

CULTURE-SPECIFIC INFORMATION

<p>Engagement</p>	<p>For which specific cultural group(s) (i.e., SES, religion, race, ethnicity, gender, immigrants/refugees, disabled, homeless, LGBTQ, rural/urban areas) is this treatment tailored? If none, please respond “not specifically tailored.” Immigrants/refugees</p> <p>Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible. Yes The International FACES program provides comprehensive community-based mental health services to refugee children, adolescents, and families. Outreach is seen as the cornerstone of the program and occurs throughout the treatment process. It includes identifying refugee children who can benefit from services, engaging them and their families in services, retaining them in services, and supporting them as necessary after the active treatment phase has ended. Outreach is provided in various culturally appropriate settings.</p> <p>Are there culture-specific engagement strategies (e.g., addressing trust) that are included in the intervention? Engagement is provided in various culturally appropriate settings in the language of the refugee. These settings include, resettlement offices, homes, health clinics, schools and on site. The strategy includes providing linguistically and culturally relevant services through a team approach of clinicians and multicultural mental health workers.</p>
<p>Language Issues</p>	<p>How does the treatment address children and families of different language groups? Trained interpreters and multicultural staff speak the languages of the populations served.</p> <p>If interpreters are used, what is their training in child trauma? Contracted Interpreters are professionally trained in mental health interpreting but are not specifically trained in child trauma. Clinicians meet before and after the session with interpreters to review clinically and culturally significant issues related to child trauma.</p> <p>Any other special considerations regarding language and interpreters? Because of the program’s emphasis on a client centered approach, the participants in the program can choose to have an on site or telephonic professional interpreter. This can be a crucial piece of establishing trust in the therapeutic alliance.</p>
<p>Symptom Expression</p>	<p>Is there research or clinical evidence to suggest that the populations served manifest trauma symptoms in differential ways? If so, are there differences in the ways that symptoms are assessed for the various populations? Yes, these differences are accounted for in the program’s Integrated Assessment.</p> <p>If there are differences in symptom expression, in what ways does the theoretical/ conceptual framework of this treatment address culturally specific symptoms? Culturally specific symptoms are expected by clinicians and are addressed by tailoring the treatment to meet each participant’s and family’s unique clinical and cultural needs.</p>

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<p>Assessment</p>	<p>In addition to any differences noted above, are there any differences in assessment measures used across cultural groups? If so, please indicate which measures are used for which cultural groups. Are there normative data available for the populations for which they are being used? Each participant is assessed using the Integrated Assessment which assesses medical needs, emotional and mental health needs, psychosocial and environmental needs, substance use needs, developmental needs, social and family history, trauma exposure and the relocation narrative. We do not use different assessment measures for different cultural groups and an Axis I-V diagnosis. UCLA PTSD-RI and other NCTSN measures are also utilized.</p> <p>If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments? The trauma and functional assessments are provided every 3 months.</p> <p>What, if any, culturally specific issues arise when utilizing these assessment measures? Often clinicians and multicultural mental health workers must explain the symptoms addressed in standard measures in order for the children and family members to understand within their cultural context the content of the assessment questions. This means it takes more time to complete measures and the validity of the measures could be questioned given the explanation of symptoms.</p>
<p>Cultural Adaptations</p>	<p>Are cultural issues specifically addressed in the writing about the treatment? Please specify. An ecological perspective that views children as embedded in family, neighborhood, school, and ethnic community systems is used to conceptualize the problems, and comprehensive treatment is provided to address problems across these systems. A more extensive presentation of the theoretical approach is presented in White Paper II of the NCTSN Refugee Trauma Taskforce: Birman, D. Ho, J., Pulley, E., Batia, K., Everson, M. L., Ellis, H., Stichick Betancourt, T., Gonzalez, A. (2005). Mental health interventions for refugee children in resettlement. White Paper II, Refugee Trauma Task Force, National Child Traumatic Stress Network, Chicago, IL</p> <p>Do culture-specific adaptations exist? Please specify (e.g., components adapted, full intervention adapted). There is currently a review of how components of TF-CBT are being integrated into the International FACES model. Also, adaptations of CBITS for refugee children are being reviewed.</p> <p>Has differential drop out been examined for this treatment? Is there any evidence to suggest differential drop out across cultural groups? If so, what are the findings? This has not been examined.</p>
<p>Intervention Delivery Method/ Transportability & Outreach</p>	<p>If applicable, how does this treatment address specific cultural risk factors (i.e., increased susceptibility to other traumas)? Specific cultural risk factors are addressed throughout the stages of treatment beginning with outreach and engagement and through the assessing, treatment planning and wrap around supportive services. It takes into account the specific cultural values of the families as well as their cultural adjustment needs.</p>

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<p>Intervention Delivery Method/ Transportability & Outreach continued</p>	<p>Is this a clinic-based treatment or is the treatment transportable (e.g., into home, community)? If the treatment is transportable, how is it adapted into the new setting? Is it still efficacious? This is a community-based mental health program that transportable. Supportive services and clinical treatment take place in various settings in the community including the home. Staff seek to treat the families in the least restrictive setting(s) that is therapeutic It is efficacious because the clinical team works with the multicultural staff or interpreters in all settings.</p> <p>Are there cultural barriers to accessing this treatment (i.e., treatment length, family involvement, stigma, etc.)? Yes, usually stigma related to mental health has to be addressed. Often times this is done through psycho-education related to trauma, normalizing trauma responses and looking with the family at their sources of strength and resilience.</p> <p>Are there logistical barriers to accessing this treatment for specific cultural groups (i.e., transportation issues, cost of treatment, etc.)? Yes.</p> <p>Are these barriers addressed in the intervention and how? Transportation issues are a barrier that is addressed by providing mass transit passes to participants who travel to and from the office. The staff also use agency vehicles to accompany participants to support them at various appointments and interactions in the community.</p> <p>What is the role of the community in treatment (e.g., local groups such as faith-based organizations, community groups, youth and/or parent organizations, first responders, schools)? Much collaboration as part of the treatment is to link participants with their communities.</p>
<p>Training Issues</p>	<p>What potential cultural issues are identified and addressed in supervision/ training for the intervention? Training and supervision emphasize the awareness of the dynamic created by the interaction of the participants' and staff's cultural perspectives while providing services.</p> <p>If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training? The cultural issues between supervisor and clinician are openly discussed from the beginning of the supervisory relationship and discussed in weekly supervision. When necessary, consultation with a clinical director is available to provide a discerning and supportive perspective.</p> <p>If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training? They are addressed from the beginning of the work with the client and then throughout the course of treatment on weekly supervision. Also, multicultural staff educate the team regarding cultural dynamics in weekly staff meetings.</p> <p>Has this guidance been provided in the writings on this treatment? Yes</p> <p>Any other special considerations regarding training? No</p>