

The Karen Chemical Dependency Collaboration: Lessons Learned in Using a Collaborative Framework to Promote Refugee Integration

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Abstract: *While refugee integration is defined as a bidirectional process of mutual learning and adaptation, in practice, the U.S. resettlement program continues to emphasize refugees' acculturation processes and places little emphasis on cultural or logistical adaptation of existing services. When adaptation does happen, it is often structured around dominant notions of health and well-being. There is a need to explore bidirectional integration processes and existing systems adaptations to accommodate people with refugee backgrounds at the institutional level. This article details a framework to build a sustainable collaboration between a refugee community and existing health and social service systems to reduce harmful alcohol use. The conceptual framework emphasizes three components: 1) adaptation of refugees' indigenous expertise, networks, systems, and resources; 2) adaptation of existing systems to serve new groups in culturally relevant and effective ways; and 3) the participatory processes through which refugees and existing systems collaborate to achieve mutual goals. This paper describes the application of this framework and concludes with a discussion of lessons to support replication of the framework in other settings. Lessons learned include: equalizing power, paying attention to relationships and roles, engaging in deep cultural adaptation of interventions, and building individual and organizational capacity to support partners.*

Keywords: *Refugee resettlement; substance abuse; refugee integration; cultural adaptation*

A note from the authors: Throughout the paper we use the language “people with refugee backgrounds” and “communities with refugee backgrounds” rather than “refugees” or “refugee communities”. We believe that overuse of the term “refugee” narrowly defines people according to one life experience, rather than recognizing the intersectional identities that people with refugee backgrounds carry (gender, race, ethnicity, etc.). “People/Communities with refugee backgrounds” recognizes that it is part of life experience, but not the totality of it. Additionally, the term “refugee” often carries with it implications of people who are traumatized, helpless, and victims, which can obscure the strengths and resilience of people who are refugees.

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In 2016, approximately 85,000 people resettled to the United States as legal refugees (U.S. Department of State, 2016). People with refugee backgrounds face a myriad of obstacles to successfully integrating into their new societies (Strang & Ager, 2010). Most have been exposed to numerous life-threatening traumas prior to resettlement. Upon arrival in a resettlement country, they often continue to face difficulty finding meaningful and living wage employment, learning a new language, accessing health care services, and adjusting to a new culture and climate (Fazel, Wheeler, & Danesh, 2005). Pre-and post-migration trauma as well as structural barriers, such as lack of living-wage employment or language barriers, contribute to elevated risk for mental health disorders such as post-traumatic stress disorder and depression, as well as increased substance abuse and family violence (Fazel et al., 2005).

Since 2005, Karen people have been resettling to the United States with refugee status in large numbers. Karen people are an ethnic minority group in Burma (also known as Myanmar). For more than 60 years, since the granting of independence to Burma, Karen people and other ethnic minority groups have been engaged in conflict with the Burmese government for their own autonomy (South, 2012). The Burmese government has perpetuated widespread human rights abuses against Karen people, including kidnapping and forced labor, imprisonment and torture, gender-based violence, and destruction of Karen villages and farmland (Shannon, Vinson, Wieling, Cook, & Letts, 2015). Since the 1980s, more than 200,000 Karen people and other ethnic minority groups have fled Burma (The Border Consortium, 2016). Many have fled to refugee camps in Thailand or live as urban refugees in Malaysia. A large wave of Karen people began resettling to the United States with refugee status in the mid-2000s, and there are an estimated 70,000 Karen people currently living in the U.S. (U.S. Department of State, 2016).

Like all people with refugee status resettling to the U.S., Karen people's resettlement is facilitated by federal and state policies and programs that emphasize integration into existing communities (Darrow, 2015). The concept of refugee integration lacks a standardized definition but can generally be described as both a process and goal of engaging newly resettling communities with existing communities. Newland, Tanaka, and Barker (2007) define integration as "a dynamic, multidirectional process in which newcomers and the receiving communities intentionally work together, based on a shared commitment to tolerance and justice, to create a secure, welcoming, vibrant, and cohesive society" (p. 10). Research on the processes and outcomes of integration has focused heavily on the adaptation processes of people with refugee status, including: language acquisition, employment, social connections, and access to health care (Ager & Strang, 2008). Indicators of successful integration generally focus on economic or social achievements of people with refugee backgrounds (Ager & Strang, 2008; Bakker, Cheung, & Phillimore, 2016). Policies to facilitate integration almost exclusively fund programming that targets the adaptation of people with refugee backgrounds, rather than facilitating adaptation of existing services to meet the needs of new communities (Kirkwood, McKinlay, & McVittie, 2014; Strang & Ager, 2010).

Integration is a broad and complex process and a term with both popular and political usage. Integration takes place on every level of society and in every sector of a community and involves a range of stakeholders such as law enforcement, politicians, employers,

neighbors, and refugees themselves. Research on the processes of refugee integration has explored the impact of social capital on refugees' ability to find employment, housing, and learn a language (Elliott & Yusuf, 2014); on the impact of policies in employment and housing sectors (Mulvey, 2015); and on barriers to integration such as racism and hostility (Dandy & Pe-Pua, 2015). Research on integration has increasingly explored the ways in which institutions and institutional capacity in an existing community influence resettlement experiences. The scholarship suggests that the capacity of sectors such as health, employment, and education to receive refugees and encourage participation with these systems can impact integration (Valtonen, 2004).

In their definitive work on markers of refugee integration, Ager and Strang (2008) identified health outcomes and access to health care as a significant marker of successful integration for communities with refugee backgrounds. Healthy practices such as routine primary care visits and nutrition were closely tied to positive health outcomes in Burmese communities (Lee, Choi, Proulx, & Cornwell, 2015). Lack of health insurance and other barriers to receiving health and behavioral health care for people with refugee backgrounds has also been shown to be associated with higher levels of mental and emotional distress (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009). Access to health and behavioral health care that is culturally and linguistically relevant has been also shown to have a direct impact on reducing health and mental health problems in communities with refugee backgrounds (Murray, Davidson, & Schweitzer, 2010).

Research and resettlement policies have placed the responsibility for adapting, adjusting, and integrating primarily on communities with refugee backgrounds despite the fact that most definitions of integration indicate that it is a two-way process that requires effort on the part of existing communities to adapt to newcomers (Ager & Strang, 2008; Newland et al., 2007). Adaptation of existing health and social service systems is needed to provide culturally relevant, appropriate, accessible, and effective services. One aspect of systemic adaptation, cultural adaptation of interventions, has received increasing attention over several decades resulting in a host of exemplars of culturally adapted services (Barrera, Castro, Strycker, & Toobert, 2013). Cultural adaptation has been defined as "the systematic modification of an evidence-based treatment or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal, Jiménez-Chafey, & Domenech Rodriguez, 2009, p. 362). Cultural adaptation is one way of reducing some of the most significant barriers to accessing health care and social services, including language and differing health beliefs (Healey et al., 2017). While cultural adaptation has received the most scholarly attention, there are other aspects of systems that require adaptation to meet the needs of communities with refugee backgrounds including adaptations to service delivery systems or geographic locations of programs.

Currently, there is sparse research on gold standards of cultural adaptation, and few models of mutual adaptation exist (Epstein, Santo, & Guillemin, 2015; Newland et al., 2007). Furthermore, the processes through which existing systems adapt to accommodate new communities remain unexamined, with the exception of cultural adaptation of social services. There are numerous methods for cultural adaptation of mental health or other social service interventions, but there is no gold standard, and scholars follow a range of

methods (Epstein et al., 2015). Attempts have been made to describe and categorize cultural adaptation processes, which can generally be divided into two categories. First, surface adaptations include the use of culturally relevant images, fonts, and language, and second, deep level adaptations include the integration of cultural knowledge, values, and beliefs (Barrera et al., 2013).

A systematic review of adaptation methods found that out of 31 studies only 14 included consultation with members of the community of interest in the process of cultural adaptation (Healey et al., 2017). Despite this finding, most adaptation frameworks highlight the importance of collaboration or consultation with members of the target community in adaptation procedures (Barrera et al., 2013; Castro & Yasui, 2017; Epstein et al., 2015). One of the authors of this paper has articulated a framework for a collaborative approach to integration (Cook, 2016). This paper describes lessons learned from the application of a framework to promote integration within the health/behavioral health sector by building collaborative relationships between a refugee-background community and existing services.

The Karen Chemical Dependency Collaboration

The purpose of this paper is to describe the application of a conceptual framework for a collaborative approach to integration that was used to build a sustainable and effective partnership between a resettled refugee-background community and existing health and social service systems in St. Paul, Minnesota. One measure of integration is that people with a refugee background are able to access and benefit from health and behavioral health systems in resettlement (Ager & Strang, 2008). Taking a bidirectional view of integration, this should imply that they are able to access services that meet their cultural and linguistic needs and that existing health and behavioral health services have actively reduced access barriers and adapted to meet the needs of the new community. While the surface or primary goal of the Collaboration was to reduce harmful alcohol use in the St. Paul Karen community, the underlying or foundational goal of the Collaboration was to build a network of mutual relationships to promote this kind of bidirectional integration between existing services and communities with a refugee background.

Harmful Alcohol Use in the Karen Community

A small number of studies have identified risk factors that are associated with an increased risk for substance use in groups with refugee backgrounds (Ezard, 2012; Ezard et al., 2011; Miremadi, Ganesan, & McKenna, 2011; Posselt, Galletly, de Crespigny, & Procter, 2014). Only a handful of studies could be identified that looked specifically at substance use with Karen people who were refugees (Ezard et al., 2011; McCleary & Wieling, 2016). One found that Karen people who were refugees were at increased risk for harmful alcohol use because of pre-migration trauma and post-migration stress (McCleary & Wieling, 2016), and another found that Karen people faced significant barriers to accessing culturally and linguistically relevant substance use treatment in resettlement (McCleary, Shannon, & Cook, 2016). There are no comprehensive epidemiological studies of alcohol or substance use in resettled Karen communities, making it difficult to estimate prevalence or scope of substance use and associated health, social, and legal issues in Karen

ethnic groups in the U.S. (Semere, Yun, Ahalt, Williams, & Wang, 2016). However, the Karen Chemical Dependency Collaboration described below emerged as a direct result of Karen community leaders, medical providers, and social service providers identifying harmful drug and alcohol use and related consequences as the most significant problem and unmet need facing the community.

Formation of the Karen Chemical Dependency Collaboration

In 2013, one of the authors of this paper received a fellowship that provided protected time and funding to conduct a needs assessment and build a sustainable response to a significant health need within a community experiencing health disparities. Drawing on previously developed personal and professional relationships within the Karen community, this author worked with Karen leaders and representatives of existing service agencies including health, law enforcement, and behavioral health to conduct a thorough needs assessment that included focus groups, individual interviews, and participant observation. The results of this needs assessment identified harmful alcohol and drug use as one of the most significant health problems facing the Karen community in St. Paul. The needs assessment, as well as other research conducted in partnership with the same community, identified pre- and post-migration risk factors for alcohol use that included exposure to trauma and human rights abuses and resettlement stress (McCleary & Wieling, 2016). Additionally, the needs assessment identified multiple barriers to accessing existing treatment systems including language barriers, difficulty navigating confusing and byzantine treatment requirements such as numerous intake appointments and treatment meetings, difficulty with health insurance, and treatment programs that did not reflect Karen people's cultural and conceptual understandings of alcohol and drug addiction and recovery (McCleary & Wieling, 2016).

In response to an increasing need for culturally and linguistically relevant responses to harmful alcohol use, the authors of this paper formed the Karen Chemical Dependency Collaboration (KCDC; hereafter "the Collaboration"). The mission of the Collaboration is to reduce harmful alcohol use in the Karen community. All authors of this paper are members of the Collaboration and three are its co-directors. The Collaboration is a cross-cultural, cross-professional group of approximately 30 individuals representing a range of organizations from numerous sectors. Members include Karen community leaders, physicians, mental health and substance use providers, law enforcement officers, probation officers, case managers, researchers, Karen interpreters, public health nurses, and social workers. The Collaboration strives to have at least 50% representation of Karen members in every meeting and works to ensure cross-sector representation. The Collaboration has met bi-monthly since 2014 and has developed four intervention areas to comprehensively address harmful alcohol use and associated consequences throughout the community. They include: develop community education, health promotion, and prevention tools; develop culturally and linguistically relevant substance use treatment and community-based recovery support services; increase the capacity of the Karen language and Karen interpreters related to interpreting in mental health and substance use settings; and train faith leaders who are often the first source of support for families. These intervention areas and the resulting strategies were identified by Karen community leaders. One of the

Collaboration members had developed a general framework of collaborative processes to promote refugee integration. In the remainder of this paper we describe the framework and discuss important lessons learned from its implementation with the Collaboration.

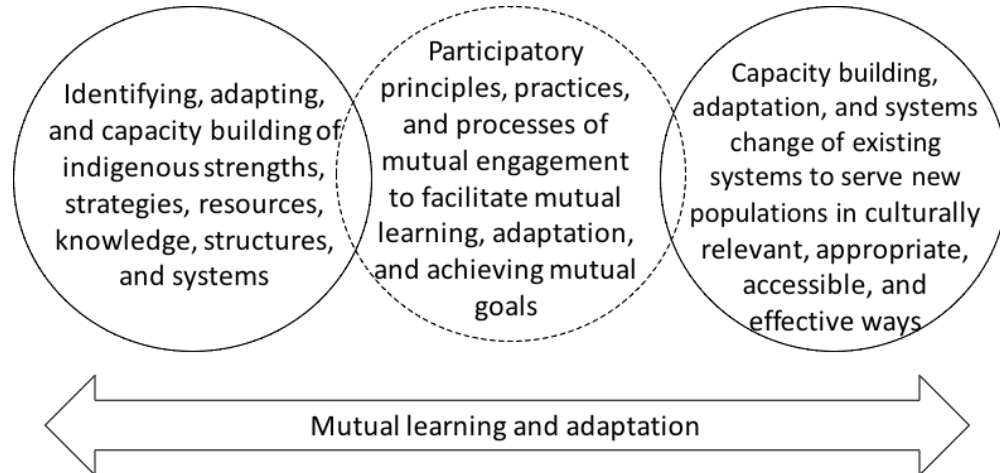
The initial founding of the Collaboration and its first years were financially supported by a fellowship received by one of the authors of this paper. The funding provided protected time in the form of salary offset to the author who acted as the primary organizer of the Collaboration in its initial years as well as ancillary funds for supplies, food for meetings, and other expenses. In the beginning, most of the Collaboration members attended meetings on a voluntary basis or as part of their employment. After this initial support the Collaboration sought and secured foundation funding to support all of the initiatives. One of the founders of the Collaboration is a primary care physician in a major health care system. Many of the initiatives are located within the health care system, which allows for connecting behavioral and primary health care as well as promotes sustainability.

Collaborative Framework to Promote Refugee Integration

One of the authors of this paper developed a general framework that has guided the work of the Collaboration (Cook, 2016). The framework is visually represented in Figure 1. It consists of three components: the first describes the indigenous expertise, networks, socio historical structures and systems, and resources (human, social, cultural) that refugee-background communities bring with them to resettlement and the processes through which they adapt and transform them for use in the resettlement context. The second consists of the resources of existing systems in the resettlement environment and the processes through which these systems adapt to serve new groups in culturally relevant, appropriate, accessible, and effective ways. The third and joining circle consists of the participatory principles, practices, and processes of mutual engagement through which representatives from new refugee-background communities and existing systems collaborate to facilitate mutual learning and adaptation to achieve mutual goals.

This framework is based on a definition of integration as a bi-directional process (Ager & Strang, 2008) that recognizes the value of mutual learning and collaboration. It is a strengths-based, empowerment approach because it recognizes that communities with refugee backgrounds have existing strengths, strategies, and resources and may have significant knowledge and experiences adapting and transforming these resources and support systems in new contexts. The relationship between mainstream providers and representatives and providers from new resettlement communities in this framework is one of allies rather than of provider-client. In the project described in this paper, this framework was used to guide a community-development approach to improving health, an indicator of integration, for the Karen community.

Figure 1. *A Collaborative Model for Promoting Integration of Existing Systems and New Refugee-Background Communities*



Application of the Framework

The intention of the Collaboration is to reduce harmful alcohol use in the Karen community. Karen community leaders and representatives initially identified four topical areas that warranted attention. Members of the Collaboration then formed smaller working groups over the past four years to create interventions that responded to each of the areas of need, which will be described below. Founding members of the Collaboration recognized that cross sector partnerships of this sort are notoriously difficult to build, maintain, and sustain. Members of the Collaboration also felt that the majority of approaches to refugee integration focused almost entirely on encouraging refugees to adapt and acculturate and promoted only surface level cultural adaptations on the part of existing services. The underlying intention of the Collaboration was to provide space to identify the Karen community's strengths, strategies, and forms of problem solving and to engage existing systems in deeper levels of adaptation and learning and contribute to bidirectional adaptation.

Collaboration members used the framework described above as a guide to build partnerships across sectors, ensure adaptation on the part of both existing systems and Karen people, and to center participatory processes and mutual learning. As such, the lessons described below are not lessons in developing alcohol treatment interventions but rather lessons learned in developing partnerships that promote bidirectional integration. In the following paragraphs we describe some of the ways we applied this framework specifically to relationship building and the development and evaluation of interventions. Then, we focus on general lessons learned that could be applied to this type of collaboration in other sectors and places.

Indigenous Strengths

This framework for bidirectional integration requires that the indigenous expertise, ways of knowing, and problem solving strategies of communities with refugee backgrounds be central to the process of integration. To ensure that refugees' expertise was a central part of decision-making and intervention planning throughout the work of the Collaboration, time was provided at each Collaboration meeting to hear from Karen people. Second, Karen people were placed in central positions within the development of each intervention and their expertise was recognized as equal to that of existing social service providers.

One example of this is the ways in which aspects of addiction, recovery, and well-being were negotiated. In the early days of the Collaboration representatives of existing treatment services focused on getting feedback from Karen people on how to adapt existing treatment modalities to better serve Karen people. For example, providers asked Karen people to advise on things like individual versus group treatment or ideas for relapse prevention. However, a lack of mutual understanding about concepts such as addiction, recovery, treatment, and relapse inhibited effective communication. Mutual adaptation thus depended on mutual learning and developing a shared understanding of these concepts from both dominant and Karen perspectives.

Existing systems

The framework also requires that existing systems engage in adaptation on a number of levels, including adaptation of how existing treatment modalities were delivered and a deeper level of adaptation throughout the entire system. To this end, we intentionally recruited not only providers to be members of the Collaboration, but also engaged with substance use treatment program directors and upper level administrators of health care systems. These members were best positioned to facilitate broader system adaptations that were needed to effectively serve Karen patients. For example, the support of program directors was needed to approve new sites for offering treatment and new processes for securing consistent interpreters.

Building the capacity of organizations and agencies to engage in this kind of deeper level adaptation takes time and resources. Much effort was spent educating both providers and upper level administration on the limitations of existing systems and the need to engage in mutual learning and adaptation to more effectively serve Karen patients. This foundational work was necessary to achieve the Collaboration's objectives.

Mutual learning

The center circle of the framework represents mutual learning and participatory practices. The Collaboration meetings served as a space for Karen community members and existing system representatives to come together and learn from each other. The Collaboration met bi-monthly throughout its existence and many sub groups of the Collaboration met independently outside of these meetings. Meeting face to face with each other was a central aspect of this framework. Two-hour Collaboration meetings were structured to provide half of the time for mutual learning and half of the time for

participatory problem solving. Mutual learning involved Collaboration members presenting to the group and has included information about Karen language and culture related to substance use, explanations of dominant treatment approaches in the United States, and relationship building between law enforcement and the Karen community. This was an opportunity for all members to learn about each other and the sectors represented. It also fostered unique and beneficial partnerships such as between educators and probation officers to engage youth in substance use prevention activities.

The second half of meetings were spent in participatory problem solving. Smaller groups of members from a range of sectors met to discuss specific issues that have arisen in the development and implementation of various interventions. The Collaboration has been most successful when there has been a specific topic to discuss in smaller groups such as adapting existing chemical health assessment tools to be more culturally relevant or engaging newer arrivals with refugee status in substance use education programs. Collaboration members reported that they bring this mutual learning back to their respective agencies and communities and are often able to make immediate small changes to their service delivery.

Resulting Interventions

The Collaboration identified four areas of need: culturally relevant substance use treatment, training for Karen interpreters, capacity building for Karen faith leaders, and culturally relevant prevention education. Working groups have developed a range of programs and interventions in each area. Some recent successes include the development of a manualized, culturally specific, trauma informed outpatient group treatment program for adult Karen men who engage in harmful alcohol use. This program was co-developed by a Karen professional with over 10 years of experience working in substance use treatment in refugee camps in Thailand and other KCDC members with expertise in mental health and substance use treatment. The Collaboration has also written a glossary of mental health and substance use terms that were negotiated, translated and back translated by a group of Karen interpreters and health professionals. The glossary was used to train over 75 professional interpreters in Minnesota. The Collaboration developed several community education tools and offered trainings in the Karen community. Collaboration members have trained existing mental health and substance use professionals, probation officers, and other existing systems on working effectively with the Karen community. Recently, the Collaboration has begun to expand its work into understanding and addressing substance use among Karen youth.

Methods

This paper does not report on a traditional research study but is a conceptual paper that describes the experiences of implementing an approach to supporting collaboration and integration in communities with refugee backgrounds. While it did not employ a traditional research methodology, per se, a systematic approach was used to develop this paper. First, the framework itself was developed out of a separate research project reported elsewhere (Cook, 2016). Approximately two years after its start, several Collaboration members agreed to an internal self-evaluation in the form of individual interviews with founding

members. A core team of Collaboration members developed a semi-structured interview guide and informal interviews were conducted with about 10 members. The interview guide included topics such as reasons for participating in the Collaboration, strengths and challenges of collaborative work, and ideas for enhancing collaborative work. All of the authors of this paper are founding members of the Collaboration. The process of developing the lessons learned had several steps. First, we reviewed the results of the evaluation interviews. Second, we developed a timeline of the Collaboration noting important and formative events. Third, we developed a list of lessons we learned as a result of these formative events. Finally, we synthesized these lessons and summarized them in preparation for writing the paper.

Lessons Learned

Numerous lessons have been learned over the past four years about building and maintaining a sustainable collaboration between representatives from the Karen community and existing systems to respond to the problem of harmful alcohol use in the Karen community. Below are three important lessons are outlined.

Lesson One: Learning How to Share Power

A host of scholarship about building cross-cultural collaborations and community organizing emphasizes the importance of sharing power with community members (Bryson, Crosby, & Stone, 2006; Wallerstein & Duran, 2008). Generally, it is suggested that this be achieved through ensuring community representation in meetings and events. We found, though, that we needed to move beyond representation to consider how patterns and styles of communication both in and outside of formal meetings contributed to power imbalances. We also needed to learn how to develop specific mechanisms and processes for sharing power in practice.

Learning about and being responsive to different communication styles. Karen Collaboration members suggested that it was difficult for them to speak up in meetings that were facilitated in English and in a style that is reflective of dominant culture in America, partly because of cultural norms of respect. Often Karen Collaboration members felt more comfortable communicating in one-on-one, informal settings with trusted members of the Collaboration with whom they had a relationship, rather than in a large group setting. We found that other Collaboration members were more likely to speak up in meetings that were facilitated in Karen with interpretation for non-Karen speakers, rather than the other way around. Additionally, Karen Collaboration members were more likely to speak up in large group meetings if they were able to debrief with Collaboration colleagues who had more experience in dominant modes of meeting and communicating before and after meetings to gain context and insight into nuances of discussions.

Once the Collaboration started being responsive to multiple styles of communication and building the capacity of all members to respect, honor, and seek out multiple ways of communicating, power shifted to be more equalized between Karen and non-Karen members. Part of sharing power in this way meant that non-Karen Collaboration members needed to let go of control and trust Karen co-directors to run meetings in their own style

and language. Lastly, shared decision-making consisted of continuously sharing ideas and being open to new ideas as the work unfolded. While the work of the Collaboration aimed at advancing clearly outlined and agreed upon goals, the process often took a circuitous route, following an iterative, flexible process that incorporated new insights and understandings as they emerged.

Recognizing the cultural context of all knowledge to facilitate listening and learning. Learning to share power also meant that Collaboration members needed to recognize the contextual limits of their expertise and to validate other ways of thinking. A key way that we shared power was in recognizing the importance of context in leveraging power and accessing resources. For example, one of the first tasks the Collaboration undertook was to develop a culturally and linguistically relevant outpatient group alcohol treatment program for adult Karen men. Initially, treatment provider Collaboration members, all of whom were not Karen, positioned themselves as the experts on treatment and addiction and Karen members as experts on culture. The intention was to combine these seemingly separate spheres of knowledge and learn from each other. However, in positioning themselves as experts on addiction, providers failed to recognize the limits of their ways of knowing when applied to a Karen context. We had to work hard to encourage providers to set aside their own paradigms and learn from Karen people's understanding, knowledge, and language related to addiction, substance abuse, and treatment, rather than filtering this knowledge through their own paradigm. For example, we encouraged providers not to assume that there were Western or English equivalents for the things that Karen people shared, but instead to seek to understand them in their own context.

One example of this occurred during a Collaboration meeting when a Karen member described the nuances of saying "no" to an offer in Karen culture. In discussing how to say no when offered alcohol as a form of relapse prevention, one Karen Collaboration member explained that for many Karen people it is culturally taboo to say no to social offers and hospitality. A non-Karen member responded that Karen people needed assertiveness training to develop skills in saying no as a form of self-protection. This member saw reluctance to say no as lack of assertiveness rather than attention to cultural norms and practices.

We also recognized that some non-Karen providers had significant experience working with Karen culture, for example, in mental health settings. However, we encouraged them not to view themselves as experts in Karen culture, but to be perpetually humble about their knowledge and continue to learn from and recognize Karen people as experts in their own culture. Additionally, some Karen Collaboration members had both cultural and professional treatment knowledge. For example, one Karen Collaboration member had extensive professional training and experience in substance use treatment in the refugee camps, though he was not licensed to practice in the U.S.

Rather than placing Collaboration members in silos of either having cultural knowledge or having treatment knowledge, we needed to recognize everyone's multiple and overlapping areas of expertise and experience. One effective way to shift this power balance was to ask non-Karen providers to critically interrogate the dominant assumptions and perceptions inherent in American models of treatment and shift from seeing these

treatments as culturally-neutral to culturally-specific. This shift allowed providers to step back and make space for Karen expertise in both culture and addiction and to recognize the cultural context of all knowledge.

One example of this is illuminated by a lengthy discussion during a Collaboration meeting of the concept of goal setting. In developing the treatment program, some members wanted to include sessions related to setting and achieving goals. Substantial time was spent negotiating a Karen translation for the word “goal”, which included negotiating the meaning of goal as a construct. As part of that conversation a Karen member said that because many Karen people have spent decades in refugee camps without hope of either repatriation or resettlement, they often did not have experience setting goals for the future. An aspect of goal setting is having a sense of autonomy over one’s future and this is limited in a conflict and refugee camp context. The Karen member indicated that while Karen people can and do set and achieve goals, the concept of goal setting needed to be considered within the context of a history of conflict and protracted internment in refugee camps.

Letting go of control and leveraging spheres of influence. One critical way in which power was shared was by actively allowing and trusting multiple leaders to leverage their own spheres of influence. Karen co-directors of the Collaboration had leadership in areas where their knowledge was most influential – most often in meetings with Karen community partners and community members – and the Collaboration followed their lead in these areas. This often meant that non-Karen participants were in meetings held in Karen language and may not know all the nuances and details being discussed. Non-Karen partners had leadership in areas of funding or navigating dominant systems and again others followed their lead in this area. This approach required letting go of control and deeply trusting each other’s intentions, competence, and understanding of what was specifically needed in various situations. The co-directors came to see themselves as standing back-to-back each leveraging their power in their own sphere of influence while standing together to move the program to fruition.

Lesson Two: Recognizing a Variety of Relationships, Roles, and Capacity

Collaboration scholarship emphasizes the importance of building trusting relationships as a foundation for engaging stakeholders (Ball, 2008). Throughout the lifespan of the Collaboration, we came to recognize the importance of paying particular attention to the difference between relationships with individuals and with the organizations those individuals represent as well as recognizing the different roles that Collaboration members have both within the Collaboration and in the greater community. Paying attention to these different roles was essential to building trust.

Building sustainable institutional partnerships. The Collaboration has consisted of a variety of stakeholders. Karen members attended Collaboration meetings as representatives of existing agencies, ethnic community based organizations, Karen churches, or as individual community members. Most, but not all, non-Karen Collaboration members attended meetings as representatives of a particular organization such as a hospital, clinic, university, treatment facility, or social service agency.

One of the founding members of the Collaboration joined as a representative of a major hospital system that provided both in-patient and out-patient substance use treatment. His presence represented an important relationship with an essential institution. As the manager of treatment services within the hospital system, his position provided access to important resources. Unfortunately, within the first two years of the Collaboration, he left his position and the Collaboration no longer had a formal relationship with the hospital system. Over the course of the next year, three other individuals filled his former role, meaning we had to work to rebuild the relationship anew with each person. Ultimately, we learned that we needed to build sustainable relationships with institutions and not just with individual representatives of those institutions. We also came to recognize that while interpersonal relationships were critical to trust building and partnering, the institutional relationships were essential to building sustainable programs.

Building individual and organizational capacity to participate. Many Collaboration members attended Collaboration meetings and worked on Collaboration projects as part of their paid positions. However, several Karen and a few non-Karen Collaboration members attended meetings on their personal time motivated by a personal commitment to the issue. Additionally, some participated as representatives of their organizations, but their organizations did not have capacity to support much time to engage in work with the Collaboration. This created an inequity and challenge to sustaining membership, because not all members were equally compensated for their equally valuable time and work. Additionally, Karen members had less capacity to engage with the Collaboration because they more frequently did not have institutions to support their time involvement.

All of the work of the Collaboration has been dependent on all members having the capacity for mutual engagement. This mutual engagement is dependent on all members being actualized partners in all endeavors. Often, this meant that the Collaboration needed to support individual or institutional capacity building to participate on equal footing. Because we recognized the value of Karen representation in the Collaboration and, in particular, the importance of involving a large, local Karen-led nonprofit organization, we found ways to build the capacity of several partners to participate in the Collaboration and to work on its strategic initiatives. For example, we tried offering gift cards to compensate Collaboration members for their time to attend meetings when they were not supported by an institution.

One significant way that we built institutional capacity for the Collaboration was to secure funding to develop a few part-time, paid staff positions. We also created a shared position between the Collaboration and a Karen ethnic community based organization (ECBO). Before we created this position, the Karen ECBO wanted to be involved in Collaboration work but had very limited staff capacity to contribute. A shared, paid position allowed for the ECBO to play a leadership role in the Collaboration and provided an avenue for increased partnership between the Collaboration and the ECBO in working on several Collaboration initiatives. The person hired for the position was a Karen person who had substantial training and experience with substance use treatment in refugee camps on the Thai-Burma border. Because this person's training was not recognized by U.S. licensing systems, he was prevented from using this knowledge and skill in a formal

setting. A shared position between the Collaboration and the Karen ECBO gave this individual a formalized setting to contribute his skills and training.

Lesson Three: Adapt Interventions at the Paradigm Level in Addition to the Implementation Level

Cultural adaptation is often categorized as surface level – incorporating culturally relevant images, fonts, and language – or deep level – incorporating cultural knowledge, values, and beliefs and involving ethnic social support systems in interventions (Barrera et al., 2013). One of the most successful outputs of the Collaboration has been the culturally-specific outpatient group treatment program for Karen men who engage in harmful alcohol use. The treatment is facilitated through the use of a provider manual (with ethnographic rationale) and participant workbook that were written by members of the Collaboration. A small group of Collaboration members engaged in an intensive process of developing the treatment program over the course of two years.

Often, developing culturally relevant programs involves adaptations that are focused primarily on implementation, such as offering a treatment group in a community center or substituting culturally relevant images. While this is an important aspect of service delivery, we found that significant adaptation was also needed at the paradigm level. We needed to think through not just how to translate words into Karen but how to engage with a Karen paradigm or cognitive framework around the meaning of addiction, treatment, and recovery. For example, we incorporated Karen proverbs, metaphors, and commonly known tales as access points to Karen ways of thinking. This meant that Karen people needed to be present for and engaged with every aspect of the development of the treatment model. It also meant that we needed to privilege Karen ways of thinking whenever possible. This theme is closely related to a previous lesson: recognizing the cultural context of all knowledge to facilitate listening and learning.

Overcoming Challenges

While the Collaboration has been generally successful in relationship building and intervention development, there have been challenges along the way and we foresee several challenges in the future, particularly around replication of this type of collaboration.

Ongoing and deeply entrenched challenges for the Collaboration are anticipated given limitations of existing agency, county, state, and federal policies. In particular, health insurance reimbursement requirements and policies regulating treatment delivery presented barriers that were difficult to overcome and required compromises that pushed against a pure application of the framework. For example, in order for treatment programs to be sustainable, they need to be delivered by a licensed therapist for insurance reimbursement purposes. Because the Karen community in St. Paul is relatively new, at the time the treatment program was developed, there were no Karen people who were licensed to provide reimbursable mental health or substance use treatment services. The program is jointly facilitated by a Karen man with substance use treatment experience who has not been able to re-credential in the U.S. and a non-Karen licensed social worker. Thus,

interpretation services are required, which are an additional barrier as many Karen people would do better working directly in their native language.

As second challenge that we foresee in the future is difficulty with replicating the Collaboration. St. Paul, Minnesota is home to a large, well-organized, and active Karen community with a long-standing Karen community based organization and a robust workforce of Karen interpreters. Several active community leaders are engaged with this project. Additionally, several non-Karen members of the Collaboration have more than ten years of experience working with the Karen community personally and professionally and were able to build on these long-standing relationships in founding the Collaboration. Lastly, the development of the treatment interventions have been spearheaded by a Karen man who resettled to St. Paul after working for many years as a counselor in one of the only drug treatment programs based in the refugee camps along the Thailand-Burma border. These strengths and experiences are unique and difficult to replicate in other geographic locations.

Discussion

Health outcomes and access to health care have been operationalized as markers of integration for communities with refugee backgrounds (Ager & Strang, 2008). Achieving this indicator of integration requires bidirectional adaptation efforts on the parts of both new communities and existing systems. This paper describes the lessons learned over the past four years in applying a general framework for collaboration to reduce harmful alcohol use in the Karen community and to, in turn, facilitate integration between a newly resettled community and existing health and social service systems.

One of the overarching principles that guided the work of the Collaboration was that integration is a bidirectional process (Ager & Strang, 2008; Newland et al., 2007). In other words, the success of this collaboration was dependent on mutual learning, capacity building, and adaption. The guiding framework for collaboration had three components: first, resettlement communities' indigenous expertise, networks, systems, and resources need to be recognized and adapted for use in the resettlement context; second, the resources of existing systems need to be adapted to be culturally relevant and accessible to resettlement communities; and third, integration is facilitated through participatory principles and practices that facilitate mutual learning and adaptation to achieve mutual goals.

The lessons presented in this paper suggest that effective cultural adaptation of existing interventions may need to go beyond surface level adaptations. In this project, significant adaptation was needed at the paradigm level in addition to the implementation level, which included engaging Karen knowledge and meaning around addiction, treatment, and recovery. Additionally, and consistent with findings by Epstein et al. (2015), Castro & Yasui (2017), and Barrera et al. (2013), this project also demonstrated that developing deep collaborative partnerships with the target community was essential for achieving mutual adaptation. It offers several suggestions for facilitating mutual learning and adaptation related to equalizing power, learning about and being responsive to different communication styles, recognizing the cultural context of all knowledge, building

sustainable institutional partnerships, and building individual and organizational capacity to participate toward mutual goals. The experiences of this Collaboration suggest that the collaborative approach to integration framework described in this paper may be a useful model of mutual adaptation, which fills a gap in existing research (Newland et al., 2007).

Implications for Social Work

The framework described in this paper has several implications for social work practice with refugee-background communities. One of the primary functions of the framework is to provide mechanisms for ensuring the inclusion of refugee-background communities' expertise, knowledge, and strategies in the adaptation of health and behavioral health systems. Social workers have an ethical mandate to engage in strengths-based work, to recognize the ways in which traditionally marginalized voices are often obscured and to actively promote inclusivity and equity.

One success of the Collaboration, facilitated by the use of the framework, was engaging representatives across a diverse range of sectors for a sustained period of time. Collaboration members include law enforcement officers, social workers, Karen leaders, Karen interpreters, doctors, researchers, and drug and alcohol counselors. There are limited opportunities for a diverse group of people to work together on community issues, and establishing structured spaces that provide opportunities for mutual learning and capacity building may be one way to enhance cross sector collaborations.

Another implication for social work is in the area of research. The framework described here would benefit from application in other geographic locations, with other communities, and in response to other issues of integration, such as employment or education. Research that tests applications and implications of the framework are needed.

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