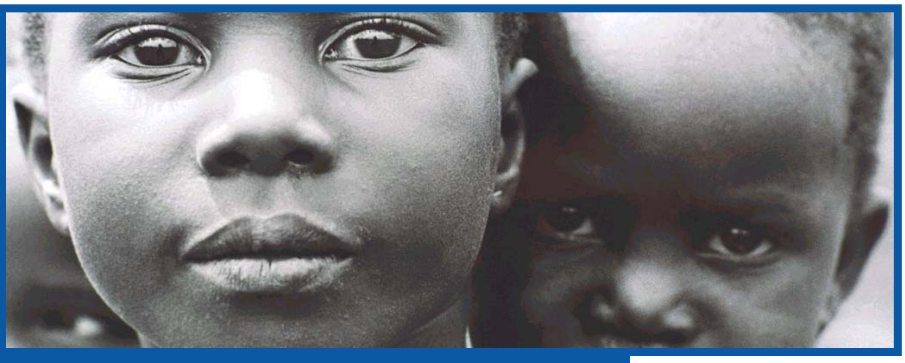
NCTSN The National Child Traumatic Stress Network



Mental Health Interventions for Refugee Children in Resettlement

White Paper II

From the National Child Traumatic Stress Network
Refugee Trauma Task Force

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In collaboration with

International FACES
Heartland Health Outreach,
Chicago, IL

White Paper II Committee

Dina Birman, PhD, Joyce Ho, PhD, Emily Pulley, MA,
Karen Batia, PhD, Mary Lynn Everson, MS, Heidi Ellis, PhD,
Theresa Stichick Betancourt, ScD, MA, Angela Gonzalez, PhD

Drs. Birman and Ho and Ms. Pulley are with the University of Illinois at Chicago and Heartland Health Outreach, Dr. Batia and Ms. Everson are with Heartland Health Outreach, Drs. Ellis and Betancourt are with Boston Medical Center, Dr. Gonzalez is with the Substance Abuse and Mental Health Services Administration.

Refugee Trauma Task Force

Kwame Asante, Karen Batia, Theresa Stichick Betancourt, Dina Birman, Keith Cheng, Marion Chew, Michael A. de Arellano, Lori Ebert, Gloria Elliot, Heidi Ellis, Anne Holland, Judy Holland, Ellen Gerrity, Angela Gonzalez, Dennis Hunt, David Kinzie, Deborah Lott, Karen O'Donnel, Lin Piwowarczyk, Crystal Riley, Jessica Roman, Leslie Ross, Audrey Rubin, Glenn Saxe, Cynthia Shirley, Alise Sochaczewski, Jenny Tsai.

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Introduction and Background

The mission of the National Child Traumatic Stress Network (NCTSN) is to raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States. The Refugee Trauma Task Force of the NCTSN specifically focuses on refugee children and their families. This White paper is a product of collaborative activities of this Task Force.

Previously, the Refugee Trauma Task Force published a White Paper titled *Review of Child and Adolescent Refugee Mental Health* ([White Paper I], Lustig et al., 2003) that reviewed the available literature. The paper described varied experiences in the lives of refugee children, including phases of migration, stressors associated with those phases, consequences of such stressors for psychological well-being, and coping strategies for dealing with the stressors. The paper also reported that high prevalence of psychopathology as defined by Western models of illness have been found in refugee children across numerous studies. Traumatic events experienced by refugee children prior to migration and during flight, as well as stresses during resettlement put them at risk for psychopathology. The paper concluded that many refugee children can greatly benefit from mental health services.

At the same time, the White Paper also noted that little information exists with respect to which mental health interventions are effective for traumatized refugee children, with no clinical controlled trials conducted with refugee children in resettlement reported in the literature. As a result, no evidence-based interventions for refugee children have been identified, making it difficult to determine appropriate standards of care for this high need population.

Despite little evidence about effectiveness of such interventions, many programs across the country, including several of the sites that participate in the NCTSN, are currently providing services to refugee children. In the absence of specific standards of care for traumatized refugee children, these programs face many challenges in creatively addressing the multiple needs of this vulnerable population. However, little is known about what service providers are doing, and which approaches they are taking to address the complex mental health needs of refugee children.

To learn about the services being provided within the network, the Refugee Trauma Task Force conducted a Survey of National Refugee Working Group Sites (Benson, 2004). The 13 sites surveyed are primarily located in urban areas, and serve a wide range of refugee populations from a variety of different countries. Most striking was the finding that mental health is not the only type of service provided across these sites, and that services are frequently provided outside traditional mental health clinic settings. In addition to mental health, a wide range of services is being provided, including medical, legal, case management and other social services. Alternatively, mental health programs have developed collaborations with other service providers where they refer their refugee clients. Further, most sites report conducting extensive outreach in the refugee communities and with other service agencies. In addition, most sites do not provide services only in a clinic setting, but also in schools, and in other community sites. These findings suggest that programs that provide services to refugees are using models of service that extend beyond the traditional clinic based mental health service model. The needs of refugee clients seem to require such a community based and comprehensive approach.

The purpose of this White Paper II–Interventions is to begin to fill the gap between a relative lack of research on effectiveness of mental health interventions for refugees, and the emerging efforts of agencies that provide services to this population. First, this paper revisits and summarizes the research reported on in White Paper I on the mental health needs of refugee children. Next, we propose that because of the complexity of needs of refugee children described in the literature, a comprehensive mental health services approach is needed. This notion is also supported by the preliminary data gathered from the NCTSN sites providing such services to refugee children (Benson, 2004). The remainder of the paper then focuses on exploring what a comprehensive mental health service model for refugees might look like. We identify necessary components or "key ingredients" of such a comprehensive model, and review the literature for any findings that may support the value of specific approaches or techniques. Finally, we make recommendations for next steps toward improving standards of mental health care for traumatized refugee children.

Who Are Refugee Children?

The focus of this paper is on mental health services to traumatized refugee children resettled in the U.S. The United Nations Convention Related to the Status of Refugee (1951) defines a refugee as a person who

> owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country (UNHCR, 2002).

Refugees are specifically distinguished from economic migrants, who may leave a country voluntarily to seek a better life. Such immigrants would continue to receive the protection of their government if they were to return home. However, refugees flee because of the threat of persecution and cannot return safely to their homes.

According to the United Nations High Commissioner for Refugees (UNHCR), there are almost 22 million refugees located throughout the world (UNHCR, 2002). Approximately half of the world's 20 million refugees are children (UNHCR, 2002; Joseph Westermeyer, 1991). Between 1988 and 2001, over 1.3 million refugees were admitted to the United States of America (U.S. Committee for Refugees, 2001).

We use the term "refugee" in this paper to refer to children who have experienced war related trauma or political violence regardless of whether they have legal refugee status in the U.S. Further, our focus is on refugee children in resettlement, who are undergoing the process of acculturation and adaptation to a new country and culture. Although they may share aspects of their experience with refugees who are internally displaced, such as during civil war, or in refugee camps, the experiences of permanently resettled refugees are distinct from these other situations, and involve different considerations in service delivery and intervention design.

Mental Health Issues for Refugee Children in Resettlement: Refugee Experiences and Mental Health Needs

Exposure to Trauma

As discussed extensively in the White Paper I, refugee children experience a great number of stressors throughout their pre-migration, flight, and resettlement experiences that impact on their psychological well being. Refugee children experience trauma resulting from war and political violence in their countries of origin prior to migration, as well as during flight or in refugee camps. These multiple stressors include direct exposure to war time violence and combat experience, displacement and loss of home, malnutrition, separation from caregivers, detention and torture and a multitude of other traumatic circumstances affecting the children's health, mental health and general well being. A large number of studies have documented a wide range of symptoms experienced by refugee children, including anxiety, recurring nightmares, insomnia, secondary enuresis, introversion, anxiety and depressive symptoms, relationship problems, behavioral problems, academic difficulties, anorexia, and somatic problems (Allodi, 1980; Almqvist & Brandell-Forsberg, 1997; Angel, Hjern, & Ingleby, 2001; Arroyo & Eth, 1985; Boothby, 1994; Cohn, Holzer, Koch, & Severin, 1980; Felsman, Leong, Johnson, & Felsman, 1990; Gibson, 1989; Goldstein, Wampler, & Wise, 1997; Hjern, Angel, & Hoejer, 1991; Hodes, 2000; Kinzie, Sack, Angell, Manson, & Roth, 1986; Krener & Sabin, 1985; Macksoud & Aber, 1996; Masser, 1992; McCloskey & Southwick, 1996; McCloskey, Southwick, Fernandez-Esquer, & Locke, 1995; Mollica, Poole, Son, Murray, & Tor, 1997; Muecke & Sassi, 1992; Paaredekooper, de Jong, & Hermanns, 1999; Papageorgiou et al., 2000; Weine, Becker, Levy, & McGlashan, 1997; C. Williams & Westermeyer, 1983), and linked the presence of these symptoms to exposure to trauma prior to migration. With high prevalence of posttraumatic stress symptoms among refugee children reported to be between 50-90% (Lustig et al., 2004), many refugee children are in need of *trauma-informed treatment and services.*

Access to Mental Health Services

Despite evidence for the need for such treatment, refugee children in resettlement are unlikely to benefit from mental health services because they rarely use them. This problem is not unique to *refugee* children, as many recent reviews have observed that few U.S. children in need of mental health services receive care (Collins & Collins, 1994; Kataoka, Zhang, & Wells, 2002; Stephenson, 2000; Surgeon General's Report, 1999). Epidemiological studies report that fewer than 20% of children who need mental health care actually receive services (Lahey, Flagg, Bird, & Schwab-Stone, 1996). In addition, of those children who do receive services, fewer than 50% receive the appropriate service relative to their need (Kazdin, 1996).

Because refugee children face additional barriers to receiving care, experts suspect that most refugee children in need of mental health services do not find their way into the existing mental health care system (Geltman, Augustyn, Barnett, Klass, & Groves, 2000; Westermeyer & Wahmanholm, 1996). One survey of refugee *health* programs in nine metropolitan areas in the U.S. found that while 78% of the sites offered mental health care, only 33% of the sites carried out mental health status examinations (Vergara, Miller, Martin, & Cookson, 2003). This suggests that refugees with mental health problems are unlikely to be identified, and thus

unlikely to receive treatment. Overall, these findings suggest that *interventions that facilitate access and engagement in mental health services* for refugee children are needed.

Culturally Competent Services

One of the main barriers to services for refugee children and families involves lack of such services available in their native language. Though no specific information on refugee children is available, several studies that examined utilization of mental health services by ethnic and linguistic minorities (Snowden & Cheung, 1990; S. Sue, Fujino, Hu, Takeuchi, & et al., 1991; Takeuchi, Sue, & Yeh, 1995; Ying & Hu, 1994) found that Hispanic and Asian groups are under-served relative to Whites. Even when refugee children and families do seek mental health care, it is not clear to what extent existing services are well suited to the values and customs of their native culture. Thus, to increase the extent to which refugee children and families make use of mental health services and can benefit from services, *culturally informed and linguistically matched mental health services* are needed.

Stresses in Resettlement

Refugee children experience a number of stressors during resettlement resulting from difficulties integrating into a new country and culture that may negatively affect their mental health, and prevent them from getting treatment. Acculturative stress is a term used to describe the multiple stressors faced by refugee families in resettlement (Berry, Kim, Minde, & Mok, 1987; Gil & Vega, 1996; Mena, Padilla, & Maldonado, 1987; C. Williams & Berry, 1991). Refugee families confront a number of everyday struggles including meeting their basic needs of housing, employment, and health care. They confront these challenges in a new language and within the norms and laws of a new culture. In addition, refugees are often separated from extended social networks of family and friends. Yet social support has been found an important factor in facilitating refugee adjustment (Emmelkamp, Komproe, Van Ommeren, & Schagen, 2002; Hays, 1991; Kovacev & Shute, 2004; Pecora & Fraser, 1985; Shisana & Celentano, 1987; Simich, Beiser, & Mawani, 2003).

For children, the family and school are the most important arenas where acculturation and coping take place. With respect to family relationships, it has been noted that acculturation unfolds at different rates for parents and children, creating an “acculturation gap” (Buki, Ma, Strom, & Strom, 2003; Gonzales, Dumka, Deardorff, Carter, & McCray, 2004; Kwak, 2003; Muir, Schwartz, & Szapocznik, 2004; Szapocznik, Kurtines, & Fernandez, 1980). Refugee children adapt to the new culture more quickly than their parents, particularly in terms of language acquisition. Over time, this gap is seen as leading to parent-child conflict around areas such as autonomy, dating, and cultural identity (Buki et al., 2003; Kwak, 2003). While parents may feel that their children should adhere to the norms of their native culture with respect to these issues, many children feel pressure from their peers and surrounding culture to abandon their cultural traditions. As a result, children are faced with negotiating dual cultural identities. In addition, lack of parental familiarity with the customs of the new country can result in lack of guidance and supervision (Aronowitz, 1984; Gonzales, Knight, Birman, & Sirolli, 2004; Szapocznik, Scopetta, Kurtines, & Aranalde, 1978). A related issue involves the use of children as interpreters or culture brokers in refugee and immigrant families (Buriel, Perez, De Ment, Chavez, & Moran, 1998). This role is a source of acculturative stress (Carlin, 1990; Portes & Rumbaut, 2001; C. Suarez-Orozco & M. Suarez-Orozco, 2001), and has been linked to adverse family dynamics at home (Weisskirch & Alva, 2002) because it places children in

difficult positions, including translating for parent conferences in school and communicating medical diagnoses to relatives in hospitals.

In addition to family, schools are also a source of potential acculturative stress for refugee children and adolescents. While parents struggle with meeting the basic family needs, children are confronted with negotiating a new school environment and integrating into new peer networks. Children and adolescents struggling with identity formation may experience psychological difficulties in the context of dual cultural membership (Phinney, 1990), particularly if they are discriminated against and receive negative messages about their race and culture (Portes & Zhou, 1994). Studies of acculturative stress with refugee adolescents (e.g. Vinokurov, Trickett, & Birman, 2002) have found that the school experience of refugees often includes discrimination from other students and teachers, daily hassles related to language inadequacies dealt with in a non-empathic manner, peer-related hassles related to intergroup issues such as friendship and, for adolescents, dating.

Further, parental pressure to succeed academically can inadvertently heighten anxiety about school success. For children whose education has been interrupted because of war or extended stays in refugee camps, the transition to school may be particularly problematic. These children and their parents may not have even the basic knowledge of how schools function, the role of parents in schooling, or of how to operate a locker or hold a pencil (Lee, 2001).

There is no question that refugee families and children can benefit from a wide net of social services, including English language training, assistance with employment, housing, transportation, acculturation classes, and general case management services. In addition, special educational programs for newly arrived children can help them become integrated into mainstream classrooms and curriculum. This is particularly important for children with no prior education and no literacy skills in their native language, who experience many difficulties in their transition to U.S. schools. Many experts also advocate for preventive programs that can help refugees cope with the stresses of acculturation and resettlement (C. Williams & Berry, 1991) However, generally such services are not considered to be *mental health services*, and the acculturative stress and other challenges in resettlement have not been seen as appropriate targets of *mental health* interventions.

Yet it has also been suggested that the stresses of resettlement create an important context that surrounds and impacts on the mental health needs of refugee children and families, as well as on any mental health interventions. For example, while struggling for economic survival, families may not consider mental health an important enough priority to address, and may not seek mental health care for their children for that reason (Westermeyer, 1996). Because refugees experience challenges in adaptation broadly across varied life domains, traditional clinic based treatment may be insufficient to meet their needs (Chung, Bemak, & Okazaki, 1997; Miller, 1999) or to maintain the gains attained in psychotherapy. Engaging a child in clinical services that result in reduction of PTSD symptoms may not sufficiently improve the quality of life for the child when he or she has to continue to function in a stressful, economically disadvantaged and socially isolated family environment. For example, a trauma-informed intervention for traumatized immigrant children (Kataoka et al., 2003; B. Stein, Jaycox et al., 2003) was successful at reducing symptoms, but not school functioning as assessed by the children's teachers. This suggests that a broader intervention may be required to improve the child's overall level of functioning.

For these reasons, experts writing about mental health services for refugee children suggest that to be successful at engaging and benefiting refugee clients mental health services must in some way address the context of acculturation and resettlement within families, schools, and other settings of relevance to refugee children (e.g., Chung et al., 1997; Collignon, Men, & Tan, 2001; Jaranson, 1990; C. Suarez-Orozco & M. Suarez-Orozco, 2001; C. Williams & Westermeyer, 1986). For example, Chung et al. suggest that providing traditional psychotherapy for Southeast Asian refugees is important, but not sufficient in a culturally informed mental health model. Rather, they stress the importance of case management as a key component of mental health services for Southeast Asian refugees (Chung et al., 1997). In addition, psychoeducation, and integration of traditional healing are also recommended. Similarly, Ramaliu & Thurston (2003) describe the development of a Survivors of Torture Program in Calgary where program staff coordinate mental health, health, social, and other services for refugees across multiple community agencies.

Thus, experts on refugee mental health consistently emphasize the importance of attending to economic, social, educational and other needs as a component of or an adjunct to mental health services. This implies that traditional models of clinic based psychiatric services and psychotherapy are not sufficient to meet the mental health needs of refugee children. Rather, a *comprehensive services model* may be required that helps refugee children and families cope with the stresses of resettlement.

The Need for Comprehensive Services

Davies and Webb (Davies & Webb, 2000) stress that the needs of refugee children and families are best addressed through "*a coordinated programme working closely with those who can help shape a culturally sensitive position*" (p. 551) The authors stress the limitations of the existing service structures that make referrals to conventional outpatient mental health clinics with no particular expertise in addressing cultural or migration issues with agencies working in relative isolation in ways dictated by their own narrow professional perspectives. As they point out, by the time the children were referred to the child mental health service:

> The "problem" had often already been defined to some extent by the referrer, was invariably pathologized, uni-dimensional, and not seen in broader psychosocial terms. Their understanding of the child's needs took virtually no account of the child's new context, disrupted psychological development, experience of transcultural stress and previous experience of loss and trauma (page 549).
>
> Instead, they suggested that
>
> child mental health services are best able to assist refugee families (on this scale) as part of a coordinated programme, working closely with those who can help shape a culturally sensitive position. However, in small multidisciplinary services with limited resources, and where the conventional medical model is still relatively strong, there is likely to be an inherent lack of flexibility. The lack of additional resources meant that key agencies were always stretched and unable to provide effective services (page 551).

Thus, a coordinated comprehensive treatment model is more likely to meet the diverse needs of refugee children and families and to be more acceptable to them, particularly since refugees often view general survival and economic issues as more pressing than their psychological concerns.

Comprehensive mental health services are receiving increasing attention in the mental health literature, and there is evidence to suggest that they are effective with some populations. In general, comprehensive service models are programs that focus on client populations with complex, persistent and varied needs across several life domains, such as adults with persistent mental illness, drug addiction issues, and troubled youth. Some examples of such treatment models include assertive community treatment (ACT) for people with severe, persistent mental illness, and treatments for children including multi-systemic therapy (MST), wraparound services and system of care treatment models for at-risk youth. Comprehensive services broadly attempt to provide multi-modal treatment approaches that address the large spectrum of needs faced by recipients, in a seamless fashion. Such services often incorporate a component of outreach to help engage populations that face barriers to accessing care.

Comprehensive services for children strive to address the children's mental health concerns within the context of their family, school, and community (Burns, Schoenwald, Burchard, Faw, & Santos, 1995). With non-refugee children, wraparound care (Burns et al., 1995), multisystemic therapy (MST, Borduin & Henggeler, 1990), and the system of care model (Lourie, Stroul, & Friedman, 1998) have demonstrated positive outcomes in studies using experimental or quasi-experimental designs. In addition, a comprehensive services model for adults with severe mental illness, assertive community treatment (L. Stein & Test), has been validated as an effective treatment for reducing social isolation, increasing access to mental health services, and improving quality of life across multiple controlled studies (L. Stein & Santos, 1998).

Although studies to support the notion that comprehensive services for refugee children are effective have not been reported, the literature on the mental health issues of refugee children supports the notion that only such an approach can address the kinds of complex needs presented by traumatized refugee children. In fact, the findings in the NCTSN survey of refugee sites (Benson, 2004) suggest that programs that provide mental health services to refugees are doing so, through either providing or coordinating multiple services for refugee families and engaging in extensive outreach. However, the needs of refugee children are distinct from adults with severe mental illness served by ACT, troubled youth served by MST, or U.S. born children enrolled in wrap around or system of care services. Thus, existing models of comprehensive services may not be appropriate or may need to be substantially revised to fit the needs of refugee children. A comprehensive service model specifically designed to meet the needs of refugee children is needed.

In reality, not all service providers will have the funding, staff and infrastructure to provide services comprehensively within one agency. Instead, mental health programs can develop collaborations with other agencies that can provide complementary services to meet the complex needs of refugee children and families. Thus, comprehensive services is an overall framework of service delivery, rather than a prescription for a particular program. The remainder of this paper will propose components of a comprehensive mental health service for refugee children, and will summarize a review of the literature that provide an evidence base for these components.

Components of Comprehensive Services for Refugee Children: A Review of the Literature

While the literature reviewed above suggests that refugee children can benefit from comprehensive mental health services, the notion of comprehensive service is broad, and difficult to delimit. It may also be impractical for any particular mental health program to address all of the economic, social, and psychological needs of a refugee family. In our review, we identified four categories of mental health issues for refugee children. Here we will present four corresponding types of intervention necessary to address these needs. They include: (1) trauma-informed treatment; (2) strategies for providing access and engaging refugee children in mental health services; (3) approaches to providing culturally competent services; and (4) strategies for helping refugee children and families cope with stresses of resettlement. We propose that these four are the essential components or key ingredients in a comprehensive services model for refugee children.

By designating these four components as "key ingredients," we mean that the comprehensive services model must in some way have a strategy for addressing each of these four needs relevant to the mental health of refugee children. A program's specific strategies and approaches may vary widely depending on its structure and focus. While some programs may administer specific interventions to address each of these four components, others may collaborate with other agencies and refer their patients for adjunct services. However we emphasize the importance of attending to each of these components in every overall intervention design.

We then turned to the literature to review what is known about effectiveness of each of these four intervention components with refugee as well as non-refugee children. As the literature on effectiveness of interventions of refugee children is only beginning to emerge, we broadened our review to include interventions with refugee adults, and immigrants, as well as other traumatized children. The intent was to identify any empirical evidence for particular strategies that can be used as components of a comprehensive services model for refugee children.

Trauma-Informed Treatments for Refugee Children

Several evidence-based interventions have been developed to address trauma in children. Cognitive-behavioral therapy (CBT) is generally accepted as an efficacious trauma-informed treatment for children. To date, published randomized controlled trials of these trauma-focused treatment programs mainly focus on children who have been sexually abused (for a review, see Cohen, Deblinger, Mannarino, & Steer, 2004; Saywitz, Mannarino, Berliner, & Cohen, 2001). Thus while these interventions can be used to inform treatments for refugee children, as currently developed they are not designed to address many of the unique circumstances of traumatized refugee children. Since the nature of the traumatic event (such as duration, chronicity, perceived controllability, and predictability) has been found to be related to the types of symptoms manifested (Terr, 1995), the intervention design may need to be altered to address war-related trauma.

School-Based CBT Interventions

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is a 10 session group CBT intervention designed to address PTSD, anxiety, and depression related to community violence exposure. It has been used with traumatized immigrants, and therefore is potentially suitable for traumatized refugee children because it addresses issues of trauma as well as culture. The

intervention uses a self-report questionnaire to identify children at school (ages 11-15) who have been exposed to trauma and are experiencing symptoms of PTSD. Group CBT sessions are then provided within the school setting. Results from a fully randomized controlled trial with English-speaking 6th graders in a predominantly Latino area of LA (B. Stein, Jaycox et al., 2003) showed that students who received the intervention had significantly fewer self-reported symptoms of PTSD and depression, and fewer parental reports of psychosocial dysfunction at the three-month follow-up assessment. These effects were not observed with regards to teacher report of classroom behavior, however.

Another study utilized an eight-session version of the intervention provided in Spanish to Latino immigrant students by bilingual/bicultural social workers (Kataoka et al., 2003). In addition, supportive and psychoeducational sessions were provided to teachers and parents. The research design and findings were similar to those reported by B. Stein et al. (2003), with intervention group children showing improvement in symptoms but not in classroom behavior at three months.

Although data on outcomes have not been reported, this intervention has also been conducted with immigrant children from multiple language groups, and materials for the interventions in a number of refugee languages have been developed (B. Stein, Kataoka et al., 2003). This makes this intervention potentially relevant to multiple refugee populations. However, a limitation of this particular intervention approach is that children are screened for appropriateness for the intervention based on a self-report questionnaire of trauma symptoms and exposure. Thus, only children old enough and willing to disclose their trauma and symptoms in a questionnaire format are selected to participate.

A similar school-based CBT group intervention was conducted by Layne, Pynoos, Salzman et al. (2001) with war-exposed, internally displaced adolescents in Bosnia. The treatment program consisted of 23 group sessions that covered psychoeducation, therapeutic exposure, cognitive restructuring, stress management-relaxation skills, and practical problem solving of current life events. The adolescents' traumatic stress symptoms were found to decrease over time, though the study did not include a control group. Since these refugees were living within their own country, the intervention did not address issues of cultural competence.

Psychoeducational and Parenting Intervention for Mothers

A psychoeducational program for mothers of internally displaced traumatized children has been studied in Bosnia and Herzegovina (Dybdahl, 2001) and found to be effective. The goal of the intervention was to improve the children's psychosocial functioning, as well as the mental health of their mothers. Mother-child pairs were randomly assigned to a control group, whose members received medical care and participated in scheduled evaluations, or to an intervention group, whose members participated in a five-month psychosocial intervention in addition to receiving medical care and participating in scheduled evaluations.

Dybdahl's (2001) intervention was manualized, and consisted of semistructured weekly group meetings of approximately five mothers with trained group leaders over the five months. The groups included therapeutic discussions, psychoeducation about trauma, and guidance on facilitating parent-child interactions and communication.

Findings suggest that the intervention was effective at improving the mental health of mothers as well as children. Mothers in the intervention groups had substantially greater reduction in

symptoms as measured by the Impact of Events Scale, and rated themselves as happier on a well-being scale than mothers in the control condition. Children in the intervention group were rated as having fewer problems at post test than at pretest by mothers and by psychologists, whereas the control group had little change. The intervention group children also improved their scores on a measure of cognitive abilities relative to the control group. Finally, children in the intervention group showed greater changes on physical measures, including gain in height and weight, and hemoglobin counts at post test relative to controls. As the intervention was exclusively focused on mothers, the study highlights the importance of focusing on caregivers' mental health and training as effective strategies in treating traumatized refugee children. However, the intervention did not need to address issues of cultural competence since these refugees were internally displaced within their native country.

Art and Expressive Therapy

A treatment approach that seems to be widely practiced, though rarely studied or evaluated, is the use of art and other expressive techniques as a tool with traumatized refugee children. Creative arts therapies are commonly used and have been proposed as potentially useful tools for the diagnosis and treatment of psychological trauma, at least with Vietnam Veterans (Johnson, 1987). For traumatized refugee children who are too embarrassed, highly resistant, or do not have the language skills to talk about their traumatic memories, creative arts therapies have been regarded as especially helpful as a way to allow clients to disclose and process their traumatic experiences in ways that are less threatening than talking (Rousseau, Lacroix, Bagilishya, & Heusch, 2003). Other clinicians have found that art therapy and art creation may provide refugee clients with a needed feeling of structure, a sense of control, a way to re-assert their identities through emotional expression, and a counterbalance to their losses (Fitzpatrick, 2002). Some clinicians have also noted that creative therapy techniques such as storytelling may be especially appropriate for refugee children from cultures that have a strong tradition of storytelling (Rydberg, 2002).

However, it is important to note that for traumatized children the process of art creation may be too ambiguous and unstructured, and may cause further anxiety (Hocoy, 2002; Neugebauer, 2003). For example, conversations about traumatic experiences in interviews were found to exacerbate negative affect among traumatized Bosnian children living in Sweden (Angel et al., 2001). At the same time, many evidence-based interventions for children, including CBT, use art as a tool within a structured session that helps the child process cognitions and affect. Thus, careful studies of uses of art and expressive therapy with refugee children are warranted to inform providers of this widely accepted, but untested, practice.

Summary of Trauma-Informed Treatments

Taken together, studies of interventions with traumatized refugees suggest that CBT may be a helpful tool to use with traumatized refugee children either in individual or group treatment. However, existing studies have demonstrated benefits of CBT with respect to symptoms but not overall functioning of the children. On the other hand, a psychoeducational and parenting program with mothers was found to be effective across a range of outcome measures including health, mental health, cognitive and psychological functioning. The intervention targeted mothers rather than children directly, and the findings suggest that this may be a promising direction for future intervention development with refugee children. However, the intervention was not carried out with children in resettlement, and thus did not address cultural issues. Finally, while art and expressive therapy remains a popular practice with refugee children, it has

not been adequately articulated as an intervention model, and evidence is not available to support its effectiveness.

Strategies to Improve Access to Care and Engagement in Services

The centrality of engagement in mental health services, particularly with immigrant populations, is stressed by Szapocznik et al. (1988), who argue that engagement cannot be seen as separate from the intervention itself. Indeed, interventions cannot be effective if they are not utilized by the intended clients. Varied strategies have been studied to improve engagement and retention in mental health services.

Several investigators have studied intervention strategies for engaging clients in mental health services, usually focused on the initial contact between agency and clients. For example, Russell, Lang, and Brett (1987), Shivack and Sullivan (1989), Szapocznik et al. (1988), and McKay et al. (1998) all have reported success with telephone engagement interventions in which providers offer detailed information about the agency and the services, and problem-solve with clients around practical concerns such as work schedules, childcare responsibilities, or transportation. While promising with respect to *engaging* families in treatment initially, these approaches have not been consistently effective at *retaining* families in services beyond the initial sessions. Rather, more profound changes in the structure of the services may be required in order to ensure ongoing access for children who need services (Horwitz & Hoagwood, 2002). Further, these interventions remain untested with refugee children and their families.

In the refugee context, Weine and colleagues (Weine et al., 2004; Weine et al., 2003) investigated the effects of a multi-family intervention focused on engagement into services for Bosnian and Kosovar refugee families in Chicago. The goal of CAFES (Coffee and Family Enhancement Services) was to facilitate access to mental health services for adult Bosnian refugees with symptoms of PTSD. Bilingual/bicultural project staff contacted refugee families and arranged a home visit in which families were invited to participate in the intervention, and randomly assigned to intervention or control. The intervention itself consisted of facilitated multi-family groups held weekly at a community agency. The groups were led by a trained bilingual/bicultural worker who conducted the nine weekly sessions following a manualized curriculum.

The intervention goals were to increase social support of the participants, provide them with education about trauma and mental health issues, and facilitate access to mental health services. Thus, the intervention did not aim to provide mental health treatment per se. Longitudinal assessments occurred every six months for eighteen months. Results suggested that the CAFES group was effective in engaging families in the intervention itself, facilitating access to mental health services, reducing symptoms of depression, and improving family communication relative to controls. The intervention also increased social support for the males participating in the study (Weine et al., under review).

Another approach to access and engagement that is frequently mentioned in the literature involves use of alternative service settings to provide mental health care. Settings such as schools and medical offices can be more comfortable places for refugees to turn to for services than traditional mental health facilities (Kinzie, Tran, Breckenridge, & Bloom, 1980; Surgeon General's Report, 2001). As noted above, schools have been identified as an important setting for delivering mental health services to children in general (Hoagwood & Erwin, 1997), and

refugee children in particular (Bemak & Cornely, 2002; Hodes, 2000, 2002). In addition to the school-based CBT group treatments described above, a number of other school-based interventions for refugee children have been reported (Hones, 2002; O'Shea, Hodes, Down, & Bramley, 2000; Rousseau et al., 2003; Rousseau, Singh, Lacroix, Bagilishya, & Measham, 2004).

One intervention specifically focused on providing mental health treatment to traumatized refugees in a primary school in London (O'Shea et al., 2000). Teachers identified 14 refugee pupils with psychological difficulties related to exposure to high levels of past violence and losses and referred them to an outreach mental health worker. A range of psychological and family interventions were offered by the mental health worker on the school site, including interventions with teachers, the children alone, and with relatives. A pre-post design with no control group showed an overall reduction in symptoms, with some children showing dramatic benefit. However, the study was not designed to test the effectiveness of the school setting as an engagement strategy, per se. Thus, while locating services in alternative locations may be a promising strategy of improving access for refugee children, studies have not been conducted to support the effectiveness of this approach.

Summary of Access and Engagement Strategies

Taken together, these studies suggest that specialized efforts at engagement can be extremely useful at providing access to refugees. Weine's intervention with refugees is particularly promising, and may be structured as a first phase of a mental health intervention for families of children identified as needing services. The advantages of locating services in schools and medical settings seem evident but have not been studied.

Approaches to Cultural Competence

The term "cultural competence" refers to the capacity of programs to provide services in ways that are acceptable, engaging, and effective with multicultural populations. A number of theoretical models and frameworks for considering cultural competence in mental health interventions have been proposed in the literature to aid professionals (see for example Cole & Bird, 2000; Cross, Bazron, Isaacs, & Dennis, 1989; Mason, Benjamin, & Lewis, 1996; Misra-Hebert, 2003; Roberts et al., 1998; Stroul & Friedman, 1986; Vargas & Koss-Chioino, 1992). Although most of these models have not been developed to target refugee child and adolescent needs specifically, they do offer guidelines for incorporating attention to culture and language in mental health interventions.

Broadly, there are three ways that programs and service providers can attain cultural competence. First, an agency can enhance the extent to which existing "mainstream" service providers recognize cultural issues and are knowledgeable about the cultures of their clients. Agencies can do this through training of their providers, and may redesign existing services to incorporate more "culturally sensitive" strategies to meet the needs of culturally diverse clients. Second, a program can employ service providers from the cultures of the groups being served; in the absence of mental health professionals from these cultures, employing ethnic paraprofessionals to work collaboratively with the mental health professionals is a possible alternative. Finally, an agency can organize ethnic/culture-specific programs or centers, gather expertise in one setting, and specialize in serving a particular cultural group.

Enhancing Cultural Awareness and Sensitivity of Mainstream Providers

Training mainstream providers to be knowledgeable and sensitive to the cultures of the people they serve has been widely advocated as a strategy to achieve cultural competence. However, Gong Guy et al. (1991), in a survey of services available to Southeast Asian Refugees in California, found that cross-cultural training for those serving refugees was virtually non-existent. In addition, while a measure of cultural competence of service providers has been developed (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002; D. W. Sue et al., 1998), studies have not examined the extent to which cultural training or cultural competence of providers is linked to better outcomes for culturally diverse clients.

One exception is a recent report by Miranda, Schoenbaum, Sherbourne, Duan and Wells et al. (2004) that described a Quality Improvement (QI) program for treatment of depression in managed care organizations that included cultural orientation to Mexican American and African American clients. Existing mental health service providers received training in issues to consider in working with these ethnic minority patients, such as the importance of *respeto* and *familismo* for Mexican Americans, and the importance of clinicians having a direct and open style, and respecting religion and spirituality for African Americans. Results suggest that both minorities and non-minorities were more likely to benefit from treatment when QI procedures were introduced; however, the additional value of the cultural orientation provided was not examined to determine whether it had an impact over and above the training on standards of care.

Other published articles provide only general guidelines for training service providers to achieve cultural competence or suggestions for how to modify therapeutic techniques (Chung et al., 1997). For example, though not focused on refugees, Roberts et al. (1998) and Vargas & Koss-Chioino (1992) suggest that cultural competence training needs to include exposure to aspects of the new culture, initially supervised experience of new skills, and expertise acquired through extended practice and research. Additionally, both models of training highlight the potentially fine line between cultural stereotyping and cultural sensitivity. Vargas and Koss-Chioino (1992) recommend that professionals who are receiving training research culture-specific differences with knowledgeable professionals, as well as members of the community of interest, rather than relying on stereotyped beliefs, cross-cultural generalizations, or experience gleaned from case studies.

Ethnically Matched Professionals and Paraprofessionals

The use of *ethnically matched professionals and paraprofessionals* has been suggested as an important means of overcoming cultural and language barriers (Gong-Guy et al., 1991; Musser-Granski & Carrillo, 1997). A number of authors have suggested that engagement, retention, and outcomes in treatment can be improved if mental health service providers are matched to clients with respect to culture, ethnic or racial group, language, prior experience, or other factors. Clients matched with a clinician with respect to their ethnicity and language have been found to stay in treatment longer (S. Sue et al., 1991) and to be less likely to use hospital emergency rooms for mental health services (Snowden, Hu, & Jerrell, 1995) and to benefit more from treatment than those not matched.

However, lack of trained *bilingual, bicultural professionals* has been noted with respect to multiple ethnic groups, including Hispanics and Southeast Asians in the U.S. (Gong-Guy et al., 1991; Kataoka et al., 2002; Musser-Granski & Carrillo, 1997; Surgeon General's Report, 2001). Most clearly documented is the gap between Spanish-speaking service provider availability and

the increasing Latino population (Kataoka et al., 2002), with about 40 percent of Hispanic Americans in the 1990 census reporting that they did not speak English very well.

With respect to Southeast Asians, Gong Guy et al. (1991), in a survey of services accessible to Southeast Asian Refugees in California, found a severe shortage of adequately trained bilingual and bicultural mental health personnel. In addition, existing outpatient services were characterized by long delays and by availability of services only through interpreters. Clearly, one way to improve services would be to increase the number of trained bilingual/bicultural mental health providers.

In situations where bicultural/bilingual professionals cannot be located, researchers have begun to examine the use of ethnic paraprofessionals, who often have bachelors degrees or lower levels of training in clinical issues (D. Williams, 2001). In cross-cultural situations, paraprofessionals may be more effective at conducting community outreach, ensuring access to services for potential clients, facilitating their engagement and retention in services, and providing interpretation when needed. On the other hand, by definition, paraprofessionals do not have any formal training with respect to case management or interpreting services. Thus, in situations where they are called on to serve as interpreters for severely disturbed refugees, this lack of training may lead to problems of misdiagnosis and other distortions which can seriously undermine the clinician's attempts to treat refugee clients (Gong-Guy et al., 1991; Musser-Granski & Carrillo, 1997). Further, paraprofessionals who are themselves refugees may themselves have lived through traumatic events and may become re-traumatized when working with refugee clients. Extensive training and supervision are then needed to address these concerns.

Studies of effectiveness of paraprofessionals have yielded somewhat conflicting findings. On the one hand, Durlak, (1979) and Nietzel and Fisher (1981) found that when dealing with non-psychiatric populations, paraprofessionals can perform effective counseling. However, these studies did not involve *ethnic* paraprofessionals matched on culture and language with their clients. On the other hand, Ying & Hu (1994) compared mental health service use and outcomes of four Southeast Asian groups (Vietnamese, Cambodians, Laotians and Hmong) with four other Asian American groups (Japanese, Chinese, Filipino and Korean). The Southeast Asians were more likely to be seen by paraprofessionals than members of other Asian groups. They were also more likely to use more sessions, and to continue with treatment when the service provider was a paraprofessional. However, outcomes for Southeast Asians were poorer than for other groups even when the diagnosis and initial level of functioning were controlled for. This study may suggest that while the use of paraprofessionals may lead to better retention, paraprofessionals may lack the training and skills needed to provide effective mental health services for these clients.

Taken together, these studies suggest that in the absence of ethnic professionals, an effective approach may involve pairing clinical professionals with ethnic paraprofessionals so that clients have the benefit of both access and effectiveness of services. However, including paraprofessionals in clinical teams requires attention to training and supervision. Refugee paraprofessionals may require assistance in analyzing coping patterns in their own immigration experience and how their current level of acculturation is reflected in their work (Ryan & Epstein, 1987). They may also need help managing their changing roles in their ethnic community, and in setting priorities, limits and boundaries with clients.

Culture-Specific Clinics or Centers

There is evidence that mental health clients in community programs designed with a particular culture in mind stay in treatment longer and are less likely to drop out of treatment than those using mainstream services (Snowden & Hu, 1997; Takeuchi et al., 1995). Additionally, Snowden, Hu, & Jerrel (1995) found that receiving treatment at an ethnic-specific program that met cultural competence criteria was more important to treatment outcome than ethnic match of provider in non-ethnic specific programs.

Snowden (1998) reviewed several ethnically matched organizations that demonstrated significant outcomes for increasing access and engagement for minority populations and identified key distinguishing features that the agencies shared. The most successful agencies tended to be affiliated with grassroots efforts, located within the community of interest, and to have members of the community represented on agency boards. Successful ethnic-specific agencies also maintained relationships with indigenous healers and had many cooperative relationships with faith-based and service organizations within the community.

Agencies with better retention rates included family-oriented planning and treatment in their assessment and treatment plans, and made conscious efforts to create a welcoming and accepting atmosphere. These organizations overwhelmingly included non-English speaking professionals or paraprofessionals on their staffs, and strove to achieve an understanding of local norms relating to beliefs about mental illness through didactic efforts with community members, and ongoing training efforts. However, studies of relative effectiveness of ethnic-specific *refugee* programs have not been reported.

In the refugee context, specialized clinics for particular refugee groups have emerged as one treatment model. The Oregon Refugee Indochinese Psychiatry Clinic (Kinzie et al., 1980), and the Harvard Program in Refugee Trauma (Boehnlein, 1987) were both dedicated to serving Southeast Asian (Indochinese) refugees. Although neither of these clinics specialized in provision of services to children, they provide important examples of models of service for refugees.

The Oregon Indochinese Psychiatry clinic was established in 1977 at the Oregon Health Sciences Center (Kinzie, 1986; Kinzie & Manson, 1983; Kinzie et al., 1980). Services were provided by psychiatrists and Indochinese counselors. Additionally, Indochinese counselors addressed adjustment problems of the refugees specifically. Kinzie et al. (1980) reported on 50 adult, predominantly Vietnamese, patients evaluated or treated in the clinic. Most patients received psychotropic medicine for psychotic disorders or depressive symptoms. These patients often had frequent, brief follow-up visits, and were reported to show good to marked symptomatic improvement.

The Oregon center continues to provide refugee mental health services, but has shifted in focus to include an increasingly diverse range of refugee populations. Currently it is a multicultural center, with the model of services extended to other ethnic groups. Ethnic counselors and professionals continue to work at the center, but are now multicultural. In addition, the center now has a specialized children's program, which is part of the NCTSN.

The Boston Indochinese Psychiatry clinic was founded in 1982 (Boehnlein, 1987) to provide services to traumatized Indochinese refugees in ways that were easily accessible, informed by the cultures and circumstances of the refugee populations, but not stigmatizing. The treatment model was framed as a medical intervention as most patients initially presented with medical

problems, were comfortable with medical settings, and expected to receive injections, pills, or other forms of medical treatment from a physician. After the initial evaluation of the patient's presenting symptoms, weekly clinic contact by a co-therapy team was begun, leading eventually to monthly or bimonthly treatment that continued, on average, for two or more years. Psychological problems surfaced later, sometimes after some treatment, as most clients regarded emotional symptoms as secondary to their somatic complaints.

Bicultural workers were given ongoing clinical training and consistent, supportive clinical supervision. These workers were already knowledgeable and empathic with their clients having experienced similar traumatic events themselves. Integration of folk healers and folk treatment systems was also attempted, although few such healers were available in the Boston area. Patients were also encouraged to engage in self-evaluation, and to use the culturally valid versions of the Hopkins Symptom Checklist, developed by the program in Vietnamese, Laotian, and Cambodian languages.

These specialized ethnic specific refugee clinics have had a long history of providing services to traumatized refugees. These programs are well known and much respected in the service provider community. They have accumulated a great deal of clinical wisdom, though no research on effectiveness of these services is reported in the literature.

Summary of Cultural Competence

Cultural competence of mental health providers is a key ingredient for effective services to refugees. However, providing culturally informed treatment is extremely difficult. With respect to training mainstream professionals, while it is likely that such training would be beneficial, there is no empirical evidence to suggest that training is sufficient to ensure provision of culturally informed services, nor have specific training models been articulated and tested. Evidence does seem to suggest that culture-specific centers have advantages over other approaches. However, such centers are only possible in communities with high refugee concentrations, and are dependent on availability of potential ethnic service providers. The use of paraprofessionals seems to have much promise, but may also require provision of extensive supervision and training. An approach not mentioned in the literature is the practice of using interpreters in psychotherapy and other kinds of treatment. Overall, creating culturally competent programs for refugees, particularly for smaller refugee groups, remains a particularly challenging task, and requires multiple strategies to accommodate unique situations in diverse communities.

Interventions Designed to Address Stresses of Resettlement

As discussed earlier, all of the literature on mental health interventions with traumatized refugees suggests that interventions must in some way address the general adaptation and stressors encountered by refugees in the process of resettlement through case management, support services, or other means of helping families problem solve practical issues in adaptation (Chung et al., 1997; Kataoka et al., 2003; Kim, Snyder, & Lai-Bitker, 1996). Although such interventions are not traditionally thought of as mental health services, they may not only support the mental health care being provided, but may also be linked to mental health outcomes. Therefore they are important to a comprehensive mental health services model for refugees.

Broadly, a mental health program can accomplish this in two ways: (1) by providing case management and (2) by providing preventive interventions, or referring clients to preventive interventions at other agencies and institutions.

Case Management

Case management has been suggested as an important component of mental health services for refugees (Chung et al., 1997) and most of the interventions for refugees described above have incorporated it as one of the services provided. Both the Boston and the Oregon Indochinese Psychiatry Clinics supplemented psychiatric services with extensive case management and counseling provided by ethnic workers (Boehnlein, 1987; Kinzie et al., 1980). The CAFES bilingual/bicultural group leaders were available to group participants to problem solve a variety of situations and provided referral to a range of services, including mental health (Weine et al., 2004; Weine et al., 2003). However, the value added by case management to the overall effectiveness of the mental health program with respect to mental health outcomes has not been studied.

Case management may be more effective when the mental health program has formed collaborative relationships with multiple community agencies. In this way, case mangers can ensure that these varied services work in concert with one another. For example, the description of the Calgary Survivors of Torture Program (Ramaliu & Thurston, 2003) notes the extensive inter-agency coordination among various community agencies and groups. Agencies that provide a range of services under one roof may have an advantage by being able to coordinate programming for refugees.

Preventive Interventions as Components or Adjunct to Treatment

A number of experts suggest that prevention is an important component of mental health services for refugees (De Vries & Van Heck, 1994; Westermeyer, 1987; C. Williams, 1989; C. Williams & Berry, 1991; Yule, 2000). Preventive programs offer many advantages, as they can often be carried out by paraprofessionals with consultation from mental health professionals, and can be structured in ways that reach a large number of children in need. In particular, schools have been noted as an excellent setting for prevention programs for refugee children that also provide opportunities to identify children that require more intensive services. For example, Yule (2000) proposes an hierarchical model of support and intervention for internally displaced refugee children whereby psychosocial help is delivered primarily through schools with only a small proportion of more complex needs being met by specially trained mental health professionals. However, no evidence-based preventive interventions designed with refugee children in mind are reported on in the literature.

For children more generally, a large number of school-based preventive programs have been developed and validated, including programs to reduce risks of disruptive behaviors, substance abuse, and psychopathology (Felner & Adan, 1988; Greenberg, Domitrovich, & Bumbarger, 2001; Weissberg, Kumpfer, & Seligman, 2003). Although none of these evidence-based programs has been developed for traumatized refugee children specifically, they may be quite relevant and useful. For example, programs that are aimed at easing a child's transition to school (Felner & Adan, 1988; Felner et al., 2001; Felner, Ginter, & Primavera, 2002), mentoring (Langhout, Rhodes, & Osborne, 2004; Rhodes, Grossman, & Resch, 2003), buddy programs (Cowen et al., 1996), parenting (Hughes & Gottlieb, 2004; Patterson, DeGarmo, & Forgatch, 2004; Webster-Stratton, Reid, & Hammond, 2004), and other interventions may be adapted and used for refugee children who also confront these risks and challenges.

Some of these programs have been developed for immigrants, and are designed to address cultural issues that may also be relevant for refugee children. For example, the Family Effectiveness Training (FET, Szapocznik, Rio, Perez-Vidal, Kurtines, & Santisteban, 1986; Szapocznik, Santisteban, Rio, Perez-Vidal, & et al., 1989) is an intervention designed to reduce the acculturation gap in immigrant families with the goal of improving family adjustment and preventing adolescent behavior problems. FET is a 13-session program that includes specific attention to these cultural issues and their implications for intergenerational communication and child problem behavior. It has been found to be effective relative to a no treatment control with respect to improvement in family functioning, problem behaviors as reported by parents, and on a self-administered measure of child self-concept.

Interventions designed to ease refugee children's transition to school have been described in the literature, but not evaluated empirically. Narrative inquiry and creative expression interventions have been used to ease cultural and school transition for refugee children. Hones (2002) describes taking a participatory action research perspective in which students were recruited to keep dialogue journals of their experiences over the course of the school year. In these journals, the adolescents catalogued their acculturative stresses and difficult lives. In so doing, they created a resource for school intervention possibilities to aid their acculturation and adaptation to American life. The journals also served the function of affirming the cultures and lives of the adolescents. As Hones (2002) writes: "*Preliminary findings of this research suggest that dialogic pedagogy has the potential to transform the lives of bilingual secondary students and those who work with them*" (p. 1182). In like manner, Rousseau et al. (Rousseau et al., 2004) describe the development of creative expression workshops to provide refugee and immigrant children with an opportunity "*to construct meaning, to structure identity, and to work through their losses and reestablish social ties.*" (p. 235). Similarly, the Playing to Grow intervention developed for Guatemalan children residing in refugee camps, has emphasized working with their teachers to build a safe environment for the children, allowing the children to heal through play, and a way to share their thoughts and feelings (Miller & Billings, 1994). In this program, activities such as collage, collective storytelling, and sociodrama are used in addition to individual and collective drawing.

Summary of Interventions Addressing Resettlement Stress

Case management and preventive interventions programs are ways that mental health services can address the resettlement stresses of refugee children and families. While case management may be a useful component of a comprehensive services model, and an excellent strategy to engage and retain clients in mental health services, its effectiveness and relevance for mental health outcomes has not been studied. With respect to preventive interventions, while many evidence-based programs for children have been developed, none has been adapted to the needs of refugee children specifically. Rather, the literature contains reports of school based preventive interventions designed specifically with refugee children in mind, but not studies of their effectiveness. Thus, the challenges of how to provide preventive interventions to refugee children that are effective and relevant to their specific needs remains. Further, the challenge remains of how to integrate preventive activities into a comprehensive mental health services model.

Conclusions, Recommendations, and Next Steps

We began this paper with the suggestions that traumatized refugee children can most benefit from comprehensive mental health services that address the trauma, but also ensure access and engagement and provide culturally relevant and trauma-informed treatment. In addition, the services must in some way address the resettlement difficulties experienced by refugee children and families. Having reviewed the literature, we conclude that although a comprehensive model for refugee children has not been empirically studied, research on existing interventions provides some evidence for the effectiveness of specific strategies that can be used to build such a model.

Each of the interventions reviewed in this paper focus on different "key ingredients" of the proposed comprehensive services model. For example, the focus of the CBITS program (Kataoka et al., 2003) was on symptoms resulting from traumatic exposure, and CBT, an evidence-based technique, was used. With respect to access and engagement, locating the intervention at school helped identify and engage a larger number of children than would have been possible at a clinic, and perhaps made the treatment less stigmatizing. Cultural competence was addressed by selecting specific language/cultural groups as targets of intervention, developing materials in the children's languages, and using ethnic professionals to provide the interventions. However, issues of resettlement stress were not addressed in this intervention model.

The CAFES/TAFES intervention, on the other hand, did not provide trauma-informed treatment. Instead, the intervention focused on engaging refugee families in the intervention, educating them about effects of trauma and mental health treatment, and referring them to mental health services provided elsewhere. Engagement in the multi-family groups was accomplished through extensive outreach in the community, by holding the groups at times convenient to participants, and by focusing group discussions on topics of interest to the participants. Resettlement stresses were a focus of this intervention, which was designed in part to be preventive in nature; thus extensive orientation and education on various aspects of resettlement was provided, and the groups were designed to increase social support. Cultural competence of the intervention was addressed through employing ethnic paraprofessionals who conducted outreach and led the groups.

Since both of these interventions provide empirical support for effectiveness at treating symptoms (Kataoka et al., 2003) and engaging refugee families in treatment (Weine et al., 2003) they provide potential building blocks for a comprehensive services model for refugees, although Weine's model did not focus on children. However, important challenges remain with respect to how to provide culturally competent treatment to diverse refugee populations, as research does not provide sufficient guidance with respect to what works. In addition, creating mental health programs that can integrate clinical services with case management and preventive services is challenging. Thus, while the literature provides us with some potential building blocks of an intervention model, there is not sufficient evidence to guide the development of a comprehensive mental health program that can combine multiple components. We propose the next steps toward better understanding and development of evidence-based interventions for refugee children in the next section.

Toward Practice-Based Evidence

In light of the absence of evidence-based interventions for refugee children, and the difficulties involved in developing interventions for refugee children that satisfy scientific evidence-based criteria, we emphasize the relative importance of "practice-based evidence." Practice-based evidence refers to the process of identifying and studying clinical treatment models and conceptualizations that currently exist in the "real" world (Barkham et al., 2001; Krakau, 2000; Margison et al., 2000; Stiles et al., 2003).

Many refugee children are currently receiving treatment in agencies and clinics thought the U.S., as multiple programs in local communities have struggled with how to create effective and accessible services for these populations. Within the NCTSN network, many sites are currently providing services to refugees. Most of these interventions have not been subjected to systematic evaluation, much less randomized controlled trials. Nonetheless, we suggest that the field has much to gain from beginning to identify and describe these interventions. Clinicians and other interventionists working in local communities have accumulated great local wisdom with respect to their work (see for example clinical reports by Hodes, 2002; Rousseau et al., 2004).

A focus on studying existing practices with refugee children can serve the long term goal of developing evidence-based interventions for traumatized refugees in several ways. The transfer of interventions found to be efficacious under tightly controlled laboratory conditions to the local community clinic can be fraught with numerous difficulties (Weisz, Chu, & Polo, 2004). Rather an "emic" or "inductive" (S. Sue & Chu, 2003) approach of studying existing local efforts may be more parsimonious for developing evidence-based practices for refugee children. Thus resources may be better expended on leaning how practices that are currently occurring within local community settings have successfully solved a number of problems of implementation, financing, access, cultural competence, and other challenges that a newly imported intervention developed elsewhere would need to address "from scratch." Further, existing programs are by definition sustainable, since they have naturally evolved from efforts of the local agencies and organizations. A "practice-based evidence" approach would focus on ways of documenting these practices and studying outcomes for children that they serve.

Our next steps are to begin to collect data in order to describe these programs and begin to document outcomes. We are interested in documenting various components of the services being provided, learning about particular background characteristics of the children that are relevant to understanding the treatment that they receive, and ultimately learning whether these children are improving as a result of the care they receive. Through its Data Core, the NCTSN has initiated a data collection protocol across all of the sites. However, many of the measures included in the Data Core may not be well suited to describing refugee mental health programs. Thus, the next steps of the Refugee Trauma Task Force are to develop a Refugee Data Core that can be implemented across all the sites that serve refugees. Our hope is that this approach will ultimately help us learn from existing practices, compare varied approaches, and build evidence for models for effective comprehensive services for refugee children.

Network Sites that Provide Services to Refugee Children

In California

- The Chadwick Center for Children and Families Trauma Counseling Program at Children's Hospital and Health Center in San Diego
  Web: www.chadwickcenter.org

- Children's Institute International at Central LA Child Trauma Treatment Center in Los Angeles
  Web: www.childrensinstitute.org

- LAUSD Community Practice Center at the Los Angeles Unified School District in Van Nuys
  Email: marleen.wong@lausd.net

- The Miller Children's Abuse and Violence Intervention Center in Long Beach
  Web: www.memorialcare.org

In Florida

- Healing the Hurt at Directions for Mental Health, Inc. in Clearwater
  Web: www.directionsmh.org

In Illinois

- International Family, Adolescent, & Child Enhancement Services (I-FACES) at Heartland Health Outreach, Inc. in Chicago
  Web: www.heartland-alliance.org

In Massachusetts

- The Trauma Center, Massachusetts Mental Health Institute in Allston
  Web: www.traumacenter.org

- The Center for Medical and Refugee Trauma at Boston Medical Center in Boston
  Web: www.bmc.org/childpsychiatry

In New York

- The Jewish Board of Family and Children's Services (JBFCS) Center for Trauma Program Innovation (CTPI) in New York City
  Web: www.jbfcs.org

- Mount Sinai Adolescent Health Center in New York City
  Web: www.mountsinai.org/msh/msh_program.jsp?url=clinical_services/cfe_pp.htm

- North Shore University Hospital at the Adolescent Trauma Treatment Development Center in Manhasset
  Web: www.northshorelij.com/

- Safe Horizon-Saint Vincent's Child Trauma Care Continuum in New York City
  Web: www.svcmc.org
  Web: www.safehorizon.org

In Oregon

- Intercultural Child Traumatic Stress Center of Oregon at the Department of Psychiatry in Portland

In Pennsylvania

- Children's Crisis Treatment Center West African Refugee Project in Philadelphia
  Web: www.cctckids.com

In South Carolina

- National Crime Victims Research and Treatment Center (NCVC) at the Medical University of South Carolina, Charleston
  Web: www.musc.edu/cvc/

In Texas

- DePelchin Children's Center Child Traumatic Stress in Houston
  Web: www.depelchin.org

In Virginia

- International C.H.I.L.D. at the Center for Multicultural Human Services (CMHS) in Falls Church
  Web: www.cmhs.org

In Washington

- Harborview Child Traumatic Stress Program, Seattle
  Web: http://depts.washington.edu/hcsats/

In Washington, D.C.

- Identification and Treatment of Traumatic Stress in Children and Adolescents in Latino and Other Immigrant Populations at La Clinica del Pueblo, Inc.
  Web: www.lcdp.org

In Wisconsin

- Mental Health Center of Dane County Adolescent Trauma Treatment Program
  Web: www.mhcdc.org/

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