are victims of abuse or torture. One service provider explains, "I want equal access for all refugees and asylees for trauma-informed care if people need it, not just if they are coming through specific resettlement agencies."[173] Finally, some service providers indicate that there should be an emphasis on improved health and mental health services for asylum seekers, since their poor healthcare often manifests into poor health outcomes once they have been granted asylum.

Second, beyond improved health care systems, service providers of all sectors call specifically for policy change to minimize the emotional stressors placed on refugees and asylees during resettlement. Some service providers believe that only through high-level immigration reform will conditions improve for refugees and asylees. This includes, improving conditions of migration and adequately resourcing resettlement programs. Other service providers, however, call for more specific policy change. Several service providers hope to address the significant discrepancy in resources between counties by expanding eligibility to resources regardless of the migrant's county of residence. For example, in San Francisco there are a few outstanding mental

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[173] Rafael, Blythe. East Bay Refugee Forum, Oakland. "Interview #18." Personal interview. 6 August 2015.

health clinics that prioritize trauma-informed care. However, because of infrastructural constraints and limitations in grant funding, services are generally not provided for Bay Area residents who do not live in San Francisco. Although San Francisco is the only county in the Bay Area which provides quality therapy specifically targeted at torture victims, many asylees and refugees are disqualified from using these services because of their home address. Service providers indicate that the rule of county lines is unnecessary, and leads to underutilization of services. Service providers also recommend increasing the national poverty level so that more refugees and asylees will be eligible for public health insurance through the ACA. While the ACA expanded healthcare for millions of Americans, including all refugees and asylees, low-income residents who are above 138 percent of the federal poverty level are ineligible for Medicaid (in this case, Medi-Cal). These residents must pay a premium for private health insurance. For many families, this will be financially consequential and they risk spending up to 3 percent of their total income on health coverage. For refugees and asylees in particular who earn a small income, the 138 percent level might be detrimental to their overall living wages.[174] As one service provider explains, "I think they need to increase that poverty line (from 138 percent). I think if you have a parent working two jobs to make ends meet, and somehow they are over that line… I'm like, come on, you don't have the resources to pay for high premium rates for the entire family!"[175]

Third, service providers believe that there should be a larger focus on using community as a tool for healing and wellness among these migrant populations. When refugees and asylees

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[174] Cassidy, Amanda. *Health Policy Brief: Basic Health Program*. Rep. N.p.: Robert Wood Johnson Foundation, n.d. Print. 2012.

[175] Madrid, Mylene. Refugee Health Assessment Program, San Jose. "Interview #4." Personal interview. 8 July 2015.

arrive with limited social networks, they face constant isolation, uncertainty and a persistent lack of belonging. As many health providers explain, "Mental health is directly linked to community building."[176] These providers agree that a stronger community base leads to better mental health outcomes for refugees and asylees in the Bay Area. One provider in Santa Clara County argues that emphasizing community health and using strategies of community well-being is the most effective strategy for encouraging mental and emotional wellness within the refugee and asylee community. This service provider practices these strategies. She said, "… we have community inspiration and community empowerment programs… I see that as a wonderful tool for reaching people and actually building community and mental health for whole populations."[177] Utilizing the community as a tool to improve well-being can involve different components. Beyond encouraging the use of community centers and community building activities by refugees and asylees, a more direct strategy involves utilizing the principles of community psychology and group therapy in order to encourage collaboration and connection in the healing process.

Policy Recommendations

Based on the research presented here, I advocate two major recommendations to improve the existing resettlement circumstances in the Bay Area. I put forward these recommendations with the understanding that there is a need for countless improvements. However, based on my findings, I believe two recommendations demand priority.

First, the overall asylum seeking process must be improved. As described earlier, the existing two-year process perpetuates extreme stress, uncertainty and trauma. Asylum seeking

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[176] Mittal, Pooja. San Francisco General Hospital, San Francisco. "Interview #28." Personal interview. 19 August 2015.

[177] Hummer, Karita and Genet Wadajo. Factr, San Jose. "Interview #6." Personal interview. 9 July 2015.

should be amended in both its time and its process. Ideally, seeking asylum should be shortened from two years to six months, and in no case should it take more than a year. The current extended period of uncertainty creates a prolonged period of fear for the migrants. Further, the legal proceedings should only ask asylum seekers to tell their story of trauma once to either a trained service provider, or during the forensic evaluation with a psychiatrist. While this story is extremely valuable in proving that the migrant faces a "well-founded fear of persecution," it can easily be recorded and shared with multiple stakeholders. There is no good reason to subject asylum seekers to repeatedly re-live their trauma. Finally, during the asylum process, asylum seekers should be offered consistent access to mental health professionals specifically trained in trauma-informed care. Overall, improving the asylum seeking process will only lead to more positive mental health outcomes for asylees once they have been granted legal status.

Second, once asylum seekers have been granted asylum, they should be assisted through a comprehensive and effective resettlement program in the Bay Area. As noted earlier, while refugees have access to the R and P Program and individual caseworker guidance for up to 90 days after resettlement, asylees receive minimal guidance once they have been granted asylum. They may attend one orientation session with dozens of other new asylees where they are inundated with complex information regarding possible benefits and services. Beyond this Asylum Orientation, asylees receive no formal or systematic guidance during resettlement. To address this gap in assistance, local governments should create and fund a resettlement program for asylees in the Bay Area. In the Bay Area, particularly in San Francisco, the asylee population has continued to grow.[178] As the need increases, the Office of Refugee Resettlement cannot

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[178] Dieterich, Cristy. Newcomers Health Program, San Francisco. "Interview #3." Personal interview. 2 July 2015.

ignore the needs of this population. Since resettlement agencies such as the IRC and Catholic Charities are already overburdened, I recommend establishing a separate agency with the sole purpose of assisting asylees in resettling and adjusting once they have been granted legal status. While eventually I believe that these efforts should be instituted at a national level, it will be most effective to start at the local level in San Francisco, a region that is home to a uniquely prevalent asylee population. Such an agency need not be expensive. Resources and social benefits already exist for asylees, and asylees generally do not have the immediate needs of refugees such as housing. Essentially, this agency would act as a central location to help guide asylees to the benefits and resources they are eligible for without requiring the creation of new resources or programs. Further, with a large base of expertise regarding asylee resettlement in San Francisco, existing service providers who strive to offer an improved resettlement experience to asylees could be utilized in this program. Overall, this program would minimize the extreme stress and uncertainty that asylees face once they have been granted asylum. And, it would close the information gaps between asylees and social benefit programs, and parallel asylee agencies. By doing so, existing resources would be better utilized by asylees, there would be increased collaboration across asylee agencies, and asylees would face a less traumatic resettlement experience.

By prioritizing the needs of asylees and asylum seekers, I do not mean to imply that refugees are well provided for or that they experience an easy transition in the Bay Area. Nonetheless, there is a stark imbalance in services and resources among asylees, asylum seekers and refugees, and the research presented here suggests that the needs of asylees and asylum seekers require more urgent attention. The next chapter will highlight how future research could

both strengthen and further this argument to increase both attention and resources for the asylee population.

Chapter V. Conclusion

As deadly conflicts around the world contribute to forced migration and a surge in people fleeing for their safety, it is essential that the United States ensures the safety and well-being of refugees and asylum seekers who reach its shores. The Bay Area is an important leader in this crisis for two reasons. First, California, and the Bay Area in particular, is home to one of the most densely populated refugee/asylee communities in the entire country.[179] And second, the Bay Area is considered one of the most progressive and sensitive host communities in the United States. It would therefore be fitting that the Bay Area set an exemplary model in its treatment of refugees and asylees to catalyze change across the rest of the United States.

General Findings

The research presented in this thesis analyzes the existing circumstances of resettlement for refugees and asylees in the Bay Area. In order to interrogate the potential harm that the resettlement experience inflicts on forced migrants in the Bay Area, I asked two questions: *What are the circumstances of resettlement for refugees and asylees in the Bay Area? And, in what ways is resettlement perceived as a traumatic experience for refugees and asylees?*

My findings indicate that resettlement is indeed a traumatic experience for refugees and asylees. Service providers unanimously believe that resettlement induces trauma and perpetuates mental health problems such as PTSD, major depressive disorders and anxiety for refugees and asylees. These problems result from major stressors of resettlement such as housing insecurity and isolation, barriers to resources, and existing mental health needs upon arrival to the United States. While both migrant groups clearly struggle throughout resettlement, asylees receive far

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[179] Zong, Jie, and Jeanne Batalova. "Refugees and Asylees in the United States." *Migrationpolicy.org*. Migration Policy Institute, 27 Oct. 2015. Web. 15 Feb. 2016. <http://www.migrationpolicy.org/article/refugees-and-asylees-united-states>.

less guidance than refugees and suffer a prolonged resettlement due to the asylum seeking process. Service providers suggest that the following three issue areas should be prioritized in order to improve the overall resettlement process: (1) increase healthcare capacity with a specific focus on mental healthcare, (2) create high-level policy change such as increasing the poverty level for ACA eligibility, and (3) use community as a tool for healing. Based on the existing literature and research findings of this study, I suggest that the Bay Area should first prioritize the asylee population by improving both the asylum seeking process and the guidance asylees receive once they have been granted legal status so they will no longer be treated as a neglected population.

Suggestions for Further Research

The research presented here is a first step in understanding and addressing the mental health needs of forced migrants in the Bay Area. Further research can extend our knowledge in three ways. First, insights from refugee and asylee voices should be gathered. This would remove the limitation of "perceived" circumstances of resettlement, since the research could focus on the firsthand experience of refugees and asylees themselves. Second, new research should focus specifically on the relationship between circumstances of resettlement and mental health impact. The qualitative research conducted here suggests an overall link between resettlement and mental health, but it did not employ formal psychological research strategies. Such methods could be utilized to strengthen the argument that resettlement directly causes mental health trauma. Third, this study does not identify which specific parts of resettlement cause the most trauma. Therefore, further research should narrow in on specific resettlement stressors, such as housing

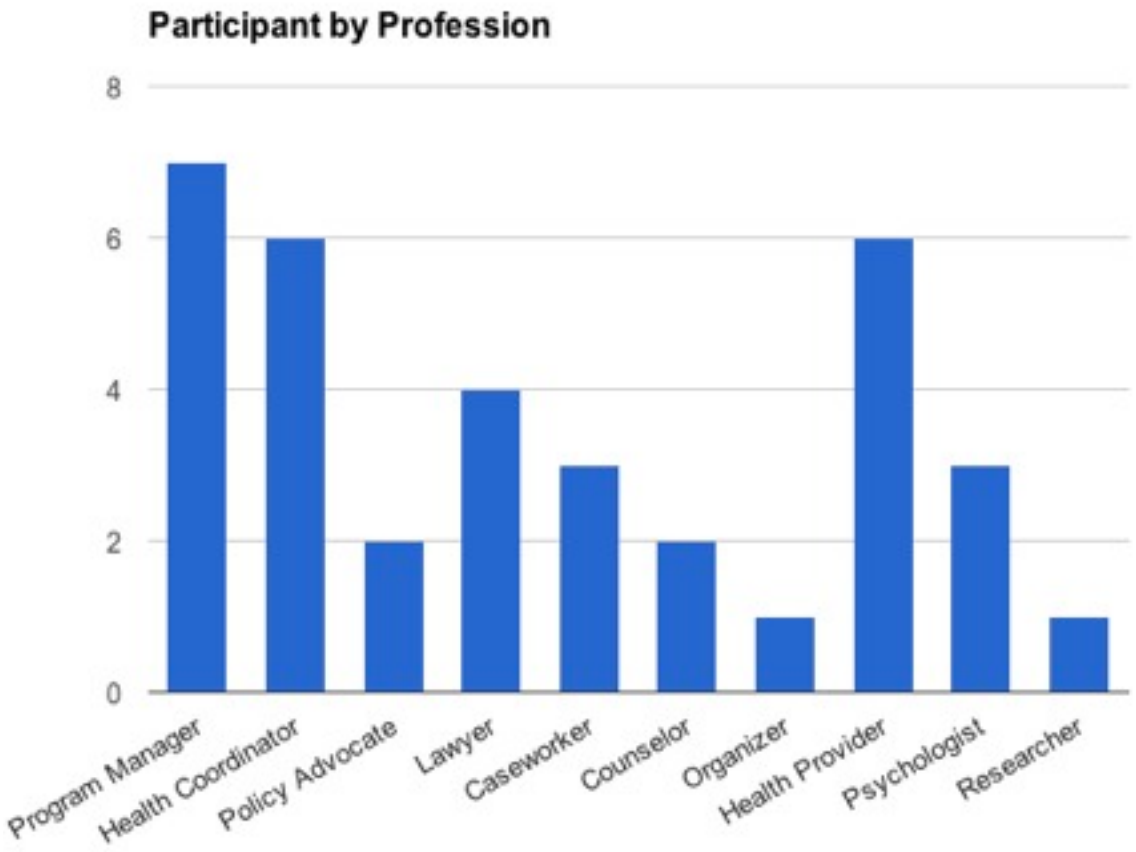
insecurity, unemployment or isolation, to more conclusively claim which specific factors contribute to trauma.

As one service provider poignantly stated, "We made a promise to refugees and asylees that we would help them resettle and help them start a new life. I think it is a promise that is not being kept in spite of all of the hard work."[180] While this study adds to the current discussion and understanding of resettlement in the United States, I hope that it acts as a catalyst for further exploration and analysis in order to improve future refugee and asylee resettlement.

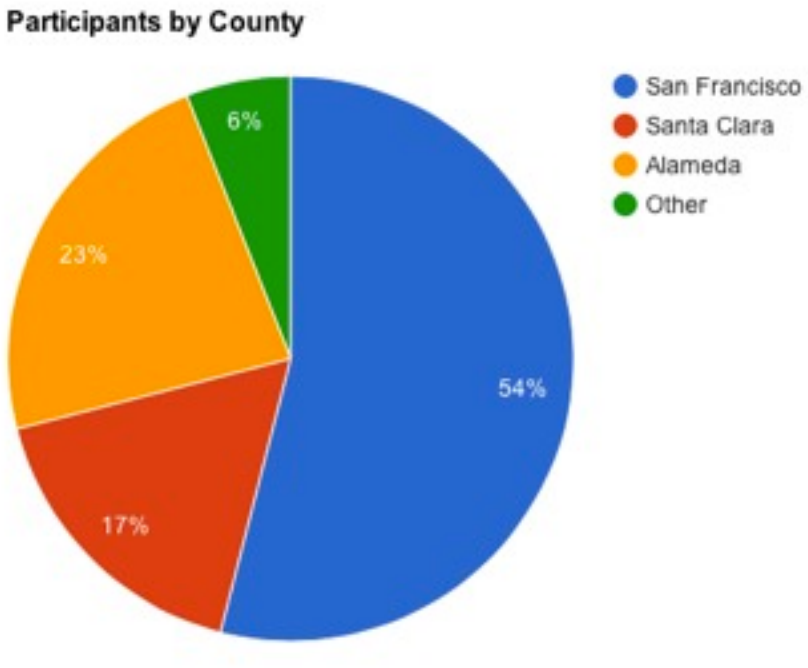
[180] Martinez, Christopher. Catholic Charities, Oakland. "Interview #13." Personal interview. 23 July 2015.

Appendices

Appendix A: Participant by profession



Appendix B: Participants by country



Appendix C: Sample interview questions

General Questions

- What are the main mental health needs of your client/patient population?
- What do you think are the biggest resettlement stressors for your client/patient population?
- Do resources exist for for your patient/client's mental health?
- Do your clients/patients have access to these resources? Why or why not?

Specific Questions

Lawyer

- Do you think the asylum seeking process impacts the overall wellbeing of your clients? How so?
- Where do you refer your patients if the legal process becomes too taxing?

Health Provider

- Which resettlement stressors do you think most severely impact the mental health of your patients?
- Are your patients aware of how these stressors impact their mental health?
- Do your patients prioritize their mental health?

Appendix D: Selections from coding chart

Push factors of migration	Any factor which pushes the migrant out of the country of origin (does NOT include pull factors of migration)	External		
Stage 2	Migration	Categorical		
Government	Federal government	Categorical		
Responsibility	Duty (commonly in reference to the duty of the United States to serve migrants)	External		
ACA	Includes: MediCal, Covered CA	External		
Sanctuary city	A city that has policies designed to not prosecute illegal aliens. Referring to instances that are both by law and by habit.	Internal		
Green card	A permit allowing a foreign national to live and work permanently in the US	External		
Discrepancy	Reference to difference in either services, needs or eligibility based on legal status	Categorical		
Refugee vs. asylee	comparison between ref vs. asy	External/Interpretive		
Refugee vs. asylum seeker	comparison between ref vs. asy-s	External/Interpretive		
Asylee vs. asylum seeker	comparison between vs. asy vs. asy-s	External/Interpretive		
Undocumented vs. documented	comparison between immigrant with legal status vs. immigrant without legal status	External/Interpretive		
Community	a feeling of fellowship with others as a result of sharing common attitudes, experience and place	Categorical		
Support	gaining emotional, or material support from a community	Interpretive		
Psychology	community psychology as a source of healing	Interpretive		

Appendix E: Sample analytic memo

Analytic memos after first pass and second pass of Samira transcription

First pass

Something that went well is that the participant clearly identified robust services that are available to population. Something that did not go well is that "discrepancy" was consistently linked with "legal status" because all discrepancies, by my definition, are connected to legal status. Moving forward, I will reexamine my definition of legal status so it will be not be used extraneously in connection with discrepancy (since it is already implied in the discrepancy definition). One interpretation I am having of my data right now is that there is much less central assistance for asylees than there is for refugees, and San Francisco County is having a hard time adapting to the changing population.

Second pass

Something that went well is identifying the discrepancy in refugee vs. asylee resources. Something that did not go well is I am lacking a sub-categorical code that implies a shift in population is often a barrier to resources. Moving forward, I will create a "shift in population" sub-code since this theme has arisen in other pieces of my data as well. One interpretation that I am having of my data right now is that the recent shift in population, from refugee to asylee, in San Francisco county is causing a failure of resources due to information gaps and inability to adapt.

Appendix F: Sample Matrix

Mental Health Needs and Resources by Legal Status

	Refugee	Asylum seeker/Undocumented combined (?)	Asylee
Resettlement stressor	cultural adjustment, economic, employment, housing cost, self-sufficiency	Housing security, economic stressor, prior persecution/pre-migration trauma, housing conditions, **adjustment of status**	Information gap (not aware of benefits), housing security, economic, finding benefits, reconnecting with family, lack of support network/welcome/orientation
Mental health need	PTSD, depression, anxiety, isolation, pre-migration trauma	fear, vulnerability, isolation, uncertainty, trauma, anxiety, depression, displacement	pre-migration trauma, anxiety, depression
Barrier to resources	availability of resources, stigma, refusal of patient, culture, overburdened system, access, language, culturally sensitive, gov't failure, benefits, waiting times, lack of resources, clinical resources are not sufficient, information gap, ACA confusion, poverty line	clinical resources are not sufficient, availability due to legal status, constraints of law, housing conditions, living conditions, racism, discrimination, language	clinical resources are not sufficient, lack of resources, shifting population, information gap, accessibility to resources, lack of health as a priority, asylees do not qualify for MediCal, no collaboration intra-agency
Existing resources	Center for Well-Being (IRC), SFGH, USCIS, RHAP (Santa Clara), RHAP (SF), ACA	SFGH, community centers (neighborhood centers), Healthy SF, San Mateo Health System, Health PAC	SFGH, Refugee Medical Assistance, Covered California
What is working	"We have also found that past clients help to encourage future clients," community support, comprehensive referral system, collaborative system	community resources, sanctuary cities, community psychology, community support	referrals from asylum office, referrals from CDC, asylum orientation

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