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# *Problems and Solutions in US Refugee Resettlement Policy:*

An Interview with Liyam Eloul, MA

by Marisa Kanof

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**L**iyam Eloul is a trauma therapist specialized in the field of refugee mental health. She received her BA in Cultural Psychology from Queen's University, Ontario, a graduate diploma in Psychosocial Interventions for Refugees and Forced Migrants at the American University in Cairo, and her MA in International Disaster Psychology from the University of Denver. Eloul has worked with resettled refugee populations in the United States and refugee populations in Egypt, Afghanistan, Syria, Oman, and Jordan. She received a Fulbright Award for cross-cultural trauma research in Oman, and has published on mental health and psychosocial programming in the United States, Oman, and Syria. Currently, Eloul is a Psychotherapist Trainer with the Center for Victims of Torture in Amman, Jordan.

For much of 2015, heartbreaking and celebratory images of refugees fleeing their home countries flooded television screens and airwaves. While the media focused on the scores of refugees crossing into Europe and called for the United States to increase the number of refugees the country would accept into its borders, the public has paid little attention to the process that resettled refugees go through once they arrive in the United States, or to the possible negative outcomes this process can yield.

Marisa Kanof spoke with caseworker and trauma therapist Liyam Eloul, who has worked extensively with refugee populations domestically and abroad, to discuss problems with the current US refugee resettlement system, as well as changes that could be made to make the system better both for refugees and the United States government. Eloul believes that the sprawling, loosely coordinated refugee resettlement system uses resources inefficiently and needs a central authoritative body and increased oversight of the agencies that place resettled refugees. With the right policy changes, Eloul believes that the United States could maximize the productivity of each resettled refugee family.

## BACKGROUND

As defined by the Refugee Act of 1980, a refugee is any person who is: “outside his country of nationality (or in the case of a person having no nationality, is outside any country in which he last habitually resided), and who is unable or unwilling to return to such country because of persecution or a well-founded fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group” (Refugee Act of 1979).

After consultation with Congress, the President sets the ceiling for the number of refugees who can be resettled in the United States in any given year (Bruno 2015, 1). For the past 10 years, that ceiling has been between 70,000 and 80,000 refugees, although the number of refugees actually resettled is usually lower (Bruno 2015, 3, 11). Refugees are resettled from all over the world to locations throughout the United States; however, California, Florida, New York, and Texas have taken in the highest numbers of refugees over the past 10 years (State 2015).

As Andorra Bruno, a Specialist in Immigration Policy with the Congressional Research Service explains, unlike immigrants who enter the United States through family or employment ties, refugees are admitted on humanitarian grounds; therefore, they are not expected to be economically self-sufficient (Bruno 2015, 8). As a result, refugees are eligible for federal programs such as Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), Medicaid, and Supplemental Security Income (SSI) for many years after they enter the United States (Bruno 2015, 10). Therefore, a major focus of the 1980 Refugee Act is to provide assistance for refugees to become economically self-sufficient (HHS, 2012).

Unfortunately, like many well-intentioned policies, the situation on the ground is often different from the text found in statutes. As Eloul explains, existing refugee resettlement operations in the United States are not helpful in promoting economic self-sufficiency or mental wellness of refugees. However, there are changes that could be instituted that could help fix the system.

### **Policy Perspectives: How did you become interested in the policy implications behind current refugee resettlement programs?**

**Liyam Eloul:** I am a trauma therapist, and I got involved in refugee work in the Middle East initially with the fall-out of the Iraq war back in 2007. Since then, I have worked

with refugees both in countries of first asylum [countries where refugees are first taken in while awaiting resettlement or repatriation, often the first country a refugee crosses into], and after resettlement in the United States. It was when I was working in Denver as the clinical social worker for a building that housed a high proportion of refugees that I began to examine the resettlement system in the United States. This was in 2012, and at the time, Alabama had just passed the harshest state anti-immigration law in the country (HB 56), the result of which had been a mass exodus of undocumented workers and the collapse of the agriculture industry in the state. Most of the families I was working with were from Myanmar (Burma), the majority from rural agricultural villages. They had been resettled in urban Denver and were having trouble finding suitable work. Most were preliterate in their own language and struggling with English, as well as with the new climate. They were begging me for garden space, somewhere to plant something. The absurdity of the situation struck me: here was a huge group of men and women who are accustomed to warm, wet planting seasons, who are skilled farmers and value manual labor, and they are stuck in an apartment tower, applying for TANF because they cannot find a job that matches their skills, while four states over, farmers are busing in the inner-city unemployed to harvest their fields and having them all quit within a day because the work is too strenuous. I thought there just has to be a smarter way to do this, and I began to wonder why it wasn't happening.

**PP: How does the current US refugee resettlement system work?**

**LE:** It's important to remember that resettlement is generally considered a last option for refugees. It's more much common that refugees either stay in their country of first asylum or repatriate to their home countries once it has been deemed safe for them to do so. For a refugee to be eligible for resettlement, it has to untenable for him or her to be repatriated to his or her own country. An example would be a refugee who flees his home country due to LGBTI persecution, and then the country of first asylum is also one that persecutes LGBTI individuals. In this way, refugees who are eligible for resettlement are often the most vulnerable of an already vulnerable population.

The resettlement process begins in the country of first asylum. Once a refugee is determined eligible for resettlement in the United States - either by the United Nations High Commissioner for Refugees (UNHCR) or another international NGO (INGO), or by a US embassy - they go through a standardized process for referral. The Resettlement Support Center (RSC), whose office is sponsored by the Bureau of Population, Refugees and Migration (PRM), develops a refugee portfolio. This portfolio contains biographic data which is used to ensure eligibility and initiate background checks. Then the refugee goes through an interview process with US Citizenship and Immigration Services (USCIS) to approve the refugee for resettlement. Following this, the refugee is submitted to a medical examination to ensure that they are not carrying a transmissible disease. Once this medical exam and the background checks are cleared, the refugee portfolio created by the RSC is shared with the PRM committee and referred to one of the 11 US-based Voluntary Agencies (VOLAGs) for sponsorship.

**PP: What are VOLAGs?**

**LE:** VOLAGs are religious or community-based organizations (such as the Church World Service, the International Rescue Committee, or the Hebrew Immigrant Aid Society) that maintain offices in a myriad of communities across the United States. There is no central authority or agency that governs the VOLAGs because the system grew organically out of the aftermath of World War II, when religious organizations were doing the work of charities and sponsoring refugees who came over from Europe. Eventually, this practice got formalized via government contracts, which is why VOLAGs receive a small stipend from the federal government for each refugee they assist.

Each VOLAG has a “cooperative agreement” with PRM/the Office of Refugee Resettlement (ORR) regarding the services that they will provide refugees (job training, language acquisition skills, housing, etc); however, there is no consistent or systematic regulation of the VOLAGs, so there exists a great discrepancy in services provided to newly-arrived refugees. I had reports of some refugees getting picked up at the airport, handed a check, and then dropped off in inner-city Los Angeles; conversely, others have been provided extensive care. In many cases, the quality of care varies by local office as much as it does by agency, and it can fluctuate depending on the current management of that office and the level of burnout of employees.

**PP: What doesn't work about this system?**

**LE:** With the passage of the 1980 Refugee Act, ORR was established under the Department of Health and Human Services (HHS) with the goal of developing a coherent policy for efficient and comprehensive refugee admissions and services. The office of US Coordinator for Refugee Affairs was also established, appointed by the President to head the ORR. However, despite the intention for a coherent system, what developed was an unwieldy conglomeration of three sectors: refugee processing, refugee admissions, and refugee resettlement. Each sector has its own budget and is managed by a separate government agency: USCIS, BRPM, and the HHS Administration for Children and Families (ACF), respectively. The result is an intricate and often inefficient system of governmental and non-governmental organizations, both national and international, which are only loosely coordinated by the USCIS Refugee Affairs division.

Due to the three arms, there have been a number of interagency coordinating issues, which have compounded over time. The lack of a single authoritative body that governs day-to-day actions and facilitates collaboration has been the source of much inefficiency and is the reason that some basic problems stretch on for years unsolved. For example, information on refugees coming to the United States to be resettled is systematically gathered, but there is currently no efficient way to share the information with receiving agencies. Once a refugee goes through the extensive processing necessary to select and clear them for resettlement in the United States, one of the nine RSC's sends their basic information to the United States/ORR, where there is a weekly meeting with the VOLAGs who will be responsible for determining the location of resettlement within the United States and for providing the first three months of services. At this meeting, the VOLAGs “bid” for clusters of refugees. The meeting is supposed to match refugees

with communities that can best provide services to support them (such as work, medical services, or special needs such as disability or identifying as LGBTI), but it is generally the case that there is insufficient information provided about each case (although more is available), and there does not exist an efficient way to sort the cases (i.e., a database). This results in refugees often being placed in locations that do not support them to be successful and ultimately has a negative impact on their mental health and well-being. Further, since the Refugee Act of 1980, US resettlement policy has focused on early employment, but due to the lack of information-sharing structures, this is usually not facilitated efficiently. This results in many cases like farming families from Burma being resettled to urban Denver where they cannot make use of their skills.

**PP: How does the inability to use their existing skills affect refugees' mental health?**

One of the elements repeatedly found in studies to contribute to mental distress and an exacerbation of existing depression symptoms is unemployment and economic hardship. The lack of appropriate employment and financial independence often results in prolonged or increased psychosocial distress for refugee families. Additionally, this compounds other role reversals within families - such as children learning English faster than their parents and having to act as interpreters and often decision-makers - and can result in dysphoria [unease or frustration] for parents, particularly fathers. Symptoms of depression and anxiety can be exacerbated when the role of the father is undermined in a traditional family. Frequently, attempts to regain control or respect manifests through anger, which can result in situations of domestic violence where none existed previously.

Additionally, many higher-skilled refugees (such as lawyers, doctors, etc.) don't have their licenses recognized when they come to the United States. Many of the job training programs VOLAGs provide don't offer a way to properly train people who already have existing skills, and their skills end up wasted in menial jobs. This leads to them being frustrated or depressed, which then perpetuates this cycle.

**PP: What kind of mental health screening, if any, do refugees receive prior to being resettled?**

**LE:** All refugees are supposed to get a mental health screening as part of their initial health screening upon arrival to their resettlement community. However, in my experience, they are often conducted cursorily. Between language barriers (which are complicated by the difficulties of working through a language line or the social censure of having an interpreter in the room who may be a family or community member), and the use of screening tools that are culturally biased (for example by conforming to Western norms of mind/body separation in terms of how somatic [of the body] symptoms might manifest for mental illnesses), these initial mental health screenings may not capture culture-specific symptom patterns or local expressions of distress that refugees typically demonstrate. As a result, these screenings are frequently token and inaccurate. Unless refugees demonstrate seriously concerning symptoms, they are unlikely to get follow-up care unless they pursue it. This is unlikely for most refugees due to stigma, lack of understanding of the system, and logistical problems such as

transportation, child care, and time constraints with the need to work long hours in low-paying jobs. Thus early detection and referral is vital.

**PP: In your experience do most refugees have existing mental health issues that need to be addressed?**

**LE:** Yes - most refugees demonstrate psychiatric symptoms during their first few months following resettlement - most commonly depression and anxiety. By definition, a refugee has experienced severe loss due to persecution, and often has suffered physical injury. These factors cause psychological harm, and impact resilience, which may otherwise be available to an individual to deal with current life changes. Equally, drastic life changes (such as moving to a new country) can impact the resilience of an individual who was previously able to manage their trauma. It is frequently the case that the initial years after resettlement result in increased stress for refugees due to the language barriers, cultural barriers, discrimination, and alienation. Previously-built coping skills and social support networks are no longer accessible, and refugees are less equipped to deal with the sudden and unexpected increase in stress.

As I mentioned before, refugees eligible for resettlement are the most vulnerable people in an already vulnerable population. Therefore, they are often the least equipped to deal with resettlement. If a country is going to be taking in a vulnerable population, it needs to build an adequate support system to help that population be successful, until they are able to acculturate.

Furthermore, the United States might want to start considering what it means for a refugee to be vulnerable in terms of his or her ability to adjust to life in the United States. For example, a male refugee with some employable skills from an urban area is likely to fare better than a female refugee from a rural area with no work history, who comes from a culture where it's not acceptable to leave the home unaccompanied by a male relative, let alone work and provide for herself.

**PP: What is currently being done to address the unique mental health needs of refugees?**

**LE:** Unfortunately, few mental health programs exist that are refugee-focused. Refugee-specific barriers to available services (including language, cultural, and logistical challenges) are not considered in making mental health services more accessible. However, some organizations and cities have started to address the unique mental health needs of refugees, including the challenge of culturally-biased screening tools that I mentioned earlier. For example, California nonprofit Pathways to Wellness spearheaded the development of a screening tool for use in the mandatory arrival physical health exam, which has been validated for a number of common refugee populations in the United States. It is now being used extensively in King County, WA, with great success, and has facilitated detection, management, and referral for refugees experiencing concerning symptoms. However, due to the lack of a centralized system for developing and regulating refugee care, this tool has not been assessed by ORR or distributed more widely.

Other programs have shown that you can ameliorate mental health symptoms in refugees through training on culturally-sensitive assessment, treatment planning, and therapy, and that this work is often most successful when the refugee community is involved. Developing peer-support programs within refugee communities in which more established community members are trained on resettlement-related stress and mental health - including combating stigma and normalizing symptoms - provides a strengthened social network in refugee communities and allows community members to feel empowered. These mentees are later able to “graduate” to become mentors and facilitators for other refugees.

However, current mental health screening tools are being used sporadically. To solve the problem of cursory mental health examinations, there needs to be some centralized way of determining screening tools for the populations we are bringing in (e.g., Bhutanese Nepalis, Syrians, Iraqis) and making sure that those tools are distributed to the health centers doing the screenings, and that health center workers are trained on using them. Alternatively, these tools need to be available on the CDC website, and there needs to be some monitoring and enforcement of their implementation.

**PP: What should the United States be doing differently to improve refugees’ economic self-sufficiency, and thus their mental health?**

**LE:** The United States could make a significant impact on the psychosocial well-being of resettled refugees, as well as improving local economies and reducing strain on public services, by implementing several policy changes. The problem of mismatch between resettlement location and refugees’ skills could be solved by implementing a systematic way of matching a refugee’s needs, geographic and cultural background, and skill-set with the corresponding information of the resettlement location, and by providing basic social mentorship and work training. A vast amount of data is already being collected on each refugee through the mandatory interviews and background checks and is compiled into portfolios. The most sensible point of intervention is facilitating the use of that data to match refugees with resettlement locations.

Additionally, to solve the problem of skilled refugees (such as nurses) not being able to practice their trades in the United States, the government or the VOLAGs should develop work-training partnerships with community colleges or vocational schools that train-up refugees with existing skills. For example, instead of being forced to take the first job he or she can find as a truck driver or a janitor, a refugee who was a physician in his or her home country should be able to go to community college or a vocational school to become a nurse or a physician assistant. That might not get them back to the title of “physician” that they had in their home country, but it would allow them to have a more lucrative job in a field where their prior skills and educational backgrounds are put to use. Finally, to address the problem of lack of coordination between the different refugee agencies, there has to be some centralized authority system for the VOLAGs such that best practices can be shared between organizations and so that the services the VOLAGs provide can be subject to some minimal standard requirements and oversight.

**PP: What's the bottom line for policy makers??**

The overarching problem is that the resettlement system grew up organically and was never organized - it was just added to, which has resulted in no central authoritative body and very limited regulation and oversight of VOLAGs. It has also resulted in a system that is not smart and does not use its resources efficiently, which means that it is throwing away the capacity that it pays so much to import. The United States is lucky - we have such a diverse geography and economy that with the right policy changes we could really maximize the productivity of each resettled family.

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## ACKNOWLEDGEMENTS

The author thanks the Policy Perspectives editorial team, Monika Jansen and Charlotte Nugent, for their guidance throughout the interview process. She also thanks Charlotte Nugent and Emily Russel for their keen editorial eyes, from which this interview benefited greatly. The author has been lucky enough to learn from some remarkable educators throughout her academic career, particularly the ones who taught her how to write, think critically, and expand her worldview. She would like to acknowledge them here: Jean Moore, Robert Haskett, John Ostlund, Randy Munsen, Connie Shalek, Chris North, Jeffrey Sedgwick, and Vincent Ferraro. Additionally she thanks her parents for their continued support. Finally, the author thanks Harold - he knows why.