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# A Needs Assessment for an ESL Classroom-Based Mental Health Intervention for Refugees

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# A Needs Assessment for an ESL Classroom-Based Mental Health Intervention for Refugees

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# Abstract

## A Needs Assessment for an ESL Classroom-Based Mental Health Intervention for Refugees

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The purpose of this report is to describe a needs assessment design for a proposed mental health intervention for the refugee population in Austin, TX. A key element of the intervention is its setting in an adult English as a Second Language (ESL) classroom, with the teacher serving as the administrator of the intervention. In the first of part the assessment, the mental health needs of refugees in the Austin area are explored through data collected from a series of informal interviews with individuals who provide services for refugees.

The second part the assessment seeks to identify the possibilities and challenges of utilizing the ESL classroom as a potential setting for mental health service provision. In the proposed design, ten ESL teachers who work with refugees will be interviewed to assess their levels of willingness and preparedness to participate in mental service provision and identify the types of training and support that they would need to serve in a mental health provision role. The interviews will also include the teachers' assessments of different mental health-related activities in terms of their appropriateness for the ESL classroom.

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# Section 1: Introduction

The purpose of this report is to describe a needs assessment design for the proposed intervention discussed in the author's Qualifying Document (QD): "Learning Wellness in a New Language: Assessing the Efficacy of Progressive Muscle Relaxation for Adult Refugees in an English as a Second Language Classroom Setting" (Krivitsky, L. (2014). In the proposed intervention, English as a Second Language (ESL) teachers administer relaxation training and a two-part psychoeducational exercise to refugee students in order to help them cope with symptoms of depression, anxiety, and somatization. While the proposed intervention and assessment take place in controlled conditions and have the primary goal of contributing to academic knowledge, a community-based intervention has different goals and requirements. Stakeholders involved with funding, supporting, carrying out the intervention might raise these questions: Do refugees in Austin actually need a mental health intervention? If ESL teachers are not mental health professionals, are they the appropriate people to provide mental health services to refugees? And since ESL teachers would be the ones to administer it, do *they* think that it is a good intervention for their class?

A thorough needs assessment would help answer these important questions. Needs assessments are a component of the program evaluation process. Unlike traditional academic research, program evaluation is not as concerned with generalizability as with making a program work in its specific setting. Needs assessments are multi-method tools that give program evaluators the information they need to make decisions for program planning and implementation (McKillip, 1998). The goals of this needs assessment is to

inform decision-making about the recipients, administrators and content of the intervention proposed in the author's Qualifying Document for a program that would be implemented in Austin, TX:

- **Goal 1:** To identify the primary mental health needs of refugees who live in Austin, TX and obstacles to fulfilling those needs
- **Goal 2:** To assess the teachers' levels of willingness and preparedness to participate in mental service provision for adult refugees
- **Goal 3:** To identify the types of education, training and support ESL teachers need to serve in a mental health-related role
- **Goal 4:** To identify mental health-related activities that would be appropriate for the adult refugee ESL classroom

Program evaluators prioritize the needs of stakeholders. The primary stakeholders in the intervention proposed in the Qualifying Document were refugee English learners. In a community-based implementation, ESL teachers will also be included as primary stakeholders, because they are likely to be directly impacted by the program's outcome. ESL program coordinators also have a significant stake in in this process, as they work closely with both ESL teachers and students, and are largely accountable the success of the ESL program as a whole.

Other individuals and organizations will have a stake in the program informed by this assessment. Some of the most important stakeholders are directors and board

members of agencies that provide ESL services to refugees, as these individuals are likely to make the final decision about whether a program will be funded and implemented. Funding sources are also stakeholders; they include government entities, religious charities, and refugee resettlement agencies, which are a primary referral source for refugee English learners. Additional stakeholders are parties who are impacted by refugees' mental health and English-speaking abilities, such as mental and medical health professionals, immigrations lawyers and employers.

In designing this needs assessment, the author was guided by Royse, Thyer and Padgett's steps for conducting needs assessments (2010). Table 1 shows each step and the section of the report in which it will be addressed. The needs assessment parameters and specific information sought in this assessment are discussed in the current section. Section 2 describes the data collection and analysis of a series of interviews that the author has conducted with key informants who are involved in service provision for refugees. Section 2 addresses the first goal of this needs assessment.

| **Eight Steps of Conducting Needs Assessment** | **In Present Report** |
|---|---|
| Step 1. Identify needs assessment parameters (goals, scope, stakeholders, resources, time constraints) | Section 1 |
| Step 2. Determine what information needs to be collected | |
| Step 3. Determine if required information is already available in literature or assessor's resources | Section 2; background literature in Section 3 |
| Step 4. Develop methods for data collection | Section 3 |
| Step 5. Implement data collection and analysis | |
| Step 6. Report results and recommendations | Section 4 |
| Step 7. Share results with key stakeholders and receive feedback | |
| Step 8. Present and distribute final conclusions | |

Table 1: Steps in Needs Assessment (Royse, Thyer, & Padgett, 2010)

Section 3 addresses the three remaining goals. This section presents the study design and proposed analysis for a series of interviews with instructions who teach ESL to refugees. These interviews will gather information about the teachers' knowledge and beliefs about mental health concerns that refugee students face; the teachers' attitudes toward the inclusion of mental health topics or activities in ESL; and the types of mental health-related support and education training those teachers have and require. Teachers will then be asked to assess the intervention activities proposed in the QD, as well as several others, for appropriateness for the ESL classroom. Section 4 of this report will discuss how the data collected in the assessment process will be used to inform the implementation of an ESL-based mental health intervention for refugees and describe a program decomposition for the proposed intervention.

## Section 2: Key Informant Interviews

### BACKGROUND

The number of refugees that enter the United States every year is significant. In 2014, close to 69,000 refugees arrived in this country. More than one in ten of these refugees were resettled in Texas, more than in any other state. The plurality of the refugees resettled in Texas in 2014 came from Iraq (2,445), Burma (2,132), Somalia (636), and Bhutan (607) (Office of Refugee Resettlement, 2015). Based on key informant interviews discussed below, roughly one thousand refugees arrive annually in Austin, and in the past year, the plurality of these refugees came from Iraq, followed by Burmese refugees. It should be noted that these figures include only individuals who have been granted refugee status, and does not include asylees and asylum seekers.

Data about refugee psychopathology is highly variable (Murray, Davidson, & Schweitzer, 2010). The struggles and needs of one group of refugees cannot be generalized to another. An Iraqi refugee in Austin is likely to have vastly different set of resources, social networks, opportunities and acculturative experiences than an Iraqi refugee in Cairo, New York, or Midland, TX. Thus, in developing a program in a particular locality, it is important to assess the needs and resource of the refugees in that locality. This section includes an informal needs assessment using data that was collected by the Principal Investigator in 2012-2013, and addresses the first goal of this needs assessment: the identification of refugee mental health needs in Austin, and obstacles to addressing those needs.

## METHOD

This assessment study consisted of six unstructured and interviews with key informants who work with the refugee community. The following guiding questions were developed to guide the interviews, observations and analysis (Corbin & Strauss, 2008):

- What are the primary mental health needs/ problems that the refugee population encounters?
- What are some potential challenges in working with this population?
- What are some possible interventions that would be relevant, feasible and effective?

### Data collection

Data were collected using informal interviews, and recorded through note-taking. It began with a brief, spontaneous interview with the director of the Refugee Services of Texas (RST) in Austin, of one of the two refugee resettlement agencies in the area. The director put the author/PI in contact with collaborators at the School of Work at the University of Texas at Austin. There, the PI interviewed a social worker who provided referrals to other individuals who worked with refugees. These individuals provided the PI with opportunities for ethnographic observations to supplement the interviews. A chart illustrating the snowball process is shown in Figure 1, with key informants in blue and ethnographic observations in red:


Figure 1: Data Collection Sequence

The following are brief descriptions of the key informants and ethnographic observations (names have been changed):

- **D.E.:** Director at Refugee Services of Texas (RST), a refugee resettlement agency in Austin.
- **K.T.:** Social worker who has worked with the refugee community in Austin for the past decade.
- **A.R.:** An Austin area psychologist who had served as the clinical director of an organization that provided mental health services to refugees and other immigrants.
- **C.M.:** The ESL coordinator at a non-profit service organization that provides ESL services to refugees.

- **L.F.:** The clinical director at a resettlement agency in Austin.
- **B.L.:** A co-founder and co-director of an Austin-based organization that focuses on community development, increasing self-sufficiency in the refugee community, and organizes gardening, sewing and soccer groups for refugees, among other services.

The individuals interviewed provided the PI with opportunities for ethnographic observations:

- Refugee Lunch: a monthly lunch organized by the ESL program to which all students and former students are invited; the coordinator gives a short and simple talk and sometimes donations from the community are distributed.
- ESL observation: An observation of beginner and intermediate ESL classes.
- Refugee Orientation: an orientation provided to newly arrived refugees about housing, medical resources, and mental health resources. One of the principle goals for attending this orientation is to observe in which refugees ideas about mental health could be introduced in a non-threatening, nonstigmatizing way.
- Gardening group: meeting on at a community garden, refugees grow vegetables and fruits on individually assigned plots.
- Sewing group: volunteers teach refugees to use sewing machines and assist them in producing clothing for themselves and potential for income.

## RESULTS

Data from interview notes were analyzed using the constant comparative method discussed in Corbin and Strauss (2008), which involves the comparison of data for similarities and differences, based on notes. The PI employed this technique both within each interview and between the different interviews. The themes that emerged were divided into common problems that refugee communities encounter and challenges that are likely to be encountered while working with refugees.

### Isolation

Themes of social isolation and cohesion in refugee communities came up during nearly all of the interviews. Some groups of refugees were markedly more prone to isolation than others. According to the key informants, refugees from Iraq were more likely to experience isolation because of a strong feeling of mistrust of each other; this was attributed to pre-immigration experiences. Interviewees also indicated that individuals in this group were very concerned about how they were perceived and talked about within the community, and that members of the community did appear to talk about each other a great deal.

C.M., the ESL coordinator, also reported that the resettlement agencies tend to house immigrants from the same country in the same apartment complexes, which in the case of Iraqis refugees, increases this isolation. K.T., the social worker, stated that Burmese and Bhutanese communities tend to be more organized and cohesive, and come

together to celebrate holidays from their respective countries. However, a sense of cohesion is not universal among any groups; C.M. reported that there is discrimination in the Burmese community based on religion. Isolation is particularly a problem for women, according to A.R., the psychologist, because they have fewer means of social connection.

**Acculturative issues**

Acculturative issues are a significant source of stress for many refugees. A.R., the psychologist, pointed out that refugees had to contend with new cultural norms in nearly every area of life; work behavior is different; ways of dressing is different; connections to church are different; relationships with family are different. Many are baffled by American norms and laws, ranging from the relatively trivial (inability to drink outside, or smoke inside), to more serious legal issues (e.g. people here get in trouble for driving without a license). Perhaps the most difficult cultural difference for many people to deal with is the difference in acceptable childrearing practices, particularly when it comes to corporal punishment. Many refugees become involved with Child Protective Services because they engage in disciplinary behaviors that they feel make them good parents. Without this type of discipline, many believe their sons will grow up to be undisciplined, and their daughters will grow up to be "bad wives." Additionally, because children are likely to acculturate and learn language faster than adults, parent-child acculturation gaps can cause stress in the family system.

**Unmet expectations**

L.F., the clinical director, discussed another common problem among refugees: unrealistic expectations of what life in the U.S. would be like. Many refugees develop expectations from American TV or from rumors about life in the U.S., they would drive a big car, own a big house, or they would not have to work. As a result, there is a prevailing feeling of dissatisfaction when expectations are inconsistent with reality. Common emotional responses are anger, hopelessness, and resentment. Several key informants have indicated that many refugees, particularly highly educated Iraqi refugees, have training and qualifications from Iraq that are not applicable here, and must therefore settle for jobs that are significantly below their previous pay grade and ability level.

**Psychopathology**

It is not surprising that the challenges described above, coupled with trauma and other stressors experienced before and during the immigration (including time spent in refugee camps), take a psychological toll. Many of the refugee clients that L.F. sees experience many symptoms of Post Traumatic Stress Disorder, in addition to anxiety, depression, insomnia, lack of appetite, self-doubt, an inability to relate to others, disappointment in themselves, and the feeling that they've made a mistake. Many have witnessed traumatizing events, and do not have the coping mechanisms to integrate these experiences using their existing frames of reference. Many do not see their circumstances changing. Given these problems and vulnerabilities, many refugees could benefit from

psychological services, and there is a strong need for research about effective ways to provide such services to refugees. However, there are considerable hurdles to both research and clinical practice with this population.

**Challenges**

The challenge most frequently mentioned by the informants was related to language and the use of interpreters. Using interpreters in therapy and in case work can pose difficulties in terms of all parties understanding each other. However, an equally significant problem is problems with confidentiality and perceived confidentiality. Most translators and many case workers hired by resettlement agencies are people from the refugee community. As a result, there is a strong perceived (and perhaps actual) risk that confidentiality will be breached. An alternative is using family members as translators, but this comes with its own set of issues relating to power structures in the family. Another important factor in providing mental health services is gender issues. Many refugees come from countries that are more socially conservative than the dominant culture in the U.S. As a consequence, a wife may require her husband's permission to participate in individual or group counseling, permission which may or may not be granted. In addition, because some cultures emphasize the separation of men and women who are unrelated to each other, any type of group therapy would likely need to be single sex.

One of the greatest obstacles to providing any type of mental health services or interventions for the refugee community is the high amount of stigma surrounding mental health issues in many cultures. According to the clinical director, the idea of mental health is associated with being taken away to psychiatric institutions "by people in white coats," in the minds of many refugees. This stigma is coupled with a lack of understanding what happens and what to expect in counseling or therapy.

Finally, several of the key informants had mentioned that funding for refugee mental health services is very, very limited. It is the exception rather than the norm to have an in-house mental health professional in a resettlement agency. Specialized, culturally sensitive services for refugees and survivors of torture are rare, particularly outside of large urban areas with very high refugee populations, such as New York or Boston.

## CONCLUSION AND IMPLICATIONS FOR PROGRAM EVALUATION

Based on the data collected in this informal assessment, many members of the refugee population in Austin experience social and psychological problems that are similar to those described in the refugee literature: isolation, depression, anxiety, and PTSD, and difficulty adjusting to life in their adopted country. Language barriers, stigma around mental health concerns and gender-related issues were cited as the most prominent challenges to service provision for this population.

To obtain richer and more representative data about the refugee population in Austin, future assessments could include interviews with refugees themselves. However, this would require a budget for interpreters, and participants may be more reluctant to be open about mental health concerns due to stigmatization. An important ethical consideration in conducting needs assessments, program evaluations and research with this population is the issue of consent. One informant cautioned that recently arrived refugees may not understand that they are not required to respond to questions or provide information about themselves to researchers – and are in fact accustomed to having to disclose personal information as a requisite for receiving refugee status and benefits to fulfill their essential needs. Another potential concern would be the program evaluator's known connection with the refugee assistance organization. A refugee may find it difficult to say no to someone who is connected to an organization that provides him or her with essential services. As a result, an evaluator must be particularly diligent about conveying the voluntary nature of participation for data collection activities.

# Section 3: Mental Health in the ESL Classroom

## Background information: Mental Health and ESL

Teachers of ESL are in a unique position to contribute to refugee mental health. Due to the frequency and structure of ESL classes, teachers have consistent, often daily access to refugees – a population that may otherwise be difficult to reach with mental health services, but that is more likely to be in need of them. Research has indicated that rates of depression, anxiety and PTSD are consistently higher than in non-refugee populations, sometimes by twofold (Lindert, Ehrenstein, Priebe, Mielck, & Brähler, 2009; Porter & Haslam, 2005). These issues are compounded by the stigma around mental illness and help-seeking for mental illness in many of the traditional, collectivist cultures from which refugees emigrate (Lauber & Rössler, 2007; Corrigan, 2004).

The ESL classroom is typically a non-stigmatizing, naturally occurring setting where students experience safety and stability in an otherwise strange and often unstable environment (Baynham, 2006). Given their role as a consistent helper and cultural informant, ESL teacher are likely to have an existing rapport with their refugee students. In fact, teachers are often the first line of contact for refugees' concerns (Adkins, Birman, & Sample, 1999).

Another reasons to explore the use of ESL in mental health provision for refugees is that ESL teachers have a professional stake in their students' mental health. There is substantial evidence that in many contexts, stress can negatively impact learning and memory. This is possibly due to the effects of stress hormones on the growth of cells in

the hippocampus, a brain structure that plays an important role in retaining newly learned information (Park, Campbell, & Diamond, 2001; Mirescu, & Gould, 2006): Joëls, Pu, Wiegert, Oitzl, & Krugers, 2006).

Jenny Horseman has produced a large body of work about the negative impact of trauma and violence on literacy learning. She conducted extensive interviews with literacy workers and counselors, some of whom work with immigrant and refugee women. In a discussion paper titled "'But I'm Not a Therapist': Furthering Discussion about Literacy Work with Survivors of Trauma," she wrote: "One counselor spoke of such women dealing with flashbacks, nightmares, disrupted sleep and depression as a result of their experiences and at the same time coping with problems of settling in a new country. They are too exhausted to learn." (Horsman, 1997). Through her interviews, Horsman found that students' trauma frequently followed them into the classroom, and that literacy workers felt ill-equipped to deal with its effects.

Indeed, literacy workers and ESL teachers are not trained therapists, and this fact may present an obstacle to ESL teachers serving in roles of mental health provision. In order to do so, a certain degree of mental health literacy is required. Mental health literacy is a term created by Anthony F. Jorm and is defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm, Korten, & Jacomb, 1997). This includes an individual's beliefs and knowledge about professional and self-help treatments.

There have been a number of studies that assess mental health literacy among teachers of school-aged children in England, Canada and the U.S. These studies have

indicated that mental health literacy among teachers is limited, and that teachers feel underprepared to help children with mental health concerns (Walter, Gouze, and Lim, 2006; Rothi, Leavey, & Best, 2008; Canadian Teachers' Federation, 2012). It is important to note that in these studies, teachers were able to identify what they did not know and what they needed to know. Gaps in a teacher's mental health literacy can be identify and remedied with training. Indeed, mental health literacy training has been found to improve teachers' mental health knowledge and reduce stigmatizing views, and also increase intent and confidence to provide mental-health related assistance.

Although few and not systematically validated through research, there are several resources specifically developed for ESL teachers for refugees. Adkins, Birman, and Sample (1990) developed a booklet to help educate ESL teachers about the refugee experience. It includes an overview of mental illness and specific disorders, acculturative and resettlement stress, and the stages of cultural adaptation. It also includes a series of mental health-related activities, including the "Total Physical Response" activity utilized in the intervention in the author's QD. It should be noted that mental health is not explicitly discussed in these activities. Another guide available for ESL educators who work with refugees discusses the negative impact of trauma on learning, and makes suggestion for ways in which educators can modify their teaching style to better cater to the unique needs of traumatized students (Isserlis, 2000).

There is much promise in the use of the ESL classroom to improve mental health among refugee students. The success of any education-based intervention depends largely on the teacher/ administrator and the selection of an appropriate intervention. The

purpose of this research is to assess the ESL teachers' willingness, preparedness, and support/ training needs to serve in this important role, and to identify a an intervention that is suitable for this setting.

## METHODS OF DATA COLLECTION

### Participants

The PI will interview 10 beginner, intermediate and/or advanced ESL teachers from three Austin, TX organizations that provide ESL services for this population: Interfaith Action of Central Texas (iACT), Multicultural Refugee Coalition (MRC), and Casa Marianella. The sample will consist of participants who are over the age of 18 and have taught ESL to populations for a minimum of once per week for at least one year. PI has contacts with the ESL coordinators in all three organizations, and has received permission to recruit teachers from each organization. Recruitment will occur in person and by email, and participants will receive a $50 gift card upon completion of the study. Interviews will take place at the site of the program or at the participant's choice of location, and will be audio recorded.

### Procedure

The PI will administer a two-hour semi-structured interview with each participant. Due to its considerable length, participants can elect to complete the interview over the course of two days. The interview questions, listed Appendix A, were developed by the

PI and based on the goals of the assessment. The PI will ask follow-up questions that are not included on the list on an as-needed basis.

The interview contains six sections. The first section is focused on the teacher's training and approach to his or her role and students. The second section consists of a brief assessment of the teacher's mental health literacy. The third section focuses on the teacher's attitudes, opinions and experiences with the incorporation of mental health into the ESL class. The fourth section gathers information about the teacher's experiences around mental health and trauma-related incidents and discussions in the ESL classroom. The fifth section queries the teacher about his or her support or training needs as they pertain to helping refugee students.

In the final section, teachers will be presented with a set of potential mental-health related classroom activities and asked to give their opinions about the feasibility, efficacy and appropriateness of each component in the ESL classroom setting in terms of language level, cultural appropriateness, suggested modifications, and the teacher's own comfort and willingness to administer the activities. The activities discussed will include the following: (1) an exercise that teaches emotion words and calls for students to act out different emotions with their facial expressions and bodies; (2) a facilitated discussion about change, acculturation and coping strategies; (3) a deep breathing exercise: and (4) progressive muscle relaxation.

## DATA ANALYSIS

### Interview questions and analysis

The purpose of this needs assessment is to inform decision-making about the intervention proposed in the Qualifying Document. Unlike academic researchers, program evaluators are required to have results for shareholders shortly after the completion of data collection. In such cases, it is advantages to choose questions, data analysis approaches and coding methods that generate a data set that lends itself to creating a plan of action for the next step in the program development and evaluation process.

In this spirit, several sections of the interview were designed to be "goal-specific," and mapped directly to the goals stated in Section 1. These goals and their corresponding interview sections are illustrated in Table. It should be noted that the *Mental Health and ESL* section is intended to address the "willingness" component of the goal, while the *Mental Health Literacy* section addressed the "preparedness" component in Goals 2, and can help identify areas for potential training for Goal 3.

| Goals | Corresponding Sections |
|---|---|
| Goal 2: To assess the teachers' level of willingness and preparedness to participate in mental health provision for refugees. | Section II: Mental health literacy<br>Section III: ESL and mental health |
| Goal 3: To identify the types of education, training and support ESL teachers need to serve in a mental health-related role. | Section II: Mental health literacy<br>Section V: Support for teachers |
| Goal 4: To identify mental health-related activities that would be appropriate for the adult refugee ESL classroom. | Section VI: Evaluation of intervention |
| (Contextual) | Section I: Information about Teacher Training and Teaching Approach |
| (Contextual) | Section IV: Experiences with Refugee Students |

Table 2: Evaluation Goals and Corresponding Sections in Interview

The remaining two subsets of questions, *Information about Teacher Training and Teaching Approach* and *Experiences with Refugee Students* are intended to add context to the other assessments. For example, an educator who has been teaching refugee ESL classes four times per week for seven years may have a different attitude toward incorporating new activities into her curriculum than an educator who has been co-teaching once per week for a year (Section I). A teacher that has witnessed several mental health crises in his class (Section IV) may express different training needs than one who has not.

Data will be analyzed using a directed content analysis approach. Hsieh and Shannon (2005) describe directed content analysis as a deductive, top-down approach to analysis that involves using theory or previous research to coding categories prior to data collection. After the data becomes available, the sections of data that are applicable for

analysis using these provisional codes are coded. The remaining data are then coded into new categories or subcategories of the provisional codes. Simple frequency counts can help identify patterns in the data (Becker, 1970). Hsieh and Shannon caution that there is a risk of confirmation bias with this approach, as well as a risk of experimenter bias during the interviewing process (Hsieh & Shannon 2005; Saldana 2009). In order to accommodate the goal-directed nature of the assessment while leaving room for more inductive exploration, a variety of coding methods will be used in the present assessment.

Table 3 shows the provisional codes for the interview questions. Coding methods were drawn from Saldana's qualitative coding manual (2009). Provisional category and subcategory codes were used for the "goal specific" sections of the interview (II, III, V,VI). These content codes were developed in connection to specific questions and based on the literature on refugee mental health and the key informant interviews discussed in Section 2. Evaluative coding will be utilized for the intervention evaluation section. These types of codes tie the participant's reaction to its source (e.g. CLEAN-RESTROOM). Evaluative coding is frequently used with magnitude codes, which are symbolic or alphanumeric codes that are added to other codes to indicate frequency, like/dislike, etc. For example, if a participant expresses approval of progressive muscle relaxation, the associated code could be "+PMR." Magnitude codes will be used throughout different sections.

| **Mental health literacy** | **Provisional codes (Saldana, 2009)** |
|---|---|
| 1. When I say the phrase "mental health," what comes to mind for you?<br>2. Based on what you know about the refugee population, what emotional or psychological problems are common? [for issue(s) listed]:<br>a. What do you think causes [issue]?<br>b. How might a person with [issue] act in class?<br>c. What are some ways that [issue] is dealt with or treated?<br>3. [For any of the following psychological concerns that the participant does NOT mention in the previous question: depression, anxiety, PTSD, psychosis] Many refugees experience [issue]. Can you tell me,<br>a. What do you think causes [issue]?<br>b. How might a person with [issue] act in class?<br>c. What are some ways that [issue] is dealt with or treated?<br>d. How would you/ do you feel when you're around students with [issue]?<br>4. Based on what you know about the refugee population, what social or interpersonal problems are common?<br>5. Are you aware of any mental health services in the Austin community that are available and accessible to refugees? If so, what are they? | PROBLEM-DEPRESSION<br>PROBLEM-ANXIETY<br>PROBLEM-ANGER<br>PROBLEM-PSYCHOSIS<br>PROBLEM-STESS<br>PROBLEM-ISOLATION<br>PROBLEM-DISCRIMMINATON<br>PROBLEM-STIGMA<br>PROBLEM-LANG. BARRIER<br>TREATMENT-THERAPY<br>TREATMENT-SELF HELP<br>TREATMETN-SOC SUPPORT<br>TREATMENT-MEDS<br>TREATMENT-EXERCISE<br>TREAMTENT-RELAXATION<br><br>**Magnitude codes (Saldana, 2009)**<br><br>Knowledge about[Issue]:<br>3K=High Knowledge<br>2K=Some Knowledge of<br>1K=Low/No Knowledge<br>-K=Mistaken knowledge<br>ST = Expressed stigmatizing view |
| **Integrating mental health into the ESL** | **Provisional codes (Saldana, 2009)** |
| 6. Are there parts of your curriculum that focus on, or are related to, mental health? If so, please tell me about them.<br>7. Do you think the ESL classroom is an appropriate place for addressing students' mental health needs?<br>a. [If yes] What about the ESL classroom makes it an appropriate place for this?<br>b. [If no] What might make the ESL classroom not an appropriate place for these types of activities?<br>8. If provided with guidelines, how comfortable would you be/ are you in incorporating mental health into your curriculum?<br>9. How willing are you to incorporate mental health into your curriculum?<br>10. In what ways can mental health education or services be incorporated into the ESL classroom?<br>What obstacles do you see or foresee in incorporating mental health into the curriculum? | ESL APPROPRIATE<br>COMFORT<br>INTEREST<br>OBSTACLES<br>WILLINGNESS<br><br>**Magnitude codes (Saldana, 2009)**<br><br>+Positive perception<br>-Negative perception<br>? Don't know/ ambiguous |

Table 3: Predetermined Codes

| | |
|---|---|
| **Support for teachers:**<br>11. What do you enjoy about working with these students?<br>12. Is there anything that makes you frustrated or angry about working with this population? If so, what?<br>13. Is there anything that makes you feel sad about working with this population? If so, what?<br>14. What resources do you have at [organization] to support you in your work with this population?<br>a. [If any] Are they sufficient for your needs?<br>15. What other types of training or resources would help you in you work, particularly with refugee mental health?<br>16. What specific types of information or education would you like to acquire?<br>17. What specific skills would you like to be trained in? | **Provisional codes (Saldana, 2009)**<br><br>RESOURCES<br>TRAINING<br><br>**Magnitude codes (Saldana, 2009)**<br>+Positive perception<br>-Negative perception<br>? Don't know/ ambiguous |
| **Evaluation of intervention:**<br>18. Are you familiar with any relaxation exercises? If so, please tell me about them.<br>19. [PI will describe the discussion-based interventions (Total Physical Response, discussion of acculturation and coping strategies) and demonstrate the relaxation exercises (deep breathing, progressive muscle relaxation) with the participant. Ask: On a scale of 1-5…<br>a. How useful do you think this exercise would be for the students in your classroom?<br>i. What about it would be useful/ not useful?<br>b. How language appropriate is this exercise for your students<br>i. [If not language appropriate] How easy or difficult would it be to adapt this activity to the language level in your class?<br>c. How culturally appropriate would this exercise be for the students in your class? This includes the exercise's appropriateness in a mixed-gender class.<br>i. [If inappropriate]: What makes it inappropriate?<br>d. In what ways would you modify this exercise to make it more appropriate for your class?<br>e. Given any changes you would make, how likely would you be to do this exercise in your own class?<br>20. In what kind of format would you incorporate mental-health related activates in your class? In a separate mental health unit, as part of the health unit, interspersed thought other units (e.g. starting each class with a relaxation exercise)? | **Evaluative Codes (Saldana, 2009)**<br><br>Exercises:<br>REC:<br>TPR:<br>PMR:<br>BRT:<br>COP:<br><br>Categories for Evaluation<br>LANG:<br>USE:<br>CULT:<br>LIKELY:<br><br>**Magnitude codes (Saldana, 2009)**<br>+Positive perception<br>-Negative perception<br>? Don't know/ ambiguous<br><br>Approval Scale<br>1<br>2<br>3<br>4<br>5 |

Table 3: Predetermined Codes, cont.

# Section 4: Next Steps

## Conclusions and next steps

Data from the key informant interviews described in Section 2 of this report reveal that many refugees in the Austin area are faced with a myriad of psychosocial and mental-health related difficulties, including acculturative problems, social isolation, depression, anxiety, and trauma-related problems. These data, combined with the literature on refugee mental health issues, demonstrates a clear need for mental health services for this population. However, two major obstacles to mental health access cited by the informants and supported by the literature are language barriers and stigma around mental illness and help-seeking (Miller & Rasco, 2004). These findings support the idea that the ESL classroom, as a non-stigmatizing setting that caters to individuals with lower-level English skills, is a promising setting for mental health service provision.

After collecting and analyzing the teacher interview data, results will be shared with the stakeholders associated with the ESL program (teachers, ESL coordinators, and agency directors) to elicit feedback and discuss the next steps. Final reports will then be disseminated to the agency board and funders. If the data indicate that ESL teachers are willing and prepared to engage in mental health-related activities their classrooms, and if they find the intervention activities presented in the interviews appropriate and potentially helpful for their students, the next step could be to plan the implementation of the intervention program. This would involve collaborating with teachers who volunteer to engage in this intervention to finalize a curriculum, working to address gaps in mental health literacy and seeking out any other resources that are called for to support teachers

in this role. To inform program implementation and aid in subsequent program evaluation, is useful to identify the inputs, constraints and intended outcomes at each stage of the program. This can be accomplished with a program decomposition, presented below.

## PROGRAM DECOMPOSITION

### First Level Transactions

The primary purpose of the program is to improve the mental health of refugee students in an ESL setting through teaching them progressive muscle relaxation, a widely used relaxation technique that has been used to cope with depression, anxiety, and somatic symptoms of distress, as well as develop less stigmatizing views toward their own emotional experiences. The inputs include the students and their teachers, who serve as intervention facilitators, as well as the classroom setting and facilitator scripts and guidelines. Constraints include the skill level of facilitators in administering the intervention, students' language aptitude (as they must learn specific vocabulary to benefit from the program), the severity of students' mental health concerns, and students' preexisting ideas about mental health.

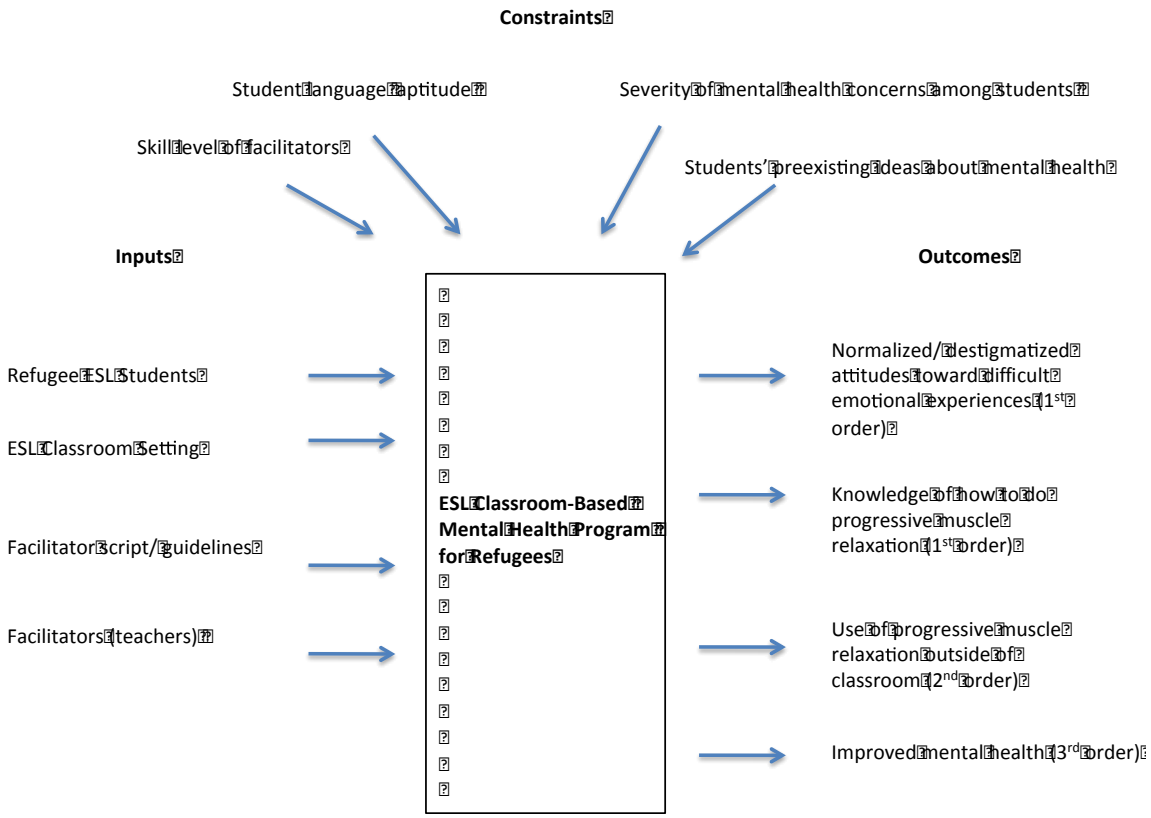


Figure 2: First Level Transactions

## SECOND LEVEL TRANSACTIONS

There are three main transactions in the program. The first two involve conducing an exercise with students in which different emotions are expressed physically and through facial expressions and discussing situations that induce negative emotions and coping mechanisms from students' home countries. These two transactions are intended to normalize and destigmatize difficult emotional experiences in order to create context for

the progressive muscle relaxation intervention and improve engagement and buy-in for the intervention.

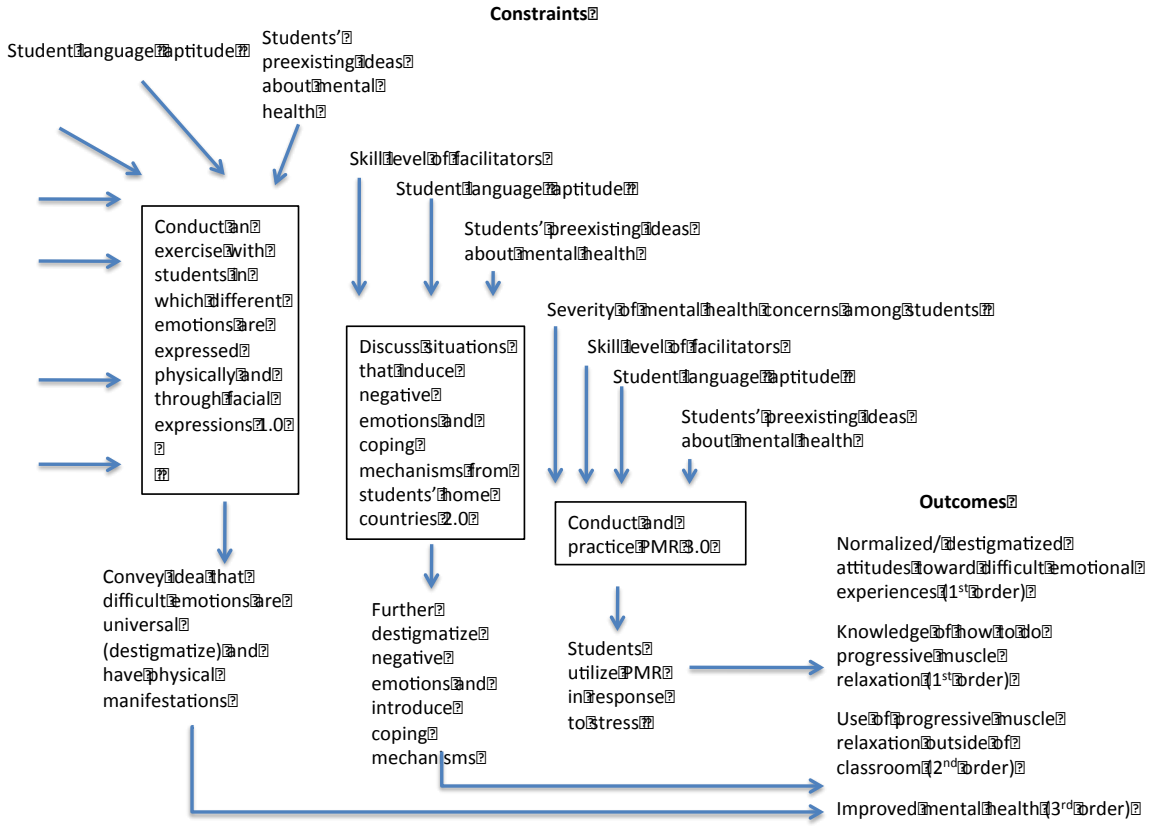


Figure 3: Second Level Transactions

### THIRD LEVEL TRANSACTIONS

This transaction is the "active ingredient" for the intervention and has three subtransactions: teaching vocabulary related to body parts and tension/ relaxation, teaching progressive muscle relaxation skills, and practicing progressive muscle relaxation skills. The goal is to allow the students to learn progressive muscle relaxation, become proficient at using it, and see its efficacy in reducing symptoms to the extent that they will utilize these outside the classroom.

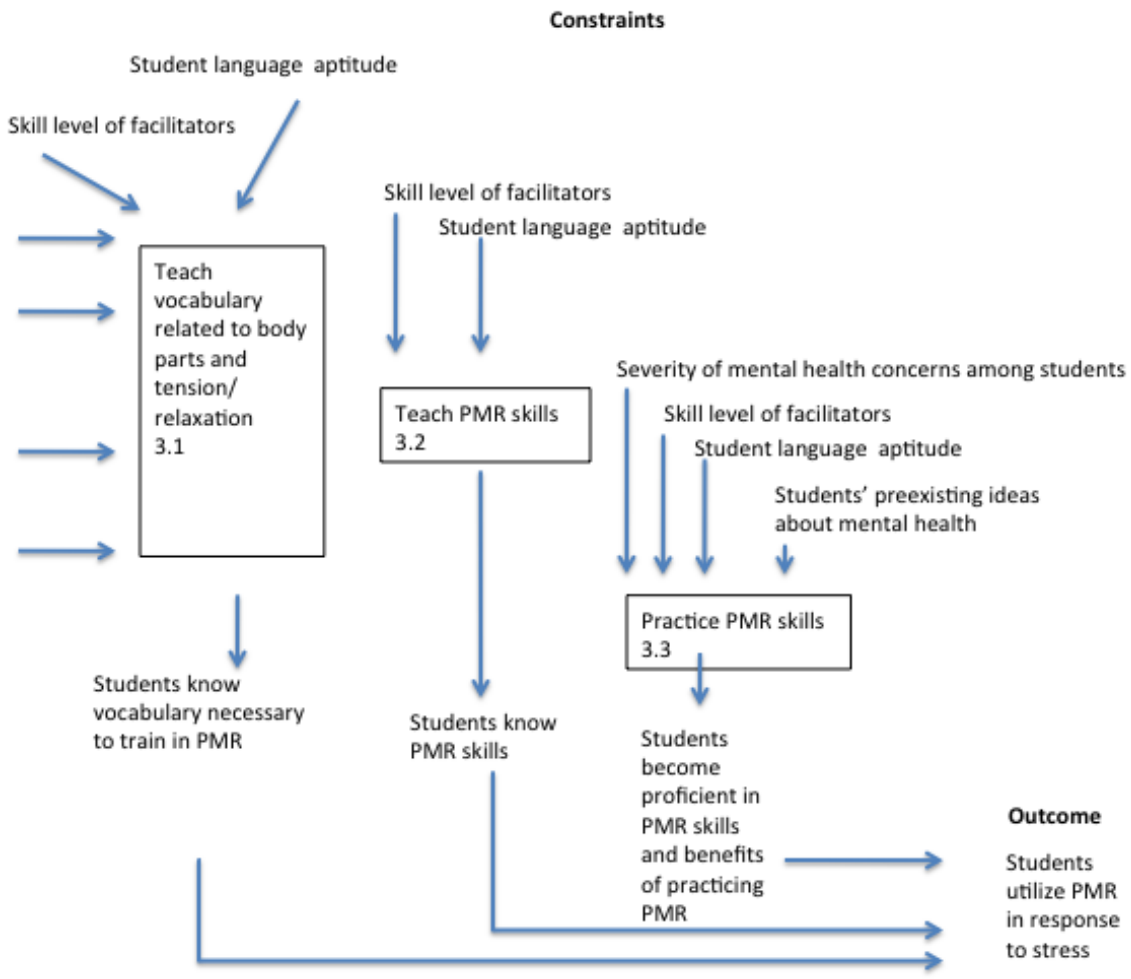


Figure 4: Third Level Transactions: Conduct and Practice PMR

# Appendix A: Interview Questions

## I. Information about teacher training and teaching approach

1. How long have you been at [organization]? How many days do you work? Do you teach your own class or do you co-teach?
2. Tell me about how you see your role at [organization]. What does your job entail?
3. What are your goals for your students? What do you want for them?
4. What kind of training have you had in teaching ESL?
5. What kind of training have you had in working with refugees, if any?
6. Have you had experience teaching ESL to non-refugee students? [if yes]:
    a. What differences did you notice between refugee or non-refugee students or in the atmosphere of the class?
    b. What, if any, are the differences in your approach to teaching this refugees, as opposed to non-refugees?

## II. Mental health literacy

7. When I say the phrase "mental health," what comes to mind for you?
8. Based on what you know about the refugee population, what emotional or psychological problems are common? [for issue(s) listed]:
    d. What do you think causes [issue]?
    e. How might a person with [issue] act in class?
    f. What are some ways that [issue] is dealt with or treated?
9. [For any of the following psychological concerns that the participant does NOT mention in the previous question: depression, anxiety, PTSD, psychosis] Many refugees experience [issue]. Can you tell me,
    a. What do you think causes [issue]?
    b. How might a person with [issue] act in class?
    c. What are some ways that [issue] is dealt with or treated?
    d. How would you/ do you feel when you're around students with [issue]?
10. Based on what you know about the refugee population, what social or interpersonal problems are common?
11. If a refugee student has psychological problems, where could he or she go to get help?

## III. Integrating mental health into ESL

12. Are there parts of your curriculum that focus on, or are related to, mental health? If so, please tell me about them.
13. Do you think the ESL classroom is an appropriate place for addressing students' mental health needs?
    a. [If yes] What about the ESL classroom makes it an appropriate place for this?

b. [If no] What might make the ESL classroom not an appropriate place for these types of activities?

[Ask remaining questions in this section only if participant answered "yes" to the previous question]

14. How comfortable would you be/ are you in incorporating mental health into your curriculum?
15. How willing are you to incorporate mental health into your curriculum?
16. In what ways can mental health education or services be incorporated into the ESL classroom?
17. What obstacles do you see or foresee in incorporating mental health into the curriculum?

**IV. Experiences with refugee students:**

18. Refugees, almost by definition, have undergone some very difficult experiences and typically have a higher rate of stress, grief, depression, and trauma. How you noticed if any of these things have come out in your class? [If probe needed: This could include looking or acting angry, withdrawn, sad or crying, etc.?] [If yes]:
    a. Tell me about those experiences.
    b. How did you respond?
    c. How did you feel?
    d. How prepared did you feel to deal with this situation?
19. Have you had situations in which students share difficult or traumatic experiences in class? [If yes]:
    e. Tell me about those experiences.
    f. How did you respond?
    g. How prepared did you feel to deal with this situation?

**V. Support for teachers**

20. What do you enjoy about working with these students?
21. Is there anything that makes you frustrated or angry about working with this population? If so, what?
22. Is there anything that makes you feel sad about working with this population? If so, what?
23. What resources do you have at [organization] to support you in your work with this population?
    b. [If any] Are they sufficient for your needs?
24. What other types of training or resources would help you in you work, particularly with refugee mental health?
25. What specific types of information or education would you like to acquire?
26. What specific skills would you like to be trained in?

**VI. Evaluation of intervention:**

27. Are you familiar with any relaxation exercises? If so, please tell me about them.
28. [PI will describe the discussion-based interventions (Total Physical Response, discussion of acculturation and coping strategies) and demonstrate the relaxation exercises (deep breathing, progressive muscle relaxation) with the participant. After each of the exercises, ask:
    a. How useful do you think this exercise would be for the students in your classroom?
        i. What about it would be useful/ not useful?
    b. How language appropriate is this exercise for your students
        i. [If not language appropriate] How easy or difficult would it be to adapt this activity to the language level in your class?
    c. How culturally appropriate would this exercise be for the students in your class? This includes the exercise's appropriateness in a mixed-gender class.
        i. [If inappropriate]: What makes it inappropriate?
    d. In what ways would you modify this exercise to make it more appropriate for your class?
    e. Given any changes you would make, how likely would you be to do this exercise in your own class?
29. In what kind of format would you incorporate mental-health related activates in your class? In a separate mental health unit, as part of the health unit, interspersed thought other units (e.g. starting each class with a relaxation exercise)?

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