NCTSN The National Child Traumatic Stress Network

Survey of National Refugee Working Group Sites 2004: Summary Report

From the National Child Traumatic Stress Network
Refugee Working Group

This project was funded by the Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services

Survey of National Refugee Working Group Sites 2004: Summary Report

From the

National Child Traumatic Stress Network
Refugee Working Group

Prepared by Molly Benson, PhD

Survey Subcommittee: Heidi Ellis, PhD, Wanda Grant-Knight, PhD, Marion Chew, PhD, Karen Batia, PhD, Heike Thiel de Bocanegra, PhD, MPH

Dr. Benson is with Children's Hospital Boston/Harvard Medical School.
Dr. Ellis is with Center for Medical and Refugee Trauma, Boston Medical Center.
Dr. Grant-Knight is with The Rehabilitation Institute of Chicago.
Dr. Chew is with International CHILD/Center for Multicultural Human Services, Virginia.
Dr. Batia is with Chicago Health Outreach
Dr. de Bocanegra is with Safe Horizon/Solace, New York City

National Child Traumatic Stress Network
www.NCTSNet.org

2005

The National Child Traumatic Stress Network is coordinated by the National Center for Child Traumatic Stress, Los Angeles, Calif., and Durham, N.C.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Contents

Tables

Survey of National Refugee Working Group Sites 2004: Summary Report

Introduction

The Refugee Working Group survey of services for refugee children and families was initiated in 2003. All agencies within the National Child Traumatic Stress Network (NCTSN) were initially surveyed regarding their provision of services to refugee children and their interest in participating in the Refugee Working Group. Of these sites, thirteen leading agencies in the area of refugee trauma were identified. These thirteen agencies completed comprehensive surveys detailing their current services, best practices, and suggestions for the future of refugee-focused programs with the Network. The following NCTSN sites participated in this survey, providing the information summarized in this report:

- Center for Medical and Refugee Trauma, Boston Medical Center
- Center for Multicultural Human Services (CMHS)
- Children's Institute International
- Healing the Hurt/Directions for Mental Health
- International FACES, Heartland Alliance
- Jewish Board of Family and Children's Services
- La Clinica del Pueblo
- LAUSD Community Practice Center
- MMHI, Trauma Center
- Mt. Sinai Adolescent Health Center
- Oregon Health Sciences University/Intercultural Psychiatry Program
- Project Tamaa: Children's Crisis Treatment Center's West African Refugee Assistance Program
- Safe Horizon/Solace

Description of Sites

The sites providing services to refugee children and families are located in primarily urban areas including Boston, New York, Los Angeles, Philadelphia, Washington DC, Chicago, Portland, OR, and Clearwater, FL. The Center for Multicultural Human Services (CMHS) in Falls Church, VA is the only site located in a suburban location. Within these sites, the existence of refugee and immigrant specific programs ranges from 2 to 27 years (M= 14.3, SD =10.3).

Seven of the participating sites (54%) describe their SAMSHA-funded program as a community-based organization with other programs. The remaining programs are described as part of a clinic (N=2), clinic and community-based (N=1), clinic and academic (N=2), and academic (N=1) settings. Services are provided most frequently in a clinic setting, by 23% (N=3) of sites, in a community agency by 15% (N=2) of sites, in the school setting by 15% (N=2) of sites, in the hospital by 15% (N=2) of sites, in community offices by 8% (N=1) of sites, and in home-based settings by 8% (N=1) of participating sites. Despite this variation, overall the following percentages reflect locations of services ranked as "somewhat frequent to most frequent" by participating sites: 61.6% community agency, 61.6% school, 53.9% home-based, 46.2% community office, and 38.5% clinic. The service location ranked with the least frequency consistently across sites was hospital-based.

Populations Served

Throughout this survey, the term *refugee* is used to refer to immigrants who have been exposed to war and/or forced displacement, regardless of their immigration status. Therefore, unless otherwise specified, the following information references this population.

The largest referral sources, identified by 31% (N=4; total N=8) of sites are, respectively, self-referrals and school referrals. Community-based organizations are identified as a primary referral source by 23% (N=3) of participating sites, whereas legal (8%, N=1) and other mental health services (8%, N=1) account for a smaller percentage of primary referral sources. Similar frequencies are reflected in secondary referral sources, with 23% (N=3) identifying self-referrals, 15% identifying schools, and 15% identifying community mental health organizations. Physician referrals are identified as a third source of referrals by 15% (N=2) of sites.

As part of their SAMHSA funding, 30.8% (N=4) of participating sites provide only refugee-focused services, whereas 69% (N=9) also provide services to nonrefugee youth. Of those that also provide nonrefugee services, the percentage of refugee clients funded by SAMHSA programming ranges from approximately 0 to 90% (M=19.0, SD=29.8). Approximately 150 children, 54 adults, and 57 families are served per month through SAMHSA-funded refugee programs across sites. Ten locations also provided an overall estimate of refugees clients served per month (regardless of funding source); they ranged from 2 to 1100 (M=180.5, SD=344.3), with a sum total of N=1805 clients served each month. The Network served refugee clients representing over 37 different countries (see Appendix A) and a range of languages (e.g., English, French, Spanish, Creole, Bosnian, West-African dialects).

Table 1 provides information about the immigration status of refugee clients served by participating sites under both SAMHSA and non-SAMHSA funded refugee programs (categories are not mutually exclusive). Within the Network, 69% (N=9) sites provide services for torture survivors.

Table 1. Immigration Status

	Sites	Estimated Percentages		
	N	Range	M	SD
Refugee- SAMHSA	13	0-100	53.5	45.4
Refugee non- SAMHSA	10	0-100	52.1	40.6
Asylum applicants SAMHSA	13	0-20	2.4	6.0
Asylum applicants non-SAMHSA	13	0-70	6.9	19.3
Qualified aliens SAMSHA	13	0-65	11.9	22.1
Qualified aliens non-SAMSHA	13	0-75	15.4	26.3
Unqualified aliens SAMHSA	13	0-50	8.5	15.7
Unqualified aliens non-SAMHSA	13	0-40	8.1	12.8
Torture survivors SAMHSA	13	0-50	3.9	13.8
Torture survivors Non- SAMHSA	13	0-50	12.7	19.4
Other SAMHSA	13	0-10	.77	2.8
Other non- SAMHSA	13	0-30	3.9	9.6

The most common length of time in the United States among refugees served by nine reporting sites was 1 to 5 years (M= 45%, SD = 22.9, Range 10-80%). However, sites serve refugees ranging from less than 1 year to over 10 years in the US, as evidenced in Table 2.

Table 2. Length of Time in US

	Sites	Estimated Percentages		
Time in the US	N	Range	M	SD
< 1 year	9	0-50	26.1	20.4
1-5 years	9	10-80	45.0	22.9
5-10 years	9	0-30	13.1	9.8
>10 years	9	0-70	15.8	25.9

Services Offered

In addition to the range of service locations noted previously, refugee programs within the Network provide a range of different types of services. Through SAMHSA funding, 10 of the Network sites (77%) provide direct clinical mental health services. Within direct clinical care, 62% (N=8) provide individual services, 54% (N=7) provide family services, and 54% (N=7) provide group services to refugee youth. Other refugee specific clinical services provided through SAMHSA funding include psychological/educational evaluations (62%; N=8), case management (46%, N=6), psychopharmacology (31%; N=4), and asylum evaluations (23%; N=3). In addition, over 50% of sites fund research (54%; N=7) and community-based outreach (69%; N=9) through SAMHSA. As well, SAMHSA-funded refugee programs include legal services (31%, N=4), education support/advocacy (38.5%, N=5), medical services (15%, N=2), and vocational/occupational services (8%, N=1). Only 1 site provides resettlement services (FACES) as part of its larger organization, Heartland Alliance. Four sites (31%) provide specific programs for torture survivors.

Table 3 provides a summary of the SAMHSA and non-SAMHSA funded refugee services provided within Network sites.

Table 3. Types of Services

Services	N	# Sites provide SAMHSA funded	# sites provide non-SAMHSA funded	% sites provide SAMHSA funded	% sites provide non-SAMHSA funded
Direct mental health clinical	13	10	11	77%	85%
Community-based outreach	13	9	7	69%	54%
Individual mental health clinical	13	8	10	62%	77%
Psychological/educational evaluations	13	8	8	62%	62%
Family mental health clinical	13	7	8	54%	62%
Group mental health clinical	13	7	8	54%	62%
Research	13	7	5	54%	34%
Case management	13	6	10	46%	77%
Education Support/Advocacy	13	5	8	39%	62%
Psychopharmacology	13	4	9	31%	69%
Legal/Legal advocacy	13	4	5	31%	39%
Asylum evaluations	13	3	3	23%	23%
Medical	13	2	5	15%	39%
Dental	13	1	2	8%	15%
Vocational/Occupational	13	1	3	8%	23%
Literacy	13	0	1	0%	8%
Other (preschool partial hospital)	13	0	1	0%	8%

The diversity and multisystemic nature of services offered by most sites within the Network likely reflects the theoretical approaches that inform mental health service provision within the Refugee Working Group sites. Most agencies (77%, N=10) report that a specific theory or approach to case conceptualization and intervention informs their work with refugee children and families. These theoretical approaches include socioecological models, cognitive-behavioral treatment, eclectic approaches, and cultural competency. General socioecological models are integrated with specific approaches such as (1) relational community-based treatment that integrates ecological systems and (2) a view of the child's problems as result of the child's emotional dysregulation and the capacity of the environment to contain that dysregulation. Eclectic approaches with notable similarities include (1) a combination of psychodynamic therapy, psychopharmacology, and cognitive-behavioral treatment of PTSD; (2) a combination of systems, cognitive-behavioral, and trauma theory; and (3) a multidisciplinary approach informed by psychodynamic, cognitive-behavioral, family systems, and psychopharmacology. Other eclectic approaches include (1) an individual approach based on specific diagnosis and problems and (2) an integrated holistic psychosocial approach with case management as centerpiece. Others note the importance of phase-oriented trauma interventions and readings on working with refugee populations. One site, LAUSD Community Practice Center, uses a specific cognitive-behavioral manual-based intervention for trauma in the schools (CBTS).

The following sites within the Network note the availability of documents that describe their approach to treatment and that they would be willing to share with Network partners:

- Center for Medical and Refugee Trauma, Boston Medical Center (BMC)
- Center for Multicultural Human Services (CMHS)
- Jewish Board of Family and Children's Services
- LAUSD Community Practice Center
- MMHI, Trauma Center
- Safe Horizon/Solace

Assessment

All of the participating sites report using a standard assessment protocol for refugee clients. As part of their assessment protocol, 77% (N=10) of sites report using structured interviews, 69% (N=9) report using questionnaire assessments, 39% (N=5) use open-ended interviews, and 54% (N=7) contact collaterals. Structured interviews used were either not identified or identified as agency specific intake/screening assessments. Similarly, few agencies identified specific questionnaires used, although the following were identified by two agencies: Pediatric Symptom Checklist, Child Depression Inventory, Life Events Scale, Child PTSD Scale, UCLA PTSD-RI, and The War Trauma Screening Scale–West African Adolescent and Child Versions. Several participating sites (54%, N=7) identify the use of translated questionnaires. Few translated questionnaires were specifically identified with the exceptions of client handbooks, consents for services, release of information forms, Beck Depression Inventory, and the Impact of Events Scale. The only language specifically identified as translated in forms is Spanish.

Many sites (69%; N=9) report measuring clinical outcomes with refugee children and families. The child specific outcomes measured across the Network are detailed in Table 4. Most notably, over 50% of sites report measuring child depression, child PTSD, and child's exposure to traumatic events. The next symptoms most likely measured in 46% of sites include child school functioning and disruptive child behavior. Child peer relations, self-esteem, coping, and risk behaviors are also measured in 31% of sites. Child acculturation (23%, N=3) and child physical health (8%, N=1) are less frequently measured as outcomes.

Table 4. Child Outcomes

Outcomes	N	# Sites Measure	% Sites Measure
Child Depression	13	8	62%
Child PTSD	13	8	62%
Child Exposure to Traumatic Events	13	8	62%
Child School Functioning	13	6	46%
Disruptive Child Behavior	13	6	46%
Other Child Mental Health Symptoms	13	5	39%
Child Peer/Social Relations	13	4	31%
Child Self-Esteem	13	4	31%
Child Coping	13	4	31%
Child Risk Behaviors	13	4	31%
Child Acculturation Issues	13	3	23%
Child Physical Health	13	1	8%

Outcomes specific to parent, family, and ecological functioning are generally less measured that the child specific factors identified above. Table 5 summarizes rates of measurement of these outcomes. Less than 25% of sites report measuring any of these outcome variables as part of their refugee program. The most likely outcomes to be measured across the Network (23%, N=3) include parent-child relationship quality, family coping, and service utilization. Fifteen percent (N=2) of participating agencies report measuring parent psychiatric functioning, parent exposure to traumatic events, legal issues, and changes in financial situation.

Table 5. Parent and Family Outcomes

Outcomes	N	# Sites Measure	% Sites Measure
Parent-Child Relationship Quality	13	3	23%
Aspects of Family Coping	13	3	23%
Service Utilization	13	3	23%
Parent/Family Members' Psychiatric Functioning	13	2	15%
Parent/Family Members' Exposure to Traumatic Events	13	2	15%
Legal Issues	13	2	15%
Improvements in Financial Situation	13	2	15%
Parent/Family Members' Acculturation Issues	13	1	8%
Improvements in Living Conditions	13	1	8%
Other (CGAS, days in community, days in school)	13	1	8%
Parent/Family Members' Physical Health	13	0	0%

Staff and Training

The Network sites staff represent multidisciplinary approaches to refugee mental health. Staff include psychiatrists, psychologists, social workers, advocates/case workers, physicians, refugee paraprofessionals, nurses, interpreters, lawyers, mental health counselors, health educators, medical assistants, student trainees, and expressive arts therapists. In total across the Network, 44 psychiatrists, 57 psychologists, 100 social workers, 40 case worker/advocates, 18 physicians, 58 refugee paraprofessionals, 10 nurses, 12 interpreters, and 4 lawyers are employed through refugee programs. Of these staff, 210 (ranging from 0 to 86 per site) are bilingual or multilingual, representing a range of languages, including Albanian, American Sign Language, Arabic, Auharic, Bosnian, Creole, Dari, Dutch, English, French, Greek, Hindi, Hungarian, Korean, Mende, Russian, Spanish, Swahili, Turkish, Ukrainian, Urdu, and Vietnamese,.

Staff are recruited from target communities by 62% of sites (N=8), outreach to local school/training programs by 31% of sites (N=4), advertisements in trade or local newspapers by 54% (N=7), internal advertising (N=1), and outreach to national school programs (N=1). Staff training includes information on refugee/immigrant mental health issues and childhood trauma in 92.3% (N=12) of reporting sites. Additional training priorities include general information related to refugee immigrant issues (62%, N=8), acculturation issues (69%, N=9), crossgeneration transmission of trauma (69%, N=9), child development (69%, N=9), child-parent attachment (77%, N=10), working with trauma survivors (46%, N=6), and life adjustment issues (39%, N=5). Staff are also consistently trained across the Network on delivering competent crosscultural care (77%, N=10), handling vicarious traumatization (85%, N=11), and stress management techniques (62%, N=8). One site noted that training in legal status issues was particularly helpful in informing its work and in helping staff reduce fear and increase knowledge about the process for clients.

Eighty-five percent of the sites provide staff with financial support and time to attend conferences or trainings relevant to working with refugees. Six of the Network sites also provide agency-sponsored conferences or educational trainings about refugee/immigrant issues.

Interpreters

Interpreters are provided by 62% (N=8) of Network sites and 69% (N=9) indicate that they work with interpreter services. International FACES and Safe Horizon/Solace have developed protocols for working with interpreters that they are willing to share with the Network. These two sites are the only locations that provide training for interpreters in conducting asylum evaluations and psychological assessments. Across sites, 23% (N=3) of interpreters are trained on conducting intake evaluations, 31% (N=4) on participating in therapeutic sessions, and 31% (N=4) in conducting community outreach. Five sites (39%) report engaging in debriefing with interpreters following clinical encounters.

Barriers

Barriers to seeking mental health treatment and receiving referrals in refugee communities, as well as barriers to continuing/completing mental health treatment, were identified. On a scale of 0 *(not important)* to 3 *(highly significant)* the following barriers to refugee clients seeking treatment were identified by providers as moderately to highly significant:

1. Barriers related to family's or community's perceptions about mental health services (M=2.82, SD=0.4)
2. Barriers related to correct identification and perception of mental health problems on the part of family members (M=2.45, SD=0.5)
3. Barriers related to mental health interventions not being in line with the families' cultural beliefs (M=2.3, SD=1.0)
4. "Other" barriers such as time to utilize services because of multiple jobs

The following barriers were rated moderately significant:

1. Families prefer more traditional support services available within their communities (M=1.9, SD=0.9)
2. Structural barriers (e.g., transportation, lack of insurance) (M=1.8, SD=1.1)
3. Barriers related to correct identification and perception of mental health problems on the part of referrers (M=1.7, SD=0.7)
4. Families' perception that Western mental health intervention would not be helpful (M=1.7, SD=1.0)

Lack of interpreter services of fluency in client language to provide mental health services were rated as a slight to moderate (M=1.4, SD=1.1) barrier in seeking treatment.

One site identified "time to participate in treatment" as a highly significant barrier to continuing or completing mental health treatment. The following barriers were rated as moderately significant to continuing or completing treatment:

1. Barriers related to family's or community's perceptions about mental health services (M=2.3, SD=0.8)
2. Structural barriers (e.g., transportation, lack of insurance) (M=1.9, SD=1.0)
3. Barriers related to mental health interventions not being in line with the families' cultural beliefs (M=1.8, SD=0.9)

The following were rated as slightly to moderately significant barriers to ongoing care:

1. Families' perception that Western mental health intervention would not be helpful (M=1.6, SD=1.1)
2. Families prefer more traditional support services available within their communities (M=1.3, SD=0.9)
3. Lack of interpreter services of fluency in client language to provide mental health services (M=1.2, SD=1.1)

Although interpreter services and language fluency were rated as less significant barriers to seeking and continuing treatment, participants did note the importance of providing good interpreter services and bilingual therapists whenever possible when asked to reflect on lessons learned in the field. Other lessons learned include identifying the importance of parents' not seeing their child's need for treatment as a failure and the need to help families overcome bureaucratic burdens. One anecdotal report also suggests that adults are more likely to stay in treatment than children.

Collaboration and Outreach

In an effort to overcome barriers to treatment access and adherence, 69% (N=9) of sites provide outreach to communities about mental health services, 54% (N=7) provide mental health services in the community (nonclinic), 85% (N=11) do outreach to schools to provide information about mental health services, 77% (N=10) actually provide mental health services in schools, and 62% (N=8) collaborate with resettlement agencies. Other strategies to engage children and families include collaborating with primary care clinics, churches, and legal agencies, as well as involving community representatives and cultural consultants with mental health/refugee backgrounds and hiring qualified staff from refugee populations.

In addition to the strategies identified to engage families in services, most agencies note a wide range of collaboration and outreach as part of their practice. The most common collaborators include community-based organizations (85 %, N=11), health clinics/hospitals (77%, N=10), legal services (69%, N=9), schools (69%, N=9), and other mental health services (62%; N=8). In addition, 20 to 46% of sites collaborate with police, courts, resettlement agencies, housing , child welfare, religion/faith-based organizations, advocacy, legislative, mentoring groups, food pantries, and substance abuse services. In sum, sites reported a mean of 7.1 (SD= 4.6) collaborative

relationships ranging from 0 to 15 total collaborations per site. For specific information about collaborative involvement, see Table 6.

Table 6. Collaborations

Collaboration/Partnership	Total N	N Sites	%Sites
Community-based organizations	13	11	85%
Health clinics/Hospitals	13	10	77%
Legal services	13	9	69%
Schools	13	9	69%
Other mental health services	13	8	62%
Resettlement agencies	13	6	46%
Housing	13	6	46%
Advocacy	13	6	46%
Religion/faith-based	13	5	39%
Police	13	4	31%
Child welfare	13	4	31%
Courts	13	3	23%
Food pantries	13	3	23%
Mentoring groups	13	3	23%
Legislative	13	3	23%
Substance abuse	13	2	15%
Red Cross-tracing families contact	13	1	8%

In approaching new communities with potential referral sources, over 60% of sites report engaging in activities including publicizing services for certain communities, working with leaders in communities, word of mouth, collaboration with resettlement agencies, and community activities. On average, over 50% of sites also report using these same types of strategies to provide health education outreach to target communities. Others identify the importance of working with religious leaders and schools in target communities as well as joining with other social service agencies through health fair interventions. Forums for providing educational informational to refugee communities include presenting at community agencies (69%, N=9), presenting at hospital venues (38%, N=5), communicating with community leaders (38%, N=5), collaborative presentations (23%, N=3), presenting at university venues (15%, N=2), and presenting at town meetings (15%, N=2). In addition, 62% report an agency interest in public policy, 34% believe their work informs public policy, and 69% report contact with state or federal legislators.

Twelve of the thirteen sites (92%) use community outreach to inform new services and interventions for refugees in their agency.

Lessons Learned

The following comments were gathered from the working group sites reflecting lessons learned from working in the field:

- The remarkable resilience of children
- The importance of providing services in child's language
- The importance of helping families reduce bureaucratic burdens
- The importance of helping parents understand how their reactions to trauma affect their children

- The importance of excellent interpreters, or a therapist who speaks the language
- The difficulty for families of bringing in children if they see it as a personal failure
- The fact that adults usually stay in treatment longer than children
- The fact that education around legal status has informed work in helping staff reduce fear and increase knowledge about process
- The importance of integrating mental health services in systems context (e.g., schools, communities)
- The importance of providing acculturation groups in schools
- The importance of working with children in groups
- The importance of using expressive modalities such as art, movement, music, and occupational

Enhancing Services

The following comments were gathered from Network sites regarding improvements for the future and specific needs to enhance services:

- Would like more collaboration and attention to
  - cultural issues in measurement design
  - use of qualitative methods
  - triangulation of mixed methods
  - issues of standard psychological terms with refugee/immigrant children
- Greater allocation of funds and personnel
- Increased access to refugee communities
- Increased collaboration with sites in Network
- Specific tools for supervision (e.g., one-way mirror)
- More staff or available translators for appointments with clients speaking African dialects
- Resources and expertise of the Network

Network Collaboration and Resources

Overall, the Refugee Working Group sites express a strong interest in furthering collaboration among sites within the Network. The most popular collaborative activities include cross-site trainings on methods of assessment (69%, N=9) and clinical trainings on effective intervention approaches (69%, N=9). Similarly, sites express a strong interest in collaborating on trainings in culturally competent interventions (62%, N=8), trainings in engaging refugee/immigrant clients in treatment (62%, N=8), and trainings in working with cultural brokers (54%, N=7). Trainings in working with interpreters were less strongly endorsed but also noted as a collaborative interest by 34% (N=5) sites.

Research collaboration is also an area of interest for many Refugee Working Group sites. Fifty-four percent (N=7) express an interest in designing cross-site research studies and in co-authoring publications. Forty-six percent of sites (N=6) express an interest in participating in cross-site research studies designed by other members. Forty-six percent (N=6) also express an interest in working with other Network sites to develop/enhance research or program evaluation at their own sites.

Collaborating to produce best practice guidelines for specific populations is another area of interest for 46% (N=6) of participating sites. Best practice guidelines for refugee children, human trafficking

victims, and community-based responses are noted. Specific populations identified include West African, Somali, Latino, Middle Eastern, and Southeast Asian ethnic groups. West African refugees are the most identified, being noted as a particular area of interest by three sites (Project Tamaa, Safe Horizon/Solace, and LAUSD).

Table 7 describes resources available at participating sites that could potentially benefit other sites within the Network.

Table 7. Resources to Benefit Network

Category	Description of Resource	Site
Assessment	Assessment protocol for children and adults	*MMHI, Trauma Center*
	Developing culturally sensitive assessment and evaluation instruments for West African refugees	*Project Tamaa*
	Translated forms	*Jewish Board of FCS*
	Evaluation methods	*CMHS*
	Psychiatric evaluation form	*OHSU*
Intervention	Classroom-based stress and inoculation intervention for children	*MMHI, Trauma Center*
	Development of domestic violence intervention and treatment services with immigrant population—mostly Latina women and their children	*Children's Institute International*
	Experience in developing, implementing, and evaluating school and community-based interventions for refugee populations	*Project Tamaa*
	Translated psychoeducational materials	*Jewish Board of FCS*
	Program manual for "Leaders of Tomorrow"	*CMHS*
Collaborative Activities	Strategies for collaborating with schools	*International FACES*
	Established relationships with other organizations (e.g., legal, housing, financial) to refugees	*Jewish Board of FCS*
	Services we provide are located in the same building as other services (medical , social work, HIV, and interpreting) and this has helped to build truly integrative model of care	*La Clinica del Pueblo*
Training and Knowledge	Information on working cross-culturally	*International FACES*
	Information on working with trained interpreters	*International FACES*
	Information on refugee children's' trauma	*International FACES*
	Years of experience providing services to refugees	*Jewish Board of FCS*
	Powerpoint presentations on refugee children and trauma	*CMHS*
	"Children of War" theater production	*CMHS*
	Training materials for counselors	*OHSU*
Research	Online Library	*Safe Horizon/SOLACE*

Table 8 describes NCTSN resources that sites feel would be helpful to access, develop, or disseminate across the Network. Several sites expressed an interest in disseminating training materials, assessment, and intervention resources related to child refugee trauma. In addition, sites noted an interest in increased time and resources dedicated to opportunities for collaborative training on important issues related to refugee health and mental health.

Table 8. Requested Resources for Network

Category	Description
Knowledge Dissemination *General*	All available resources on child development and the impact of trauma on children and families
	More information on PTSD in different populations
	Compiling research in areas of trauma and resilience
	"Manual" for creating manuals for NCTSN
Assessment	Information on developing appropriate and culturally sensitive assessment and evaluation instruments for refugees
	Assessment instruments in various languages
	Information from other sites on specific structured interviews and translation of measures
Intervention	Information and experience from other sites serving West African refugees on the following; developing, implementing, and evaluating school-based and community-based interventions for refugee populations
	Psychoeducational materials in various languages
	Psychoeducation and group curricula for refugee children, families, and individuals
	More information on interventions others have found helpful
Funding	Description of funding/functioning of various programs
	Funds for programming
Collaboration and Training	Having the time and resources to work with other Network sites and other national agencies and organizations working with refugee populations
	More opportunity to collaborate and learn from other centers serving similar populations
	Participation in refugee conferences
	Training in refugee health, legal and acculturation issues, advocacy for refugees
	Training presentations on the Network, trauma, and resilience
	Training programs for staff

Summary

As members of the NCTSN Refugee Working Group, thirteen sites from the Network participated in one of the first national surveys of current mental health services for refugee children and families in the United States. The results of the survey suggest that agencies who focus on providing services to refugee and immigrant clients engage in a range of different approaches to provide multisystemic and multidisciplinary treatment. One of the most unique aspects of services provided by these agencies is the focus on developing collaborations and community-based services to meet the needs of refugee children and families. As a result, these Network sites are able to provide services in different locations (e.g., schools, clinics, community agencies) and address many of the systemic

challenges (e.g., housing, legal services) that face this population. Different theoretical approaches to therapeutic intervention are represented (e.g., ecological, cognitive-behavioral), however, the importance of community collaboration and outreach, as well as multimodal systems of care, is consistent across the Network. This flexible and community-based approach is seen as an important aspect of addressing barriers to care such as cultural beliefs related to mental health services and perception of mental health symptoms. Most agencies engage in various forms of community-based outreach, education, and collaboration to specifically address these barriers. Currently, the Network provides services to approximately 1,800 refugees and immigrants per month representing over 37 countries and various languages. Resources within the Network include a large staff representing a range of disciplines, 210 of whom are bilingual or multilingual. Throughout the Network sites there is a strong interest in collaboration related to measurement and intervention with this population, as well as training relevant to working with refugee children and families.

Future Directions

The results of this survey suggest many avenues of future collaboration, development, and research with the Refugee Working Group. Some of the key areas of interest and directions for the future are identified below.

- Measurement: Developing, standardizing, and disseminating assessment tools and techniques for specific populations. This theme is consistent with the recent formation of the measurement subcommittee, which will focus on gathering information about current assessment practices within the Network and avenues for future development.

- Collaboration: Several areas of interest related to trainings, conferences, and collaboration with other agencies providing refugee services were identified. This suggests a role for the working group in leading the field in developing training materials and forums for discussion for our own Network, as well as the general public, related to refugee mental health issues and cultural sensitivity in mental health care. The current "Children of War" accelerated project is an active example of a new forum for educating the public through providing training materials and information to schools.

- Dissemination: Given the wealth of experience within this working group and identified resources available, it would benefit the Network to create methods for consolidating and disseminating current knowledge, as well as collecting information about resources that sites are interested in developing. The resource list compiled as part of this survey provides a first opportunity to begin disseminating relevant materials within the working group.

- Research: Two key areas of research development identified were measurement and intervention. Both the measurement and White Paper II subcommittees provide opportunities to discuss future directions in these areas.

National Child Traumatic Stress Network
Refugee Working Group Members

Cynthia Shirley	CCTC, West African Refugee Project
Heidi Ellis	Center for Medical and Refugee Trauma, Boston Medical Center
Glenn Saxe	Center for Medical and Refugee Trauma, Boston Medical Center
Terence Keane	Center for Medical and Refugee Trauma, Boston Medical Center
Audrey Rubin	Center for Medical and Refugee Trauma, Boston Medical Center
Theresa Stichick Betancourt	Center for Medical and Refugee Trauma, Boston Medical Center
Molly Benson	Center for Medical and Refugee Trauma, Boston Medical Center
Lin Piwowarczyk	Center for Medical and Refugee Trauma, Boston Medical Center
Karen Batia	Chicago Health Outreach
Dina Birman	Chicago Health Outreach
Joan Liautaud	Chicago Health Outreach
Kwame Asante	Children's Crisis Treatment Center, Philadelphia
Anne Holland	Children's Crisis Treatment Center, Philadelphia
Alise Sochaczewski	Children's Institute
Irma Seilicovich	Children's institute
Marion Chew	International CHILD/Center for Multicultural Human Services, Virginia
Kacie Fisher	International CHILD/Center for Multicultural Human Services, Virginia
Dennis Hunt	International CHILD/Center for Multicultural Human Services, Virginia
Gustavo Jimenez	La Clinica del Pueblo, Washington, DC
Jessica Roman	La Clinica del Pueblo, Washington, DC
Roberta Bernstein	Los Angeles Unified School District
Judy Holland	National Child Traumatic Stress Network, Duke University
Kimberley Ling (Debbie)	NCCTS
Crystal Riley	Oregon Health Sciences University, Intercultural Psychiatric Program
Keith Cheng	Oregon Health Sciences University, Intercultural Psychiatric Program
Jenny Tsai	Oregon Health Sciences University, Intercultural Psychiatric Program
David Kinzie	Oregon Health Sciences University, Intercultural Psychiatric Program
Heike Thiel de Bocanegra	Safe Horizon, New York City
Ernie Duff	Safe Horizon, New York City
Angela Gonzalez	SAMSHA/CMHS
Margaret Samuels	Yale Child Study Center
Beth Hudnall Stamm	Center for Rural, Frontier and Tribal child traumatic stress interventions
Michael A. de Arellano	National Crime Victims and Research Center, Medical University of South Carolina
Koku Kuwonu	Chicago Health Outreach
Kelly Heiges	International CHILD/Center for Multicultural Human Services, Virginia
Deborah Lott	NCCTS
Amy Blalock	Duke
Karen O'Donnel	Duke

Appendix A

Countries Represented Across NCTSN Sites
(listed in alphabetical order)

1. Albania
2. Afghanistan
3. Azerbaijan
4. Bosnia
5. Cambodia
6. Cameroon
7. Central America (unspecified)
8. China
9. Columbia
10. Croatia
11. Dominican Republic
12. Egypt
13. El Salvador
14. Eritrea
15. Ethiopia
16. Guatemala
17. Guinea
18. Honduras
19. Iran
20. Iraq
21. Kosovo
22. Liberia
23. Loa
24. Mexico
25. Middle East (unspecified)
26. Mien
27. Nicaragua
28. Nigeria
29. Pakistan
30. Romania
31. Russia
32. Sierra Leone
33. Somalia
34. South America (unspecified)
35. Soviet countries (unspecified)
36. Sudan
37. Turkey
38. Ukraine
39. Uganda
40. Uzbekistan
41. Vietnam
42. West African (unspecified)