

Community Dialogue and Needs Assessment for Trauma Informed Systems of Care for Resettled African Refugee Youth in New Hampshire



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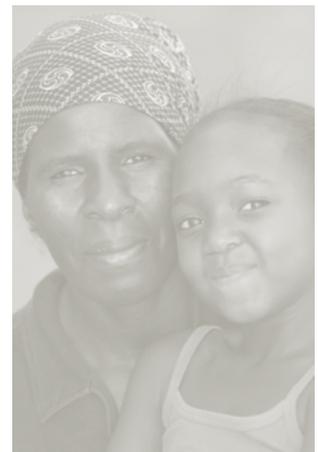
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EXECUTIVE SUMMARY

The mission of the New Hampshire Project for Adolescent Trauma Treatment (PATT) has been to disseminate evidence-based practices for youth who have been exposed to traumatic events and seek care in the New Hampshire community mental health system. The introduction of standardized trauma assessments and Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) training and supervision across all 10 Community Mental Health Clinics in the state have given promise of greatly improved care for traumatized children in NH. However, a sizeable and growing group of multiply traumatized and highly vulnerable refugee and non-English speaking minority youth in the state are still in need of services.

The purpose of this needs assessment is to begin to identify the emerging efforts and needs of agencies that provide services to this population in New Hampshire. This project utilized key stakeholder interviews, community dialogue groups, and a review of local resources for integrating youth, family, provider, school and community knowledge and expertise towards identifying necessary next steps for creating trauma informed systems of care for refugee youth and their families.

There are several agencies who work with refugee resettled families in New Hampshire. There is a need for further developing and improving trauma informed systems of care through coordinated interventions in the areas of: school programming, access to primary care health, culturally informed and trauma informed mental health services, inclusion of refugee concerns in state programs addressing employment, homelessness/affordable housing and family literacy initiatives. There is an active and committed African leadership which is responding to refugee family needs by addressing afterschool programming, literacy and employment, interpreter support and coordination of services. Coordination with other service sectors and funding support could assist the African leadership in expanding programming and to work collaboratively with schools, mental health services and employment services to address some of the key findings and suggestions described below.

Key Findings

FAMILY: Addressing the needs of the family is crucial in addressing the needs of youth

- The importance of family-centered interventions has been found in other research and was a consistent message in this needs assessment.
- The mental health needs of parents and children are different but are interrelated and each should be addressed. Providers need training in providing culturally competent care and services to African families.

FAMILY CONTEXT: Jobs, Financial Resources and Disappointments

- Psychosocial needs for daily life are in the forefront and require policies, practice and allocated resources for employment, literacy and social supports.

HEALTH CARE: *Attention to Basic Needs Most Often Raised*

- Health insurance beyond the initial eight month period is currently unavailable to African refugee families.
- Access to interpreter services, and ethnically matched professionals and paraprofessionals is available but still limited.
- There is a need for primary care and prevention that extends beyond refugee health screening.
- There is a need for the identification and treatment of emerging chronic illness including diabetes.
- There is a need for cultural competence training in health communication for families.
- There is a need for refugee family health literacy.
- Medical home models where services can be coordinated and are accessible can assist with mental health, social services and primary care.

THE SCHOOL CONTEXT: *Learning and Adjustment*

- Multi-Systemic, multi-stakeholder interventions are needed.
- School counselors and teachers need opportunities for trauma-informed training designed for the educational setting.
- Supporting youth academic success is critical to ease adjustment and promote social success and well-being.
- Youth must have positive opportunities for success or they will turn to negative attention-seeking behaviors.
- Programs should include a focus on diversion from truancy, drop out, and juvenile justice.

FAMILY CONFLICT: *Differential Integration*

- Parents and children become integrated to the U.S. at vastly different rates, as children learn English much more quickly because of school immersion.
- The experiences of acculturation and adjustment differ by gender and between parent and child.
- U.S. ideas about independence and individualistic freedoms of children are in direct conflict with African culture that emphasizes community and obedience to authority. African children learn from U.S. peers that they are now “free” and no longer have to obey their parents. Parents are restricted from maintaining practices of corporal punishment for discipline, yet are given no significant assistance to learn alternative forms of discipline.
- Poverty and mental health stressors (including post traumatic stress disorder: PTSD) are related to youth involvement in the juvenile justice system.

THE NEED FOR FAMILY AND COMMUNITY BASED INTERVENTION

- Providers, families and African leaders alike confirm the need for family and community based interventions as well as provider networking and collaboration towards that end.
- African refugee adults need access to English literacy programs that also assist with empowerment, social engagement and mastery including improving skills for employment.
- While individual psychotherapy has unique advantages in the treatment of psychiatric problems, its focus on the individual fails to consider fully the impact of community and family circumstances.
- Traditional, narrowly focused treatments often do not adequately address the extent to which altering interactions with the social world can positively affect one's general wellbeing.
- While individual psychological treatment is the primary empirically tested treatment for post traumatic stress disorder (PTSD) among young people, in large part, this individual focus has stemmed from the downward extension and application of adult treatments to children, without appreciating the extent to which context shapes and influences children's functioning.
- Interventions focusing on the family should help (1) establish security and safety in their new environment, (2) facilitate the integration of self and family into the new cultural context, and (3) support identity and strengths during the process of integration and mastery of new skills.

SCHOOL-BASED INTERVENTIONS FOR MENTAL HEALTH

- African leadership in New Hampshire has voiced a need for the emergence and support of African leaders in professional and paraprofessional roles in mental health and schools.
- Support, integration and respect for the critical role of African leaders and professionals are critical next steps.
- Engaging and empowering parents in their child's academic success and adjustment is vital.

DISSEMINATION AND NETWORKING

- Dissemination and networking should occur across sectors in NH
- Learning opportunities exist within New England, and other communities around the country which can assist NH in building trauma informed services.
- Strategies for developing African community meeting spaces should be considered, especially positive after-school spaces for youth
- When developing and enacting social policy initiatives in NH (i.e. addressing homelessness, unemployment, education), policy makers should address the specific needs of racial, ethnic and linguistic minorities, including refugees communities.

THE COMMUNITY OF RESETTLED REFUGEES IN NEW HAMPSHIRE

So another example are Rwandans who fled went into Congo. A few years later Congo erupts in war, the refugees are fleeing again. So it's a very common situation for many refugees to be on the run for years as well.

---Resettlement Official

Refugees are specifically distinguished from economic migrants who voluntarily arrive in the United States 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. This report primarily focuses on refugee resettled communities from African nations who arrive in the United States under these circumstances. We use the term refugee in this paper to refer to children and families who have experienced war related trauma or political violence regardless of whether they have legal refugee status in the United States. Further our focus is on refugee children in resettlement, who are undergoing the process of integration to a new country and culture including a new school system. Informants and refugee families describe a process of constant moving from one country to the other and moving between refugee camps before resettling in the U.S.

Here we use the term integration, as suggested by Grantmakers Concerned with Immigrants and Refugees (GCIR), as they describe the “dynamic two-way process in which newcomers and the receiving society work together to build secure, vibrant, and cohesive communities. We use the term “integration” rather than “assimilation” to emphasize respect for and incorporation of differences, the importance of mutual adaptation, and an appreciation of diversity” (see also Fix, Zimmermann, and Passel, 2001). There is extensive psychological literature on “acculturation,” which also assumes mutual influence of different cultures and is often measured as an individual psychological construct, and which has been developed as an alternative to the construct of assimilation. For this report we refer to integration rather acculturation, with exceptions for specific reference of psychological constructs that are not interchangeable (i.e., acculturative distress) or when referencing specific psychological literature.

African countries represented and named by participants in this needs assessment in New Hampshire include: Burundi, Cameroon, Congo, Equatorial Guinea, Eritrea, Ethiopia, Kenya, Liberia, Rwanda, Sierra Leone, Somalia, Sudan, Tanzania, and Zimbabwe.

Other countries named: Afghanistan, Bosnia, Cuba, Iran, Iraq, Vietnam, and Bhutan. The next large waves of immigrants are expected to come from Iraq.

Informants working with refugees on initial resettlement steps provided information about key policies: *First the US is by far the largest [country in taking in refugees] but in*

terms of New Hampshire's population size they are the 7th in the country in terms of receiving refugees. Additionally, we were told that "All refugees receive a travel loan to come to the United States and they're required to pay that loan back so already when they step foot [in the U.S.] they're in debt." This particular fact is not widely known, even among providers.

Key informants gave a range of responses when asked how long refugees received health care benefits, often underestimating the time. However, the rule is that refugees are eligible for these benefits for the first eight months of resettlement. Most informants reported that this initial time was one that was spent focused on settling in and obtaining housing and employment, with little time to attend to mental health concerns. More often, it was suggested that it was after a year or two of being in the U.S. that individuals began to experience a greater need for services, at a time when support was no longer available.

OVERVIEW OF PRIMARY CONCERNS FOR YOUTH

I think that actually to serve the youth better, we really have to serve their parents better. And that pushes us back to the resettlement agencies. It will be important for them, in terms of serving the youth, to take a holistic approach, where rather than, you know, having one of those mechanical, you know, Cartesian kind of, "The family is a machine, and we can take it and repair this part and plug it back in." I mean they've got to take a much more systemic approach, where if there's a problem with the youth, then we need to look at the environment that the youth is in, that includes the parents and the family and all. Because often times what we view as problematic for the youth are symptoms of a larger problem. So if we focus in on the youth, we're only dealing with the symptoms and not the cause. And so we're not really solving the problem.

Provider – Community Resource

NEEDS OF THE FAMILIES

- **Support the family, address the needs of youth**
- **Adjustment strain to the US is compounded by financial, employment, educational, and family stressors**

Family: Addressing the needs of the family is crucial in addressing the needs of youth

Initially, we expected the focus of the needs assessment would be on the resettled children and adolescents and our interview protocols reflected this line of inquiry. However, it immediately became clear that solutions developed outside of a family context would likely fail. African leaders helped us understand that not only would this U.S. individualistic approach run counter to African collective culture, but also that such efforts would be impractical as they would address some symptoms but ignore important underlying issues of integration as well as the devastating effects for families who lack basic human needs such as adequate housing, food, and meaningful employment.

There is a disruptive change in parental roles because of language and cultural issues. Children are often able to learn English quickly because of their immersion in ESOL classes at school. Because of their greater facility with English they are relied on to take on the role of interpreter in many situations where this is not only inappropriate but results in shifts in family roles and power dynamics. Additionally, as a result of being in school children have greater exposure to U.S. laws and customs regarding discipline. Through the lens of children newly arrived in the “Live Free or Die” state, the concept of freedom and rights is disconnected from responsibility and misinterpreted to their short-term benefit and long-term disadvantage.

The differential integration and acculturative distress between parents and children is heightened by this sense that “*I am free to do what I want,*” especially where parents are working multiple jobs and African families are spread apart with limited opportunities for community activities. Without sufficient afterschool and or other drop-in activities, youth spend more time outside of the house, without structure, and reject what limited adult/community supervision is available.

Miscommunication and cultural misunderstandings sometimes lead to police involvement that further jeopardizes family relationships. For example, children and adolescents who are more familiar with the support and shared child-rearing of extended family and larger community of the camps and villages in Africa do not understand that they are now expected to have a more restricted range of activities in terms of how late they can stay out and how far from home they can be. Neighbors may assume that the children are being neglected and call in the Police when it is not warranted. Similarly, children learn from U.S. born peers that they can call the authorities if capital punishment is used, and thus children might call 911 or threaten to make that call to avoid being disciplined in native African parenting. In both cases, police rely on the children for interpretation

It is a big barrier and that's what frustrates the parents more, because when the kids come here the first thing they [teachers, peers] tell them "you are free of their rights." They don't bother to check—they don't make efforts to check how their parents bring them up or what values they want to observe or to continue or whatever. So when they go in the school they tell them [about the rules here] so [the children] say. "Oh, we are free. So I'm free to do what I want!"

services and this increases stress within the family as well as the potential for serious consequences for the parents.

For me the way I look at it, the problem—when they come they are so excited, there is the period for six months when they are under the resettlement and they are doing everything for them. I don't see them thinking too much about the past, but now it comes when this time of support is over, six months, then they are on their own, one day to struggle to get somebody to read for them the letters from welfare, whatever, to bills, when they are struggling to get jobs on their own, struggling to get transportation, to do everything on their own is when they remember and go back to those problems. So yes, the post-resettlement, I think there should be a process, settlement program, to help them move on, because when they are left after six months it's really a torture to them and that's when the trauma comes back and back and back. So even if I was being tortured in my country I'd rather go back. If my kids are not listening to me and the teachers and the police all sided with the kids, they don't side with us as parents, see us as monsters, then maybe we better take our kids back to Africa.

---Ethnic Leader

Families have all experienced some degree of trauma and loss and very few come to the U.S. as an intact unit. Many leave behind immediate and extended family members and experience a great deal of stress in longing for reunification with those left behind. One Somali mother wept as she told us, “*It doesn't matter what services you provide. I will never be happy as long as I am separated from the child I had to leave behind.*”

Family Context: Jobs, Financial Resources and Disappointments

One of the biggest injustices for refugees world-wide is that most people who seek sanctuary or seek safety in the camps [do not have opportunities for] employment as far as I know. And at least with the groups we've worked with, they can't work. And, you know, partly it's because they're outside of their country and so they don't have residency, so in the country they're living, they can't earn money. And so that's a big transition—maybe they've worked, but in a very um under-the-table kind of way. So people might have, you know, sold vegetables at the market or made dresses in their houses for some, you know, for people, and really did earn an income in some way. But it didn't come with the same types of responsibility or expectations that Americans expect from their worker. So I think most of them come here just ready to have a job and work. I mean they want, you know, just to have a normal life. I think that's really the goal from the beginning. And so it's never an issue that people don't want to work. They do want to work. It's just being able to find jobs that, you know, really can support their lives. That's really hard.

--- Administrator, Community Resource Organization

For refugee parents, the stress and disappointment regarding limited resources in the United States can be debilitating. Although refugees receive orientation about the U.S. prior to arrival, their expectations are usually based on limited exposure of U.S. culture through popular media which presents a picture of wealth and opportunity in stark contrast to reality:

You need to know that when they come from Africa they almost tell them that they're going to get everything for free. What they see on TV is those things from CNN, from movies, big buildings. They think they're going to live a life like Hollywood, but when they come here it's another life.
 --- Ethnic Leader

In reality, available housing stock in New Hampshire tends to include smaller apartment units that are not well suited for many of the larger resettled families (relative to average family size in NH), and larger units that were available and affordable tended to be in more urban settings and were not adequately deeded. This was a particularly difficult situation for Somali families whose children had been raised in the camps, because “their bodies’ propensity to absorb metals, which of course the body needs to run, absorbed it rapidly.” The lead poisoning had particularly deleterious long-term effects for many young children.

For parents, finding work is difficult, with a narrow range of opportunities for employment, in some cases more restricted for men compared to women who can more easily pick up odd jobs such as child care and housecleaning. With the economy slowing down, these problems are exacerbated. Community resettlement agencies are able to help secure the refugee’s first job, but don’t have the resources to help if workers face layoffs and then need help finding their next job.

Some refugees experienced discrimination in their efforts to find and maintain employment. With ongoing challenges related to housing and employment, there is growing fear and mistrust, intensified feelings of disempowerment.

Yeah. I think transportation is an issue for sure. Um if they could just have a bus on Sunday, that would be huge. [Laughs] You know, people do work on Sundays in the city. And then people are riding their bikes all the way to South Willow Street or the airport. And I think about, you know, that's just not safe. And so that—and then some way to get driver's licenses to the people who've never driven. If you happen to be on TANF then you can get driving lessons—ten driving lessons, you know. But that's the only place I've heard of where that's possible. So there's a lot of people we have now that are young and single, they don't have kids, but they have no idea how to drive a car. And it's going to take a while for them, you know. And they're actually paying, you know, six hundred dollars to go to Driver's Ed,

--- Administrator, Community Resource Organization

Family Conflict: Differential Integration

While the challenge of obtaining safe and adequate housing is present, seeking employment is particularly stressful; these concerns begin to feel more unmanageable in with the added distress of becoming estranged from one's children. Children in school become integrated much more quickly than their parents, becoming proficient in English at a much quicker rate and also picking up US culture, exposed to popular media and peer pressure.

Or the kids are now assimilated so they need toys, they need shoes, they need new clothing and so on, where do they get the money to do that? And these kids persist they want "I want this!" like American kids, "This is my right, you have to give this to me." So what is the parent to do?

These concerns about fractures in the family structure were echoed by parents, ethnic leaders, and providers. Difficulties because of varying levels of integration are common for most families who enter the U.S. from other countries. However, this vulnerability is compounded by a history of trauma, and the distress of feeling one's children slipping away, of losing one's identity as parent and head of the household, may exacerbate PTSD symptoms.

Their kids are poisoned, Then they see bugs, then the mice, they say, "Oh, is this America?" People don't tell them the truth that not everything is going to be roses. So when they had to face the problems at home and now they are seeking refuge where they hear there are at least good jobs and housing and so on, they come here and jobs are harder to get. It's very hard, transport is very hard. They walk all the way they are really confused. Now if it is their family gets benefits from the welfare and one of them gets the job, suddenly they cut off the benefits. You can think how they are confused, because the person who is working or both of them working because their payment is not all that high, their salary's not all that good all that, so they calculate to pay the rent.

THE SCHOOL CONTEXT: LEARNING AND ADJUSTMENT

- **Mismatch in African/U.S. styles of discipline**
- **Parental illiteracy high for some refugee groups, making it difficult to help children with school**
- **Great parental interest in their child's academic success and prosperity, but this might not be understood or acknowledged by school staff**
- **Need for teacher and staff training in differentiating trauma-related responses and behaviors from other disruptive disorders/difficulties and what to do about it**
- **More cultural competency needed for school staff**
- **Fighting between groups of children from different cultures, or different tribes**
- **Youth belonging vs. isolation**
- **Youth needing to catch up with academics; opportunities for higher education**

Challenges to Authority

One of the greatest aspects of misunderstanding and distress centers on the cultural differences between African and U.S. styles of discipline. Historically, corporal punishment had been widely used in the U.S. educational system and in those of other countries around the world, but has been in decreasing use in the U.S. and prohibited in public schools by state law in half of the states including New Hampshire. These relatively recent changes in the U.S. are in conflict with established practices in many African counties, thus restricting established parental routines upon arrival in the U.S. These new rules are quickly learned by refugee children during their integration and often used as a wedge between parents and children. There is a great need for refugee parents to develop alternative disciplinary strategies that comply with U.S. law but allow for clear limit-setting, respect for authority, and integration of African cultural values.

Let me tell you the experience of how they do. In Africa, I think most of the African countries to bring up the kids is everybody's responsibility. When you see a young person doing something wrong, you feel like I have that obligation to tell him, "No. You are doing wrong." For instance, if you go to school and do something wrong on the way, any parent can punish you. Any adult can punish you. And when you go home, and if your parents know about it, they will actually punish you more. So everyone has that responsibility of correcting the kid, which is different from here. Like here it's none of your business if that's not your kid.

--- Ethnic Leader

[In Africa, punishment is] very clear-cut. Punishment is also corporal. I mean, wherein the parents, relatives, whoever is connected, like schools—they can discipline the child because they know they have the authority to do it. And then most of the parents, when they come over to the United States, they feel very frustrated because before they used to discipline their kids in Africa, and they can discipline their kids without getting in trouble. Then you move to the United States and you can't discipline your kids, then you get in trouble with the authorities, with the law. So now they're kind of in a struggle for what should I do, like before, the only way I knew how to discipline my kid was through corporal punishment or through using a cane or a belt, but now I'm here, I can't discipline my kid. So now they're kind of lost, so basically—and they find themselves in a conflict of what should I do with my kid? And then sometimes this is difficult for them to control their kids because it's confusing, it's difficult, and they're just not aware of what the boundaries are, what they tolerate or what expectations for punishment are.

Mental Health Provider and Refugee from Sierra Leone

Limited Exposure to Formal Education Opportunities

African refugee children in U.S. schools are often far behind their U.S. born peers because of their limited exposure to formal schooling as a result of growing up in refugee camps or being unable to attend school in their home countries because of safety reasons. Older children are particularly vulnerable because U.S. schools systems are designed to segregate students by age and corresponding grade level (in contrast to mixed age/level schooling that might exist in the children's home country). Thus adolescent refugees must be placed in high school classrooms according to age despite the fact that their formal education level would put them at a much lower grade: *“So they will take you and put you in the class, maybe according to your age, which is a total disaster because you don't know how to read and write.”* Although supportive educational services are available they are often not enough to help youth catch up for such a huge educational gap: *“In Africa, or in other countries, these kids who will go to adult school, a special school, they will not go to the main system. Even though here they put them in something they call ELL [English Language Learners], I don't think that that's really effective.”* While U.S. born students would feel distress at being placed in lower grades than age mates, African refugee youth would find that experience more helpful and also more in keeping with the educational practices of their home countries. Given the need to adhere to U.S. educational policy, there is little recourse for older students who enter the school system without basic literacy skills. However, this is an area in need of creative interventions that would offer additional support for students who need to accelerate learning to stay on task within their grade level.

In addition, the parents themselves, many exposed to war and political violence for more than a generation, may also have had limited opportunities for formal education and struggle with low literacy skills. The result is that many parents are ill-equipped to help with homework and other schooling tasks. Moreover, there is a mismatch in expectations of African parents and U.S. teachers, such that parents extend their greatest respect for

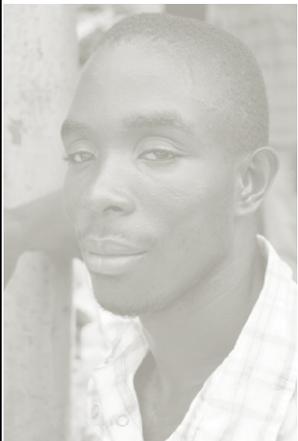
authority of the school staff, traditionally seen as having a singular responsibility for the formal education of African children. For African parents (and for many other refugee and immigrant groups, or U.S. parents lacking cultural capital) a trip to the child's school and a meeting with a teacher is only necessary if the child has serious behavioral or learning issues. In contrast, the practice of parent involvement as a shared responsibility of formal education is the norm in most U.S. schools and teachers may misinterpret deference of African refugee parents as lack of interest. More work needs to be done to make parental involvement expectations for refugee parents more explicit. Outreach to refugee parents from teachers would work best with the assistance of cultural brokers who could explain the parent-teacher partnership and assure parents that greater involvement is not requested because the child is "in trouble."

During the conflicts and fighting in Africa, education was disrupted. So basically there was no schooling and no education. And most of the immigrants that have been brought over to the United States, basically we are adults, older people—most of them, they never went to school anywhere. But their children would have—should have—gone to school, but because the fighting and the conflicts, they didn't go to school. Most of them lost a huge part of their education, like the fundamental parts, the early education, so basically they lost like ten years of early school, preschool, kindergarten, first year of school. We find for most of the students, besides the challenges there because of the PTSD and other disorders, they will find English to be very challenging.

---Mental Health Provider and Refugee from Sierra Leone

Training Needs for School Staff

Teachers, counselors, and administrators described their needs for additional training designed to increase their knowledge of culture and practices of the various African ethnic groups, particularly in the context of historical political violence in the home countries of the refugees. Although interpretation services are available this increased understanding is essential to fully engage with students and families. Some school staff have taken initiative to learn more about other cultures, for instance watching films about the African refugee experience and attending presentations to increase knowledge of the culture. However these opportunities tend to be limited and more training is needed in the area of cultural competence as well as training in trauma and school-based mental health.



Enrollment of resettled African youth in New Hampshire's schools follows enrollment of previous refugee youth from other countries affected by war and political violence, including Bosnia. Future waves of refugee youth are expected to include those from Bhutan and Iraq. Although each group has unique challenges for adjustment reflecting specific cultural practices and circumstances of relocation, there is some shared trauma and stress symptomatology. Training on trauma and stress more generally, as it relates to children's emotional and cognitive development, behavior, and learning would benefit all school staff. Generalized training for teachers and administrators might include information to help identify trauma response, when and where to refer students, and classroom management techniques to help limit classroom disruption as result of behaviors related to trauma and stress. School counseling staff would benefit from training on individual and group therapy strategies designed to support children with exposure to trauma.

These trauma trainings should happen alongside cultural competence trainings in order to provide support to staff in being able to adapt responses to African youth, and to subsequent groups of refugee students. For instance, various groups of refugee students might have all experienced exposure to war, but differ in their prior educational experience. As one teacher pointed out for African youth, *"It's their first educational experience. And a lot of them enjoy learning but maybe exhibit some behaviors that are difficult in school -- a very difficult time sitting and attending for long periods of time, which is very natural."* Understanding the difficulty of adjustment to school within this context helps teachers temper their expectations about appropriate behavior when students first begin attending school. Currently, some teachers and counselors are collaborating with community mental centers to form support groups for students:

And we had this opportunity in the after-school program to work with a group of girls. The therapist from [the community mental health center] really wanted to do a play-based type of group that they could support the girls in their development and sort of get at a lot of social issues and getting along with other kids, and how they solve problems and that sort of thing. So we currently have seven or eight girls that are in that group, two therapists and an intern. And then we have our ESOL teacher working as the assistant in that program so she can help. We are a responsive classroom school. So using the language and the approaches of responsive classrooms so that the therapists in the afternoon understand, you know, how the procedures work.

Educators are hungry for information. There are sort of different levels. I think that just understanding cultures is a really important piece of the training. "God Grew Tired Of Us", a movie about the Sudanese boys, was presented and a lot of our staff went to that. But to understand that it's a truly different experience for kids. You know, we all feel at a loss with some of the behaviors. So we do a lot of trial and error. So it would be nice if someone that's had some good success with trauma could train us. Tell us about good research showing how to teach kids who've experienced trauma.

---Teacher

However, the availability of this type of professional collaboration is limited and in their absence, school staff have to piece together other strategies without much support, relying on “*trial and error*” to provide effective therapeutic services to students.

Youth Experience in Schools

Although African refugees may be more likely to acknowledge similarities rather than emphasize differences, clashes between African students from different ethnic groups based on a history of combat do occasionally occur. Knowledge of, and sensitivity to, this history of warring groups could be useful for de-escalating classroom conflicts. A teacher described, “*And there what [the girls] brought with them from their homeland and from the refugee camp was a lot of tension and dynamics between clans, and so then that started to act out within the school setting.*” One provider informant told of an agency placing refugees together in some circumstances in order to address isolation, however unwittingly placed families “*from warring factions next to each other.*” As he described it, “*Who would have known? I mean you know what I mean? But that is the level of subtlety and maybe sophistication that we really have to approach.*”

African youth who spoke with us told of feeling isolated at first but more a part of their schools as their English proficiency improved. They generally reported good relations with the white students but more likely to have conflicts with other African and other minority immigrant students:

[Interpreter] She says sometimes the kids have some problems with all the Spanish students in the school and some other Africans [laughing], who came from Africa. Some same refugees. They're not having problems with the white kids in their school. They're having more problems with other, minority kids.

INTERVIEWER: SO WHY DO YOU THINK THAT IS?

[Interpreter] It's easier to challenge each other, cause they sometimes interact with each other, so that's easier for them to have conflict. Especially African and other groups.

One informant working within the local government suggests that poverty, rather than race, is a stronger influence in the fighting that takes place between minority groups. Limited financial resources and opportunities may provide an obstacle for much needed coalition building. Additionally, an African girl attributes these conflicts between the minority students to the fact that the refugee and immigrant children are all placed together in the same ESOL classrooms. In addition, much of the conflict goes unnoticed by teachers:

So they are in a classroom with you, in ESL classroom, people from different countries they have to come over there every day—every single day. So when you get over there, when the teacher gets out, they're gonna say something bad to

you. When the teacher get in, they're gonna be quiet, they're gonna act like they not said anything in the classroom. But when teacher went out, they're gonna say something bad to you. That's how it is.

In contrast, a Somali girl understood these behaviors, though difficult, as the beginning of a more natural progression towards friendship. *"It was so hard. You know, sometimes, when you don't know each other, you're not gonna understand each other. Sometimes, like, you're gonna, like, fight each other and tease each other, and after that you're gonna know each other, like be friends and everything when you start helping each other."* She goes on to give a prescription for moving forward toward success for students as they learn to work together for academic success and social support: *"The first time, like, when you start to be friends with other people, when new people come in the classroom, you have to help, you have to tell how to do the work, because that person doesn't know how to do it. That's how you gotta get friends."* Where possible, school staff can help facilitate these pro-social behaviors for newcomer students.

The Need for Opportunities for Success

Ethnic leaders and school mental health providers made similar observations that refugee students are driven by the need to feel successful in school, and that if they cannot experience academic success then they will aspire to social markers of success. These might include, for instance, wearing the latest items of popular clothing. With limited financial resources and unlikely odds that parents will purchase these, youth might resort to obtaining such status symbols in undesirable ways such as taking clothes from another student. Along those lines, being tough and intimidating classmates is a strategy to draw attention away from academic struggles, especially in classroom situations where older students who have not yet mastered simple literacy skills are placed with students who far surpass them in academic subjects. As one teacher pointed out, *"The kids aren't just being difficult or bad or obstinate or oppositional or whatever. That there may be some deeper reasons for some of their behavior."*

These kids, what they will do when they find themselves behind the class with other kids, and they don't even know what to do. They will find a way that they will challenge the other students, and that way is to be a criminal or to be—to show off, to come in the school with new clothing, to come, to look on TV what is cool and what is cool, mostly for the Black kids who are the coolest, that person who's wearing those jeans that are expensive, those Nikes. Where will they find them? They will go to steal. The other thing, they will find the kids in the school to be stronger and everybody will fear them. So they will go do other things to make them look better.

---Refugee, Health Educator

Community

Poverty and mental health stressors (including PTSD) related to youth involvement in the juvenile justice system.

Disproportionate numbers of youth of color are placed in the juvenile justice system and many youth all backgrounds in juvenile justice have ongoing mental health concerns. Youth of color who also experience poverty are also unlikely to get mental health evaluations and services through mainstream venues, thus their first opportunity for receiving mental health care is while incarcerated.

As stated above, there are often conflicts between parents and children associated with differential levels of integration. Some children are told by their peers that they can call the police on their parents if they don't like the way their parents treat them. On the other hand, some parents are given advice to call police as a way to address these family conflicts, or are given advice to file petitions for Child in Need of Services, while not fully understanding the potential implications of this action. Typically, a parent or guardian can file a CHINS petition on a minor child who runs away from home or does not or cannot follow the rules at home (the school district or police can file a petition as well). Once a petition is filed, the case goes to Juvenile Court and the judge, rather than the parent or guardian, makes all decisions for the child and the child is placed in the custody of the Department of Social Services (DSS). The child may be placed in foster care, in a residential treatment center, or monitored in the home. In essence, parents are giving up custody of their child to DSS and the court

She says that not every time that the teachers should be strict. But the times when the kids make mistakes, they should be accountable for that. They should be punished so that they don't repeat the same mistakes. But here they get a free ride. Eh? They run away with it. They make mistakes with no punishment. Tomorrow another one...

She knows that the environment is powerful in changing and shaping the kids. But, the problem is in the school. Because what they teach them there is different from the way that they behave [in their native country]. They teach them if their parent says this or punishes you, you call 9-1-1 and they call 9-1-1 and they say you know the policeman is coming if the kids call them. [The police] don't listen to the parents, they listen to the kids. And the parents sometimes get problems because of the kids. So that is sad.

Congolese Refugee Mother (Translated)

NEED FOR LANGUAGE ACCESS SERVICES

- **Language barriers and literacy barriers result in a need for increased access to interpretation services, greater variety of interpreters in order to maintain privacy of those needing mental health services**

There is a need for increased access to interpretation services which are also needed for appointments outside of healthcare. Interpreters and community based coordinators can assist with language barriers but also with family understanding of systems of care, and serve as cultural brokers. Providers may not fully understand their legal responsibility to provide interpretation services for English language learners under the Title VI anti-discrimination act.

Title VI of the Civil Rights Act of 1964 prohibits discrimination via failure of providers to overcome language barriers. However, there were a number of reports from key informants about difficulties in obtaining interpretation services across many of the public sectors including health care, schools, and police.

All of the providers we interviewed who talked about language barriers expressed concern about the need for more interpreters. One health care provider reported that these costs are an increasing line item in budgets of community mental health centers: *“When we began our cultural competence initiative back in 2000, we had zero in terms of translation costs—our interpretation costs. Now this year it will be probably over \$65,000. Unreimbursed.”*

GENERAL HEALTHCARE SERVICES NEEDS

- **Health insurance beyond the initial eight month period currently available**
- **Expanded access to interpreter services, and ethnically matched professionals and paraprofessionals**
- **Primary care and prevention that extends beyond refugee health screening**
- **Identification and treatment of emerging chronic illness including diabetes**
- **Cultural competence training in health communication**
- **Refugee family health literacy**
- **Medical home models where services can be coordinated and are accessible**

Health Insurance: Refugee resettled families have a limited period covered by health insurance, which usually includes only the first eight months of their resettlement in the United States. Refugee families are legally documented immigrants into the United States and qualify for other public assistance. However, families are in need of ongoing coordination of services and assistance with connection to relevant agencies. For example, some families may be able to obtain services for their children through the State Children’s Health Insurance Program (SCHIP).

She said that she had diabetes and it was very hard because the Medicaid was closed and so she's had difficulty with the doctor. And her, she said, the sugar in her blood was 480, so very, very high. And she was very close to dying, so she contacted me and the insurance helped her for that. But, those are some of the toughest things she had while she's in the U.S. And in addition to that she said, I really see a lot of diabetes in our community, just in a lot of people who just came.

--African leader on community outreach

Diabetes and somatic illnesses: Some parents report the onset and detection of chronic illnesses like diabetes once here in the United States. Now requiring ongoing medical care, prevention and nutritional interventions, insurance and access to service become critical. Similarly, screening for TB, malaria, sickle cell disease, and lead poisoning in children require accessible health services which can build relationships with family. It is through these health care services that mental health referrals can also be obtained.

Models of Care that reflect refugee community's needs

Several providers suggest that there is a need for models of health care that reflect refugee families' patterns of services use. This can be accomplished through coordinated services as might be seen in medical home models, in which the physician provides a higher degree of personalized care coordination than is usually the case. This could include coordination with medical and community providers trained in refugee and immigrant health. In order to be successful in assisting families, primary care providers need access to trauma and culturally informed mental health referral options.

There's also the trauma of being separated from their homeland, separated from their homes – everything from the life that they've known – separated from loved ones, not knowing if their loved ones are alive or dead.

They are giving her medication [for asthma]. Every day she takes medication. And it doesn't help. And in the course of time, with the cold weather, the situation got worse. And then she developed the high blood pressure. Her pressure is up all the time. She's got a lot of stress—she's always thinking. The kids are making her crazy. So she says that her children are doing bad things in the school. And here at home, they are doing bad things. The police are always here. The children make a lot of noise, she can't sleep. So...she's worried. Because even with the police she doesn't know, and she sees them come and she can't express herself. She says even in the—in the—when she goes to see the doctor, sometimes she doesn't have anybody to interpret. So she fumbles around.

---Tanzanian Refugee Mother (Interpreted)

MENTAL HEALTH CARE SERVICES NEEDS

- **Cultural barriers exist which include differences in perception of mental health and needs.**
- **Competing demands for employment, housing and other psychosocial concerns limit any focus on addressing primary mental health concerns. Yet, underlying emotional distress compounds the impact of these social stressors and vice versa.**
- **Stigma and cultural differences limit use of traditional mental health services**
- **There is a need for culturally indigenous professional and paraprofessional providers**
- **Schools are interested in providing an excellent avenue for access to combined mental health, academic and family supports, especially if done in collaboration with African leadership and community liaisons.**



Qualifications of Mental Health Service Providers

Most providers interviewed desire providing a combination of professional and paraprofessional services, and employing interpreters when needed to assist mental health providers in treatment sessions and in coordination of services. Further, a triadic model that involves interpreters as partners in the interaction between clinicians and patients has been proposed. This is especially desired when there is also a component of care coordination. Concerns about providing competent mental health care to refugee children focus on issues of competence with respect to treatment of trauma in children, as well as competence with respect to culture and language. Providers have employed a range of approaches to address these issues. Some programs, including school based and mental health centers employ mental health professionals with U.S. training exclusively to provide services and outreach. These professionals agree they need ongoing training in cultural competence and youth trauma. On the other end some programs including African leadership organizations employ preventive and psychosocial efforts employing culturally indigenous professional and paraprofessionals. African leaders are seeking support and collaboration with other African leaders in other states such as Minnesota in order to plan effective strategies.

Modalities of Intervention

Providers in schools and mental health clinics desire training in culturally and developmentally appropriate trauma treatment. Lustig's (2003) review of child and adolescent refugee mental health describes that a "variety of modalities of interventions have been proposed for refugee youth with trauma in the literature including individual psychotherapy, family, group, medication treatment, preventive interventions (Williams and Berry, 1991), and school-based services (Layne et al., 2001; O'Shea et al., 2000)" (p. 25). Further, Lustig goes on to say that while we have good information on the use of cognitive behavioral therapy for PTSD in children and adolescents, we lack information on effectiveness of CBT for refugee youth, and suggests some strategies for intervention with CBT:

Testimonial psychotherapy may be a promising technique for older adolescents that borrows from previously tested treatments for traumatic stress, such as exposure and desensitization, relaxation training, and cognitive restructuring. Testimonials have the dual purpose of healing through both story-telling and transcending one's persecution by using one's testimonial for political purposes, enabling the survivor to become an educator or advocate. Importantly, a refugee giving testimony does not need to take on the culturally determined role of a psychiatric patient to participate (Agger and Jensen, 1990; Lustig et al; Mollica, 2001; van der Veer, 1998; Weine and Laub, 1995; Weine et al., 1998). (p. 26, 27)

Specific training and supervision in any of these culturally adapted modalities would be required for providers in New Hampshire.

One area of potential intervention in which to build upon in New Hampshire is the Project for Adolescent Trauma Treatment PATT program at Dartmouth. Stanley Rosenberg, PhD and his colleagues have trained 10 Community Mental Health Clinics in TF-CBT (trauma-focused cognitive behavioral therapy), and have trained other agencies the CASEY Foundation in other models of cognitive behavioral therapy. The PATT program is now also engaging in treatment training around disruptive behavioral disorders and Parent-Child Therapy. There is a need to connect these trainings to cultural competent adaptations to address the needs of African refugee communities in New Hampshire. In addition, consultation with the developers of other models like CBITS (Cognitive Behavioral Intervention for Trauma in Schools) which have evidence in immigrant and refugee populations would be important (Kataoka, 2003).

TRAUMA TREATMENT SPECIFIC NEEDS

- **Multiple traumatic experiences are compounded by loss , separations and adjustment in families**
- **There are intergenerational, shared and differing traumatic experiences between youth and family.**
- **Gender roles differentiate the stress and consequence of stress and adjustment among men , women and children**
- **Refugee experience of trauma suggest a community vs. an individual approach to intervention or at least a need for a combined approach**
- **Co-morbid alcohol abuse and addiction are emerging consequences of trauma and psychosocial stress especially among men and young people**

Yes, this widens the pains of travel, because when they were in their refugee camp or in their own countries whatever they faced, especially women, rape, torture, the experience of their loved ones being shot or beheaded, some of the women faced like—these rebels can come and force the wife, the woman to—they start to rape the woman or their mother or their sister, so this is really a big wound, but when they manage to run away, they run with their children. Children are a treasure—in Africa, people are poor, but when they have kids they think that that is wealth. So, now even if they were ready to put their problems behind, their trauma behind, these [new struggles] of their kids intrigues their wounds.

---African Leader

The Context of Trauma

Refugee children experience a number of stressors during resettlement including difficulties integrating into a new country and school system. Although many youth learn English quickly and aspire to succeed in school, many also become discouraged, drop out of school and develop other economic and social difficulties. This is a particular risk for older youth/adolescents and is a concern reported by both providers and parents. Acculturative stress can negatively affect youth mental health, and cultural differences and economic barriers prevent them from getting treatment. Acculturative stress is a term used to describe the multiple stressors faced by refugee families in resettlement and cultural adjustment, including experiences of discrimination and isolation. 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, there is often separation from extended family networks. These stressors can result in differential experiences for families and youth, and highlights the need for developing and implementing intergenerational supports.

Specifically, parental trauma can be severe and compounded by stressful changes in the culturally valued parent-child relationship once here in the United States. Schools specifically have noted that there is a need to understand the ways that school staff and counselors can support young people in their trauma and in their adjustment to the US and to the school setting.

A number of informants expressed their belief that the experience of being in the camps, including the extreme deprivation and exposure to violence was somewhat normalized because of the nature of the shared experience: “So we live there, in these camps, everybody among me is poor, or in any case there is beating going on there, everybody’s being beaten up. When you are a kid, you see that’s normal. It becomes something normal. It doesn’t really traumatize you.” Thus, the more traumatizing situation was the transition to the U.S. and resulting hardships related to integration and splintering of family cohesion. It will be important to explore this further within the development and implementation of interventions for youth and families. This may be a testament to the resilience of the resettled refugees

We had a project where we were—well, we tried to have this project and it didn’t fly, because it was a little too difficult, and I think it made people upset, where they were going to do some writing about the country that they came from, and what they remembered, and draw some pictures. And she [young refugee girl] cried. And she talked about her cousins and missing them, and missing the pretty clothing, and she couldn’t get out more than that, because she really doesn’t say a lot yet. She’s been here about six months, and really can do the academic work, but still doesn’t have a whole lot of language to use. Um and it’s hard—it’s hard to tell, it’s hard to know.

while also pointing to the need for greater understanding of precursors to psychological distress and subsequent catalysts for its onset.

Mental Health Treatment Needs and Potential Interventions

The first thing for students from Africa to be successful, they need to have a very extensive cultural transition. It would be best to make it possible for them to feel comfortable to ask someone who understands their cultural development and language to work with them, and then to make them feel comfortable, to make them feel that this is gonna be a home, this is gonna be a new step. When they see someone new, someone different, and someone even White who's working with them, they're just like scared. They're worried that, I mean, that somebody's gonna come and someone's gonna come and attack them. So if the orientation is being provided when the refugees and immigrants feel that they're part of what's going on and they feel like they have nothing to worry about, nothing to fear, and they even know basically that there's nothing bad expected from them, then I think there will be a way that we'll start to make sure that there will be some success in whatever the programs that have been implemented.

--- Mental Health Provider and Refugee from Sierra Leone

Settings of Mental Health Intervention

The settings where interventions take place have been noted as important factors that can support and enhance mental health services. Locating interventions in clinics, community settings, or schools, etc. can facilitate or impede access to services for refugee children. Clinics and medical settings have been noted to have some advantages for some populations, as medical care is more readily accepted and not associated with stigma among many groups. On the other hand, among some groups stigma associated with seeking psychiatric or medical care for mental health problems prevents people from accessing services.

Schools can provide an opportunity to intervene

Schools provide an important opportunity to intervene with refugee children in New Hampshire. It is in the school setting that refugee youth spend a great deal of time and it is in this setting where they encounter their daily integrative struggles. This includes sociocultural integration and academic achievement. School professionals have the benefit of extended and daily interaction with students who are refugees and are now becoming integrated into US culture and academics. The use of programs which promote successful social and academic success in the school setting can empower teachers, counselors, youth

Some of [the boys], especially if they experienced their father being shot, they are angry. They are very angry and their behavior is...they easily mix with other bad kids and pick up their behaviors when they are seeking [attention], they end up with the wrong people and doing—messing themselves up.

and families to work towards a shared goal. Provision of preventive efforts and interventions in the school setting rather than in mental health care settings can also assist with the stigma of accessing mental health care.

Involvement of Parents

The importance of involving parents and other members of the child's social network in interventions is supported by research. The mental health providers and African leaders interviewed for this needs assessment agree that parents' well being is critical for refugee children's mental health and coping with trauma. The overall sentiment is that in order to address the needs of youth we need to address the needs of parents and the entire family. Parental involvement with schools is an important factor that affects children's education and social adjustment. Our needs assessment and previous research supports that refugee and immigrant parents highly value their children's academic success. Exploring school based settings for intervention may address some of the barriers to involving parents. The African leaders in NH have made attempts to develop afterschool programs which can assist youth in their social adjustment and can provide support to parents all within school spaces. Physical space and financial support have been limited for these endeavors but would be critical areas to consider in developing family and youth responsive systems.

The Need for Family and Community Based Intervention

Providers, families and African leaders alike confirm the need for family and community based interventions as well as provider networking and collaboration. Individual psychotherapy is well received in western cultures, but its focus on the individual fails to consider fully the impact of community circumstances and the centrality of family in many cultures. Traditional, treatments often do not adequately consider how interventions that focus on improving the social world of individuals and communities can positively affect mental health. While one-on-one therapy is the most often used model of treatment in working with young people in the U.S. who have experienced trauma, it may not be the best choice of primary strategy in working with refugee youth. More needs to be done in studying about the ways in which context shapes and influences children's mental health, recovery from traumatic experiences, and adjustment to stressful circumstances. Most of the providers and African leaders we interviewed placed an emphasis on the need to explore these more contextual and community based intervention which support family and youth being..

This young boy was really missing his father. And it's— apparently in refugee camp they separated. And this little boy was really missing his father, wanted his father to come here. And that's what he really wanted. So he thought if he came to treatment we would get his father for him. Mom—she wanted him to come to treatment so that he would stop talking about his father. And our sense was that he needed to talk about his father

I think a lot of [the refugees] would benefit from more social activities. Some of them would not go for the whole one-on-one counseling let-me-talk-about-all-my-pain. I think that might not go over so well, because a lot of cultures that we work with, they don't do that. But I do see the benefit of when they do come to ESL and they're all together and they're talking, and like it just gets you doing something. And I think that maybe a group therapy kind of thing would be more productive. Because I think that they would want to get out and talk, you know, and just share and talk about their relationships or this or that that's going on now.

*Administrator,
Community Resource
Organization*

interviews, with families also support a need for these more contextual and family based supports, which can assist with social and economic inclusion.

Interventions Focusing on the Family

Providers in interviews and dialogue groups confirm the need to support family parenting in an empowering way but agree that this can't be done outside of the family cultural values. Bemak (1989) suggests a three-phase model to employ in family therapy with refugees including: (1) establishing security and safety in their new environment, (2) integration of self and family into the new cultural context, and (3) redefining one's identity, including acculturation and mastery of new skills.

School-Based Interventions for Mental Health

African leadership in New Hampshire has voiced a need for the emergence and support of African leaders in professional and paraprofessional roles in mental health and schools. Interventions outside of clinical settings have been proposed to reduce power disparities. Further, paraprofessionals working in such settings can help diffuse these issues, though they themselves may be relatively powerless in their roles in their agency.

Therefore, support and respect for the critical role of African leaders and professionals is a critical next step and a foundation for integration, as established school practices can be adapted to reflect African cultural traditions and expectations.

School based interventions are an important modality to explore in services for refugee children as they offer a number of ways to both overcome barriers to accessing services as well as ways of effectively intervening with refugee children. First, because school is a setting that all children attend, integrating mental health services with other school programs can avoid the cultural barriers that may interfere with access to services, such as stigma associated with contacting a mental health agency (Adelman, 1996; Adelman and Taylor, 1998; Adelman and Taylor, 1999; Atkins et al., 1998). Second, public schools represent the setting where many of the integration struggles of refugee children unfold. Several school officials and youth in this needs assessment voiced the importance of receiving supports and cultural competency in integrating refugee youth but also

school appropriate trauma training. School interventions could provide an opportunity to intervene not only with the children but also with the environment that shapes their experience. From an ecological perspective, interventions designed to address integrative conflicts can be most effective when they address not only the acculturation of the child, but also the “acculturative press” of the school environment that may contribute to stress or facilitate adjustment. This should include the promotion of opportunities for youth to share their culture with others in the school community so that they see aspects of their culture and history reflected within the school environment.

Schools provide a potential avenue to engage the youths’ parents in interventions and create a bridge between the worlds of family and school. Though increasing parent involvement in schooling can be challenging across parents of all backgrounds, it is particularly important for parents who themselves often know little about the ways that schools work. This is also an important opportunity for school staff and other parents to learn about the successful parenting strategies used by African refugees – strategies that have proven to be crucial for survival and which promote collectiveness rather than individuality. By engaging parents, school-based interventions can provide an orientation and education about the larger culture and the lives of their children, facilitate parental involvement in school, and reduce the integration gap that often develops between parents and children. Such an intervention in New Hampshire will need the coordinated efforts of schools, mental health and African leadership.

Because we are going to use the women from the communities they will know their language, their culture. At the same time they’re going to be learning English so that when they go to school they catch up very well with the other kids, so the program also includes normal daycare curriculum and in this way we are going to partner—to be partners—we are thinking of being partners to do that.

---African Leader



PRIORITIZING SOLUTIONS

A social inclusion framework, which is used extensively for responding to social policy issues in the United Kingdom and the European Union, has been suggested as an alternative to public policy currently in place in the U.S. Boushey, Fremstad, Gragg, and Walker (2007) define social inclusion as “based on the belief that we all fare better when no one is left to fall too far behind and the economy works for everyone. Social inclusion simultaneously incorporates multiple dimensions of well-being. It is achieved when all have the opportunity and resources necessary to participate fully in economic, social, and cultural activities which are considered the societal norm.” In considering potential approaches to responding to the needs documented across stakeholder groups, it is useful to incorporate this framework as way to improve mental health and well-being.

The following is compilation of priorities regarding the recommendations that emerged across provider sectors, ethnic leaders, and families and youth during interviews and also reflect conversations from dialogue group meetings. Several themes emerged regarding these area of potential intervention and/or expansion of services which can be integrated for trauma informed services. These are the products of the needs assessment interviews and are among the solutions prioritized and agreed upon during dialogue groups.

1. Networking and Training in Trauma and Cultural Competency

- Networking and training is needed across provider sectors: mental health, schools, primary health care
- Evidence Based Treatments should be introduced, with appropriate adaptations training and supervision
- Cultural and developmental understanding of trauma
 - Increased understanding of the secondary effects of trauma on children whose parents experienced direct trauma, increased understanding of the effect of long-term stays in refugee camps
- Trauma training with specific attention to different cultures, community and family level interventions
- Cultural competency training that includes increased understanding of
 - differences related to countries of origin as well as tribal differences within specific countries
 - religious practices and customs
 - gender roles and expectations
- Medical and mental health literacy for parents
- Cross training between sectors for mutual and cross learning (providers, ethnic leaders, school)
- Ethnically Matched Professional and Paraprofessionals including “homegrown” ethnic leaders to fill positions in schools, outreach and health education positions

2. Family Centered Post-Resettlement Programs:

- Short-term resettlement support and educational workshops that might start once the “honeymoon period” is over, so that individuals know what to expect and better understand and receive supports for feelings of distress
- Address feelings of isolation for youth and families through social resource groups which provide information, social connections and needed resources
- Women-centered groups and educational advancement of girls and women
- Literacy projects for parents
 - ESOL classes that fit work schedule better
 - Train the trainer model of ESL so that individuals learn English from African community leaders who share the same ethnic background
- Employment training and opportunities that combine with English proficiency efforts
- Culturally competent interventions to respond to domestic violence and family stressors

The kids are interpreting and the teacher's looking to the kid to tell the parent—I see parents struggle. That's what I think the hardest thing parents are dealing with—these refugee parents—is how can I be a strong parent again?
--School Administrator

3. Youth centered programs for support

- Drop-in centers
- Youth leadership and development groups
- After-School programs that address skill building not taught in schools, to help students stay in school rather than dropping out to take a job
- Summer camps, summer enrichment collaboration with prep schools
- Team sports, dance
- Connect with existing agencies, such as the YWCA/YMCA
- Focus on maintaining culture, religious traditions and respect for elders

We have already started the traditional dances so that they keep their culture and values and they also use their time wisely so that they don't get involved with the law enforcement

4. School Based Programs:

- Accommodation strategies for working with students who have behavioral problems related to trauma
- Information for teachers regarding strategies for working with traumatized students. Help them to understand boundaries of involvement but with clear directions for referrals
- Funding that would allow mental health to partner with schools: consultation around how to set up a classroom, appreciation of culture, training about trauma and its meaning for youth, psychotherapy sessions in the school or a group.

- Culturally indigenous professional and paraprofessionals person within the schools that match to clients in respect to culture, ethnicity, language.
- Family orientation nights at the children's schools, with interpreter assistance

5. Community Outreach and Institutional Accountability

- **Messaging:** Increased understanding of the effect of traumatic stress on health and destigmatizing help-seeking for mental health. Training around effective messaging, i.e. effective, targeted, culturally and ethnically appropriate messages to our communities.
- More venues for welcoming and sharing between/among communities as a way of addressing traumatic experiences and loss
- Professionally trained interpreters, community health workers, paraprofessionals available beyond health care contexts
- Consideration of refugee and racial and linguistic minority specific concerns within other NH public health and policy focus: homelessness, housing, hunger, education.

6. Cultural Brokers and Mentors

- Newcomer groups providing access to information about nuts and bolts of daily living in NH, school systems, social service agencies, local and US culture
- Reverse mainstreaming [in schools], where the other youth can come in and work together with refugee/resettled youth, so that they develop peer relationships

7. Adaptation of evidence-based treatment

- Adaptation of interventions so that they are responsive to trauma but focused on communities rather than individual families.
 - Group work rather than individual therapy
 - Training of ethnic based community members to be mental health workers
- A medical home: full-time psychiatric mental health services from providers skilled at working with the refugee and immigrant population, and also with adolescents and people in poverty, and that they would become part of a larger team and part of someone's medical home, the place where they feel comfortable.
- Home visits by providers to see families where they are most comfortable

I think that really um one of the most important things that can happen for uh the community of African descent here in Manchester and anywhere—for anyone—the most important thing that we can do for any person is to place them in a community where they feel safe, where they feel loved, where they feel respected. One of the things that the organization tries to do actually, is to provide opportunities for people of African descent to have the chance to be in leadership positions, to express themselves, you know, to be in control of their experience and to define for themselves what's happening or what's going to happen... Some might have some traditional role within their home or their community. But they don't have an opportunity to engage a larger community in a leadership role. And so what we attempt to do is to provide an opportunity for folk to express themselves and to be engaged in a way that supports them in a self-affirming way.

---Provider – Community Resources

8. Faith Based Programs

- “Radical Welcoming” and understanding of cultural differences for faith groups
- Interfaith dialogue and planning

9. Safe and Adequate Housing

- Space to accommodate larger families
- Training and education for families in lead safe housing, where elimination of lead is costly and unlikely to occur immediately. Parents can learn strategies for creating healthy homes which avoid significant environmental hazards even in the presence of potential lead contamination.
- Timely repair of property

10. Support of African Leadership Groups

- Ethnic leaders and community members should be able to take on greater collaborative/administrative role in interventions
- Support of emerging African leaders in professional and paraprofessional positions

11. Consider Implications for Intervention/Program Development

- Need for programs that target African resettled refugees directly
- Need to consider what trauma informed systems for African youth and families would be useful for future refugees and immigrants from other countries resettling in New Hampshire.

I think even the community here, the way they look at them is just like, “Well those are people who had hardships, and so they have nothing. All they need is for us to give them.” Now the society or people who are living with them, instead of helping them to understand and maybe do something different when they do something wrong, they just say, “Well, maybe they think this is okay.” But the process is very slow. And so in that way, these people now, they stay and think like, “Everything should be given to us.” But I don’t think so. They have potential and I don’t know how we can tap from those potentials, but yeah, that’s the problem. When they hear the story, people feel really sorry and you sympathize with them. And I think that’s how it has been, even the groups that brought them here. They always sympathize with them, rather than looking at the other side like, “Well, you had problems, but you may have something which we can benefit from you.” And these people, they have a lot.

---Ethnic Leader

PARTNERS/COLLABORATORS

The involvement of youth, families, ethnic-based community organizations, governmental agencies, health care providers, schools and other stakeholders were essential to the needs assessment process and will ensure that interventions are culturally relevant to New Hampshire's diverse populations and that there is momentum to implement them. Invaluable assistance with data collection was provided by Kim Calhoun, MSW and Melinda Warner, PhD. The following are key collaborators united towards meeting the goals of the needs assessment described in this report.

The ***Dartmouth Trauma Interventions Research Center***, directed by ***Stanley Rosenberg***, is spearheading an initiative called the Project for Adolescent Trauma Treatment (PATT). The PATT is collaboration between each of New Hampshire's ten community mental health centers and the Bureau of Behavioral Health. Each of the collaborators is receiving training, and ongoing support to implement and evaluate evidence-based therapies proven to be effective in treating traumatized children. The proposed scope of work builds on the success of the PATT's collaboration and seeks to expand trauma services to sub populations of children who are not being reached by the mental health centers.

The ***Endowment for Health*** is a tax-exempt foundation founded in 1999 to improve the health and well being of New Hampshire residents, especially those who are most vulnerable and currently underserved. The grantmaking philosophy of the Endowment views "health" in the broad spectrum of the World Health Organization, that is, health is the state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity. Since October 2001, the Endowment has awarded 472 grants totaling nearly \$22 million to support a wide range of health-related programs and projects in New Hampshire. The Endowment's core theme areas of funding include: Economic, Geographic, and Social-Cultural Barriers to Accessing Health; and Mental Health of Children and Families. As a funding partner to the PATT, this initiative aligns with the foundation's work in reducing social and cultural barriers, and improving the mental health of children and families.

Lisa Fortuna, Director of Multicultural Child and Adolescent Mental Health Research, University of Massachusetts Medical School, Department of Psychiatry, Dr. Lisa Fortuna is a child and adolescent psychiatrist and health services researcher. She currently is the principal investigator of a National Institute of Drug Abuse funded Career Development Award focused on the cultural adaptation of a manualized CBT for PTSD treatment or Latino youth and youth with co-existing substance use disorders. CBT for PTSD was developed at Dartmouth Medical School by Dr. Stan Rosenberg and his colleagues. Dr. Fortuna has also recently joined Dr. Rosenberg in the PATT and telemedicine initiatives. She has dedicated her research to the implementation of evidence based treatments for multicultural youth with a broader interest in the use of public health models for the integration of such treatments into systems of care.

Michelle Porche, Wellesley Centers for Women. Michelle Porche is a Research Scientist at Wellesley Centers for Women, Wellesley College. Her primary research is on socio-emotional correlates to academic achievement for children and adolescents, with specific attention to literacy development. Much of her research has been with low-income and minority youth. She is currently collaborating with Dr. Fortuna on a series of projects related to mental health and achievement for adolescents and preparedness of school personnel to address mental health and trauma concerns of students. In addition, she also collaborated with Dr. Fortuna on an investigation of mental health service use for Latinos exposed to political violence. Dr. Porche has expertise in the use of mixed methods and in managing large scale and longitudinal research projects. Wellesley Centers for Women is a multidisciplinary center for research and action dedicated to improving the lives of women, children, and families.

New American Africans Mission Statement: To be together to identify our problems and resolve them. To Integrate and contribute to the development and growth of the local community. Our Goals: 1. To integrate New American Africans in to the American society. 2. To help members understand the countries laws as well as their rights 3. To help develop social and economic skills so that they can contribute to the safety and growth of their locality. 4. To help members to access information and resources that promotes self sufficiency. 5. To understand the role of the family in the American society, and how African families' values can be integrated into this role. 6. To help resolve conflict arising from cultural differences between traditional African culture and the US Culture.

Somali Development Center (SCS) New Hampshire is a grassroots, community-run organization providing services to the Somali refugee and immigrant communities of New England, with offices in Boston MA, Chelsea MA, Springfield MA, Hartford CT, and Manchester NH. The organization's single most important goal is to empower women, a group, which is traditionally excluded from the decision-making process in a male-dominated community. Strategies include: providing safe, supportive, and accessible space for Somali women to gather and discuss issues important to their well-being; facilitating the economic and social integration of Somali women into American society; promoting and defending the rights of women and children in the areas of health, housing, education, employment, and personal safety; and advocating for women and children within the Somali community and in the wider community. Since 1996, the Somali Development Center has been the lifeline to vital educational and social services for New England's growing Somali refugee and immigrant community. SDC was founded by a group of Somali Americans who originally came to the U.S. for higher education but identified a pressing need to assist newly arriving Somali refugees with various social services. SDC's mission is to provide services to Somalis and other African communities to help them obtain basic resources, information and skills needed to build productive and self-sufficient lives. While strengthening the Somali community by promoting mutual assistance, cultural identity and leadership, SDC fosters the ability of Somali individuals and families to advocate on their own behalf and participate constructively in the larger community.

Southern Sudan Community of New Hampshire was founded in late 2001 by the first group of the Southern Sudanese who were admitted to State of New Hampshire as refugees in late 1999 and early 2000. The organization was officially registered as a New Hampshire State non-profit Organization in February 8, 2001. The main goals of the Southern Sudan Community of New Hampshire are specifically to provide multiple services to the Sudanese refugees and other African immigrants who are in need of any kind of assistance. Mission Statement: Southern Sudan Community of New Hampshire is a multi-service, non-profit organization with goals to empower and assist South Sudan Community refugees and other African immigrants living in State of New Hampshire. Our main goal is to empower all former residents of South Sudan and other African immigrants living State of New Hampshire to attain self-sufficiency by providing access to employment search assistance, helping with preparation of resumes, teaching how to use internet job search engines, provide educational opportunities such as ESOL classes at convenient times, provide introduction to computer training classes to help them gain the computer skills needed by today's employers, provide financial assistant for their cultural events so they can practice their multi-tradition cultures and to inform the wider communities they live in about their traditions and cultures. Our programs are designed to promote the development of each individual's work-maturity competencies, emotional growth and social development. These can be achieved through the availability of appropriate trainings to help them gain skills, knowledge, and as well as attitudes needed for successful integration into New Hampshire communities.

Women for Women Coalition

The Women for Women Coalition (WFWC) founders envision a society that empowers women and girls to build better lives for themselves and their families, a society that give them a voice and the opportunity to contribute to economic development and social changes to eradicate poverty, violence, diseases and other social issues. WFWC's mission is to bridge the socio-economic and cultural gap hindering the smooth integration of African women and girls in the new community. Our ultimate goal is to empower and strengthen the role and participation of African women and girls in all spheres of development; to promote self-reliance and self-sufficiency, and to provide a forum where they can be actively involved and where their voices can be heard. Our organization will foster the mindset that supports smooth integration and development of a positive identity for children and young people by stimulating the foundations of learning that manifest confidence, self-esteem, resilience, respect and non-violence. We will collaborate with organizations that have interest in refugee and immigrant issues. The goals of the WFWC include: Goal 1: To empower and strengthen the role and participation of African women in all spheres of community development and bridge the gap that hinders them from integrating fully in their new country. Goal 2: To create African women's and girls' community support to promote healing from the wounds of war and oppression experienced in the past. Goal 3: To provide a learning environment that enriches and remediates the children academic, social and health gaps, and helps them set goals for the future. Goal 4: To facilitate parental involvement in children's academic and social progress by creating a learning environment strengthening their social and language skills

through functional literacy, workshops and parenting seminars. Goal 5: To mobilize, organize, and energize our community for healthy outcomes for youth and families.

The New Hampshire Charitable Foundation Our fundamental purpose is to improve the well-being of every community we serve. Many community foundations are dedicated to a city or county; our Foundation is one of the few with a statewide span and was one of the first to develop a regional structure. Seven regions tap local leadership and expertise. Both the breadth of vision and deep local knowledge can help you focus your giving where it will have the greatest impact. Over the last four decades, the New Hampshire Charitable Foundation has launched initiatives and built trusted partnerships with a diverse array of individuals, families, corporations, nonprofits, and government agencies. These partners represent many different backgrounds, income levels, and political sensibilities. Our work together is living proof that collaboration better serves the public good.

The New Hampshire Refugee Resettlement Program at the Office of Energy and Planning provides federally funded services to refugees resettled in the State of New Hampshire in accordance with federal statutes. The major goal of this program is to assist refugees in achieving economic self-sufficiency and social adjustment upon arrival to the United States.

The ***New Hampshire Office of Minority Health*** is responsible for ensuring access to culturally and linguistically appropriate services within the NH Department of Health and Human Services' wide array of programs and services, operated internally and externally. The Office provides technical assistance and support to other governmental agencies including the Department of Education, the Office of Juvenile Justice, the Office of Refugee Resettlement, and various community-based organizations including the New Hampshire Minority Health Coalition.

The mission of ***Bi-State Primary Care Association*** is to foster the delivery of primary health care services to medically underserved and geographically, culturally, and linguistically isolated persons in the states of New Hampshire and Vermont. Bi-State Primary Care Association is a private, 501(c)3 not-for-profit organization with a broad membership of thirty-two organizations in Vermont and New Hampshire that provide and/or support community-based primary care services. A "voice" for the medically underserved, Bi-State members include community health centers, rural health clinics, private and hospital-supported primary care practices, Community Action Program, health care for the homeless programs, area health education centers, clinics for the uninsured, family planning, and social service agencies.

The New Hampshire Minority Health Coalition is a community-based non-profit organization committed to closing the gaps in health disparities among New Hampshire's underserved populations. The organization's Board of Directors, Advisors and staff members represent diverse minority communities concerned about health issues facing New Hampshire's underserved populations.

APPENDIX: STUDY DESIGN AND METHODS

Background and Significance

The mission of the New Hampshire Project for Adolescent Trauma Treatment (PATT) is to disseminate evidence-based practices for youth who have been exposed to traumatic events, and who seek care in the New Hampshire community mental health system. Additional support for this state-wide initiative is also now being provided by a three year grant from the New Hampshire Endowment for Health to enhance dissemination activities via a telemedicine network (spearheaded by PATT), and to expand the number of evidence based treatments being introduced to include common comorbid disorders seen in traumatized youth (e.g., disruptive behavior disorders and depression). The rapid acceptance and use of standardized trauma assessment procedures, and the introduction of Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) training and supervision across all 10 Community Mental Health Clinics in the state, have been very gratifying, and give promise of greatly improved care for traumatized children in NH.

However, changing demographics, recent events and emergent information from community-based organizations suggest that a sizeable group of multiply traumatized and highly vulnerable youth will not receive the benefits of this progress. These are children and adolescents from the recently-arrived and less integrated refugee and non-English speaking minority youth in the state. Our recent partner in this entire initiative, the NH Endowment for Health (EH) has been involved in a number of projects attempting to build better access and integration of services for this group, and PATT has recently added to its core team an expert on multi-cultural mental health issues, Lisa Fortuna, M.D.

One of the EH four priority areas is to reduce social and cultural barriers to access. This work has included creation of an infrastructure that supports the provision of culturally and linguistically appropriate care. Some of the major initiatives funded by the EH have included:

- Creation of a statewide interpretation service called the Language Bank, which provides face-to-face interpretation using trained interpreters and has capacity in over 20 languages and dialects;
- Development of a state plan to improve and increase provision of medical interpretation and convening of the New Hampshire Medical Interpretation Advisory Board.
- Creation of a medical interpretation training program to develop workforce interpretation capacity to meet the diverse needs of NH's new populations, and to increase the quality of interpretation provided in health settings;
- Creation of a cultural competency-training program for health care providers;
- A Cultural Effectiveness and Quality Health Care Project led by the NH Hospital Association to institutionalize effective models to improve access to

care for NH's deaf and hard of hearing and limited English proficient populations and;

- Community-based efforts to educate consumers about their rights and advocacy related to the provision of health services.
- Capacity-building funds for nascent refugee mutual assistance organizations that are addressing the various needs of recent arrivals.

While NH has made great strides towards development of a more culturally effective health care delivery system, we know there is much more work to be done in this area.

The population of New Hampshire, historically almost exclusively white, is changing rapidly. The 2000 Census revealed that nearly 30,000 residents spoke English "less than very well," which was a 22 percent increase over the 1990 Census. A significant part of the increasing diversity in New Hampshire is a result of refugee resettlement. Since 1997, 4,000 refugees have been resettled in New Hampshire from over 30 countries and many are children. More than half of the refugees during this time period came from European countries and regions including Bosnia, Croatia, Ukraine and Russia. More than 1,500 of the refugees during this time period came from 15 different African countries including Sudan, Somalia, Liberia, Rwanda, Nigeria, and Sierra Leone. A smaller number of refugees during this time period came from five Middle Eastern countries, Vietnam and Southeast Asia, and Cuba. In the coming year the New Hampshire Office of Refugee Resettlement anticipates approximately 400 new refugees; 60 percent of which will come from the Near East and South Asia; 25 percent from African countries; and 15 percent from Europe and Central Asia. Since fiscal year 2002, the majority of resettlement activity has occurred in three New Hampshire cities: Manchester, Concord, and Laconia. Because of the availability of housing, public transportation and employment opportunities, the city of Manchester has resettled the most refugees during this time period, followed by Concord, and Laconia respectively. Each of these cities has a community mental health center that provides children's mental health services.

Refugee children straddle old and new cultures, old traumas and new adjustments (Lustig et al., 2004). Trauma has been found to be negatively related to both mental health and educational achievement for youth in countries with high levels of terrorism, political violence, and war (Finzi-Dottan, Dekel, Lavi, & Su'ali, 2006; Masinda & Muhesi, 2004; Saigh, Mroueh, & Bremner, 1997), and for refugee youth fleeing those conditions (Clarke, Sack, Ben, & Lanham, 1993). There is evidence for effective treatments and interventions for refugee youth (e.g., CBT, Narrative Therapy, school based strategies) (Ehnholt & Yule, 2006; Onyut et al., 2005). But there is a need for understanding strategies for achieving trauma informed systems of care and support within resettlement communities (especially mental health and educational systems). The breadth of cultures and languages has made the delivery of culturally and linguistically appropriate care increasingly challenging for all health care providers in New Hampshire.

Although there is a large body of research documenting the prevalence of PTSD among refugee children, few of NH's refugee families seek available mental health treatment from the community mental health centers. Reports from eight local centers collected in conjunction with this proposal describe existing services and concerns typical

in NH. The number of refugee youth seen annually varied from 3 to over 30 per site, with less than 5% of all youth seen being non-English speaking. However estimates of local refugee families were much higher than the number seeking services. In addition to refugees from the African countries of Somalia, Liberia, Congo, Burundi, Tanzania, Zimbabwe, Uganda, centers also serve refugees from Bosnia and immigrants from Latvia, Russia, Ukraine, Pakistan, Mexico, Dominican Republic, Ecuador, El Salvador, Guatemala, Laos, and China. All but one center claimed they needed further resources to work with patients of linguistically and culturally diverse backgrounds. All were interested in receiving additional education about and training in treatment of trauma for refugee and immigrant youth, including culturally specific information regarding refugee and immigrant groups, culturally specific parenting styles, ways to integrate treatment with school and community activities, issues related to integration and discrimination, as well as increased and more effective use of interpretation services. The need for culturally adapted therapy and treatment delivery was a common theme. Leaders of emerging ethnic-based community organizations are beginning to identify refugee mental health issues as an important priority for their communities to address. Based on their experiences, these leaders have pointed to a number of barriers that families face including stigma associated with mental health, and a lack of understanding of the health care delivery system, including public benefits for which they may qualify. Previously our understanding of need was anecdotal and insufficient to formulate a specific community-based response. A more formal needs assessment is critical to enhancing our understanding of the major barriers to addressing trauma related mental health issues and to design culturally and developmentally appropriate interventions.

Statement of Objectives and Aims

To further our understanding of barriers to mental health care, we conducted a needs assessment of child and adolescent refugee mental health services in New Hampshire. A community dialogue strategy was used for integrating youth, family, provider, school and community knowledge and expertise in order to address refugee mental health needs especially in relation to PTSD and trauma and in the context of resettlement and integration. Youth and their families were seen at the center of this dialogue as critical informants and participants in intervention planning. The *primary objective* of this project is to foster the creation of trauma informed systems within New Hampshire by strengthening awareness of treatment gaps, the intersection of immigration, culture and trauma and making informed decisions about necessary next steps for beginning to better address traumatic stress among resettled refugee youth. The *specific aims* of the pilot were to:

1. Consult multiple local stakeholders to identify community, client, caregiver, provider, school and mental health care system opportunities and barriers to quality mental health services for refugee children and adolescents;
2. Identify feasible quality improvements and opportunities in the community, educational and health care system to address the consequences of traumatic stress among refugee children.

Use the information generated in Aims 1 and 2 to launch a participatory dialogue process with multiple stakeholders to identify a menu of pilot projects/interventions from which

2-3 will be selected for further design and development in preparation for implementation.

Methods

Theoretical Model: In our design and sampling for this project we used a socio-eco-developmental model of youth mental health. Ecological systems theory (Bronfenbrenner, 1979) posits development occurring within the interactions between individuals and their environment among four nested levels: the macrosystem (societal and cultural belief systems), exosystem (community and neighborhood factors), microsystem (family factors), and the ontogenic level (individual factors). Cicchetti and Lynch (1993) applied this ecological/transactional model to understand childhood and traumatic stress. In considering the broader context of risk and protective factors operating across these social ecological systems, the model has salience especially for the development of interventions aimed at addressing trauma across, family, socio-cultural and systems contexts.

Aim 1 & 2: Key Informant and Multiple Stake Holder Interviews and Analysis.

We conducted 49 in-depth key informant interviews with families (mother-father and parent-child dyads) and individuals from institutions important to youth social, educational health and mental health services in order to document: 1) type and pervasiveness of traumatic exposure for refugee youth; 2) available support and mental health services; 3) mental health services use; 4) barriers to services use including language; 5) demographics on refugee youth served; and 6) organizational needs to improve mental health services delivery. The core set of stakeholders included:

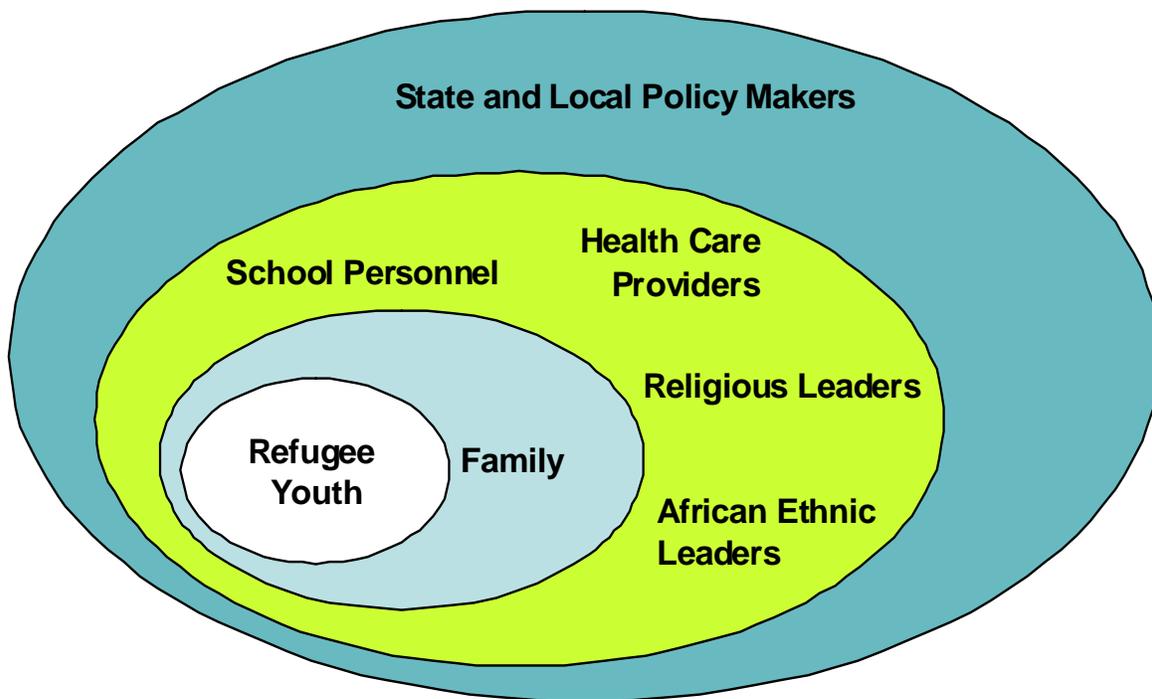
- school age youth ages 13 to 18 (interviewed with their mothers; n = 5)
- young adults ages 18 and over (interviewed individually; n = 4)
- parents of refugee youth (n = 13)
- community-based mental health providers (n = 7)
- community resource providers (n = 6); primary care providers (n = 3)
- school personnel (counselors, teachers, administrators; n = 6)
- ethnic community leaders (n = 5)
- religious and spiritual leaders (n = 2)
- state and local policy makers (n = 5)

Purposeful sampling design

We used a purposive sampling design informed by the socio-eco-developmental model for recruitment of interview participants (See Figure 1). Purposive sampling is a social science research recruitment strategy that involves selection of key informants best positioned to answer the research question (Barbour, 2001). The sampling method is useful when you need to reach a targeted sample quickly; efficiently and where sampling for proportionality is not the primary concern. Interviews with youth and families were identified through community agencies, as having had a particular type or range of experience germane to the needs assessment and who are comfortable speaking about their experiences. We recruited other informants named by key stakeholders, youth and families as critical to interview, or who we identified as operating across social ecological systems important to youth well-being. Culture brokers in the community helped to

identify appropriate key informants who helped us explore themes identified in youth and family interviews and who spoke to systems needs relevant to refugee youth mental health. We conducted a total of 49 interviews for Aim 1, including 13 parent interviews (5 were parent/child dyad interviews). Bilingual informants and interpreters from among the ethnic leaders assisted in the interview process and dialogue groups (described below) for all except for 2 English-speaking Liberian parents and the 4 young adults.

Figure 1. Purposeful Sampling Plan



Content and Development of Interview Guide for Different Stakeholders

Questions for informants were constructed to identify service needs and opportunities from the perspective of families and across provider and social systems which include policy makers. An overview of question themes for each group is as follows:

1. *Refugee Youth and Family*: Context of immigration, barriers and supports to resettlement and integration, health care needs, experiences with health care system, help and support seeking activities beyond health care system, models of

- resilience, cultural beliefs about child rearing, youth development, mental health, paradigms for dealing with traumatic experiences
2. *Providers*: Mental Health Care Providers, Primary Care Providers, School Personnel, Youth Service Providers, Religious and Spiritual Leaders, Ethnic Community Leaders: Services provided, context of interactions with refugee youth and families, barriers to providing quality care, cultural competence in working with youth and families, programs offered for positive youth development and family support, extent of trauma-focused services and proposed treatment modalities, training needs
 3. *State and Local Policy Makers*: System resources (financial, expertise, personnel) for providing health care, legislative action plans, coordination with organizations and agencies at the provider level, barriers to providing quality care systems, attention to cultural competence service systems

Data analysis for interviews

All transcripts of interviews, surveys, field notes and researcher impression notes were entered into, and analyzed using, NVivo, a qualitative data analysis program by Qualitative Solutions Research (International Pty Ltd, Victoria, Australia, 1998). This software package allows the researcher not only to code the transcripts but also write memos and create graphical representations of the emerging connections between narrative, community social contexts (including current events), themes, theories and the researchers' personnel impressions. For interviews conducted in languages other than English, we relied on the recorded verbal English interpretation which was transcribed. Data will be analyzed using a grounded theory approach (Chenitz & Swanson, 1986; Glaser & Strauss, 1967) with the goal of generating consistent themes regarding opportunities and barriers to mental health care. This means constant comparison was conducted over the course of the study in order to identify and refine theoretical categories. Members of our interdisciplinary team (psychology, psychiatry, education, social policy) reviewed the transcripts to identify significant themes from transcripts. We compared responses and drew conclusions, using triangulation across multiple theoretical disciplines to compare and analyze differences. Triangulation methods offer multiple perspectives on an issue, leading to a more comprehensive understanding of it, and facilitating better in-depth analysis of the data (Giacomini & Cook, 2000; Malterud, 2001; Mays & Pope, 2000).

This process was also used to revise and refine the interview protocol as needed, based upon the findings that emerge from the interviews. In addition, close attention to the social realities of the youth and community members in the analyses further framed and contextualized the understanding of barriers to access and quality mental health care. Part of the process was to identify the most effective ways to bring groups together in providing mental health services to refugee youth and families. We explored the degree to which the identification of potential leverage points from a multiple stakeholder perspective can lead to feasible recommendation for health care system change regarding quality improvements and effective problem solving to reduce service disparities. This included suggestions from all stakeholders as well as established therapeutic modalities suggested by mental health experts (e.g., CBT, narrative therapy which have been successful for the treatment of trauma in refugee communities).

We generated a series of products from these activities aimed at documenting the findings for use in dialogue groups and services planning as well as expanding upon current understanding of the mental health needs of refugee youth from a health services perspective. First, we prepared a brief report with key findings from the analyses of interviews to be made available to stakeholders especially in the service of focusing dialogue groups. This information was also shared at the Endowment for Health 2008 Kick-Off meeting at a poster session, and in a joint presentation with researchers investigating African refugees and Latino immigrants at the Medical Interpretation Advisory Board (MIAB) Conference 2008. Secondly, we expanded these findings and integrated comments from key stakeholders gathered during the dialogue groups (discussed further below) into this final report of the needs assessment for local dissemination. Third, the investigators of this proposal are in the process of preparing presentations and publications for wider dissemination in the field of child trauma, mental health and education in the spirit of advancing the field in this area. All proposed activities in this project were submitted to the institutional review boards of the participating academic institutions to ensure appropriate protections of participants, including consideration of confidentiality and potential risks to participation.

Aim 3: Dialogue Meetings

Dialogue group meetings were modeled on a method of mutual inquiry that emphasizes not only problem solving but also community building capacity for collaboration across multiple stakeholders (A. Katz, Conant, Inui, Baron, & Bor, 2000; A. Katz, Siegel, & Rappo, 1997; A. M. Katz & Mishler, 2003). Dialogue groups differ from focus groups in that the participant members are co-learners in a mutual process of participation and learning. We initially conducted two separate stakeholder meetings with providers, policy makers, and ethnic leaders. One meeting was conducted in Manchester (20 people attended) and the other in Concord (21 people attended), in order to ensure geographic representation. A third dialogue group meeting was subsequently conducted with four ethnic leaders and one cultural broker to allow them the opportunity to comment and expand on any information gathered in the larger group meetings. The groups were led by Drs. Fortuna and Porche. They lasted approximately two hours each and were audio-taped with permission of all in attendance. The dialogue group process was designed to foster the development of a multiple stakeholder advisory group, which should evolve as this report is disseminated. Based on the analyses conducted in Aims 1 and 2, specific themes were identified for further investigation/discussion in dialogue groups. There were several areas of investigation as part of dialogue groups including:

- an iterative process of meaning making for the themes collected in interviews;
- identifying and sharing best practice interventions from other resettlement communities;
- compilation of a menu of pilot projects; selection of prioritized pilot projects; and
- identifying partners to collaborate in an advisory group and to participate in next steps for implementing selected interventions.

The goal for these groups was to jointly define a trauma focused system of care for refugee youth in New Hampshire communities, jointly articulating challenges and opportunities regarding access barriers to mental health care, identifying potential and

actual resources that can be further developed, and identifying leverage points in the community and the system for change and collaboration.

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