NCTSN The National Child Traumatic Stress Network

TST-R: Trauma Systems Therapy for Refugees

GENERAL INFORMATION

Treatment Description

Acronym *(abbreviation)* **for intervention:** TST-R

Average length/number of sessions: Length of engagement/intervention varies by the four tiers of TST-R:

Tier One: Community and Parent Engagement: The broadest level of care includes community engagement activities focused on developing trust between communities and providers and providing education about culture, mental health, and community needs. Throughout these activities, efforts are made to de-stigmatize mental health services and seeking care. These activities are ongoing throughout program implementation.

Tier Two: Skills-based Groups: The second level of care focuses on preventative skills-based groups for refugee youth that focus on increasing self-regulation skills, decreasing acculturative stress and increasing social support, factors known to be associated with better mental health among refugee youth. The groups are typically co-led by a group leader and cultural broker. Groups are designed to be non-stigmatizing and run weekly over the course of 12 weeks. The groups also serve as an opportunity to decrease stigma related to services and to identify children who may need a higher level of mental health intervention.

Tier Three/Four: Intensive Intervention: The third and fourth levels of care focus on youth who demonstrate significant mental health needs. These youth receive community-based, linguistically and culturally sensitive care under the Trauma Systems Therapy (TST) model (Tier 3 involves individual therapy and Tier 4 involves home-based/family therapy; see the TST general information fact sheet available on the NCTSN website for a more in-depth description). TST is a phase-based model of care that includes both individual and/or home-based support depending on the child's needs. TST interventions address both a child's self-regulation and social environment. In TST-R, services are often embedded in school systems in an effort to reduce barriers to seeking care based on evidence that refugee families are more likely to seek help in a school setting. Of note, cultural brokering, the inclusion of a cultural expert is an essential component of the TST-R model. A cultural broker is incorporated into each of the four tiers.

Timeframe: In the implementation of TST-R, there are unique tasks for each of the six steps in the process by which a child transitions through TST treatment:

Step 1. Assessment
Step 2. Treatment Planning
Step 3. Treatment Engagement
Step 4. Treatment Implementation I: Safety-Focused Treatment
Step 5: Treatment Implementation II: Regulation-Focused Treatment
Step 6. Treatment Implementation III: Beyond Trauma Treatment

All children sequentially transition through Steps 1-3 (total time of approximately one month) and start Treatment Implementation at Step 4, 5, or 6. Length of treatment implementation varies by level of severity and phase of treatment implemented. The Safety-Focused Treatment (indicated for most acutely symptomatic children and/or an insufficiently helpful social environment), for example, averages three months in length.

Treatment Description continued

Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, transportation barriers)***:**

TST-R is specifically designed to reduce barriers to mental health services commonly faced by refugee youth and families through the following mechanisms:

1. Reduce distrust of authorities by engaging the community
2. Reduce stigma of mental health services by embedding services in existing service systems
3. Reduce linguistic and cultural barriers by creating a partnership between providers and cultural experts
4. Reduce primacy of resettlement stressors by integrating services

Trauma type *(primary)*: Refugee

Trauma type *(secondary)*: Various

Additional descriptors *(not included above)***:**

TST-R focuses on the experience of trauma that refugees face, from pre-migration, during migration, and during resettlement and beyond, thereby providing a socio-environmental context to the intervention. TST-R is not limited to one specific trauma type. Refugee children have experienced a wide range of traumas including exposure to war, domestic violence, physical abuse, and community violence, among others. Most refugee children who participate in TST-R programs have experienced multiple traumas as well as enduring other stressful daily experiences such as discrimination. TST-R also specifically addresses social-environmental factors that compound the problems associated with trauma exposure such as poverty, inappropriate school placements, and acculturative stress.

Target Population

Age range: 10 **to** 18

Gender: ❒ **Males** ❒ **Females** ☒ **Both**

Ethnic/Racial Group *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** Target populations for TST-R include newly arriving, recently resettled, and established refugee youth and communities. To date, TST-R has been adapted for use with Somali, Somali Bantu, and Bhutanese refugee youth.

Other cultural characteristics *(e.g., SES, religion)***:** Although not limited to these groups, TST-R has been implemented with those of lower SES, and with those of various religious backgrounds including Muslim, Buddhist, Christian, and Hindu.

Language*(s)***:** English is the primary language used, but cultural brokering (the use of a person from the culture of interest who speaks the language) is utilized in tandem with a clinician to ensure conceptual clarity and cultural understanding.

Region *(e.g., rural, urban)***:** Will be utilized with both inner-city and rural communities.

Target Population continued	**Other characteristics** *(not included above)*: TST-R targets refugee youth who are having difficulty with emotional regulation capacities and the ability of the child's social environment and system of care to help him or her manage emotions or to protect him or her from threat.
Essential Components	**Theoretical basis:** TST-R was adapted from TST to address the specific needs of refugee youth. In addition to the TST model of care, TST-R includes new components such as skills-based groups focused on acculturative stress and community outreach. TST-R is a comprehensive method for treating traumatic stress in children and adolescents by specifically addressing social environmental/system-of-care factors that are believed to be driving a child's traumatic stress problems. In TST-R, TST was adapted to address the experience of war and violence prior to resettlement, and the ongoing acculturative and resettlement stressors that refugee families experience. TST-R specifically seeks to improve engagement of refugee youth and their families by offering services along a continuum of care, and is embedded within systems of care (e.g., schools). It was developed to provide culturally appropriate trauma-informed mental health care for refugee youth and their families who may not seek services otherwise. TST was inspired in part by Bronfenbrenner's social-ecological model (Bronfenbrenner, 1979), which acknowledges the complexity of the social environment that surrounds an individual, and how disruptions in one area of the social ecology may create problems in another. Interventions in TST-R/TST are designed to work in two dimensions: strategies that operate through and in the social environment to promote change, and strategies that enhance the child's capacity to self-regulate. The TST model involves a phase-based approach to intervention that correspond to the fit between the traumatized child's own emotional regulation capacities and the ability of the child's social environment and system-of-care to help him or her manage emotions or to protect him or her from threat. **Key components:** **Three key** prevention and intervention components necessary for TST-R implementation are: **1) Community Engagement.** *Refugee and immigrant community engagement*: Parent education forums help families understand how mental health problems affect children's functioning and ability to learn, and how parents are critical partners in promoting their children's health. This component also elicits feedback from parents about the specific challenges and needs they perceive for children within their particular ethnic community. *School and community engagement*: Teacher trainings and student and teacher resources to promote understanding of cultural diversity and a more inclusive school community will be developed and delivered. In addition to face-to-face trainings, the Refugee Trauma and Resilience Center has developed web-based resources for teachers and educators that can be used to supplement these trainings. The web-based resources are located on the refugee section of the NCTSN website.

Essential Components continued

2) Prevention/Early Intervention.

Within the school, prevention/early intervention skill-building groups are conducted with school-based clinicians and cultural brokers to help refugee students with acculturation and socialization. These groups also serve to help identify youth who are in need of more intensive mental health services. Teacher trainings and consultations further minimize acculturative stress within the school setting and help teachers understand how learning and behavior may be affected by trauma and stress.

3) Intensive Intervention.

Individuals who demonstrate significant mental health needs receive community-based, linguistically and culturally sensitive care under the Trauma Systems Therapy (TST) model. Intensive treatment may include home-based care, office/school-based care, pharmacology, and/or advocacy.

Four critical elements for the implementation of a TST-R program include:

- All TST-R programs must partner with the community of interest
- All TST-R teams must include a cultural provider or a cultural broker
- TST-R teams must include a combination of home-based clinicians, an outpatient clinician, school-based clinicians, a clinical supervisor, and organizational support persons; and
- The capacity for the delivery of services to occur in home, school, or community settings

Clinical and Anecdotal Evidence

Are you aware of any suggestion/evidence that this treatment may be harmful?
❒ Yes ☒ No ❒ Uncertain

Extent to which cultural issues have been described in writings about this intervention *(scale of 1-5 where 1=not at all to 5=all the time)*. 5

This intervention is being used on the basis of anecdotes and personal communications only *(no writings)* **that suggest its value with this group.**
❒ Yes ☒ No

Are there any anecdotes describing satisfaction with treatment or dropout rates *(e.g., quarterly/annual reports)***? ☒ Yes ❒ No**

If YES, please include citation:
See "other qualitative impressions" below (unpublished qualitative data).

Has this intervention been presented at scientific meetings? ☒ Yes ❒ No

If YES, please include citation*(s)* **from last five presentations:**

Ellis, B. H. (2014). Immigrant Health: Mental Health Interventions for Refugee Youth. *Harvard Medical School: Office for Diversity Inclusion and Community Partnerships*. Boston, MA.

Ellis, B. H. (2011). Trauma and Refugees, recent advances in science and practice—Adapting interventions for refugee youth: trauma systems therapy for Somali adolescents. *American Psychological Association Annual Convention*, Boston, MA.

Clinical and Anecdotal Evidence continued

Ellis, B. H. (2010). Treating Traumatized Immigrant and Refugee Youth Center for Health and Health Care in Schools. *Georgetown University*, Washington, DC.

Ellis, B. H. (2009). School-based Trauma Systems Therapy for Refugees: Engaging Partners. *The annual meeting of the International Society for Traumatic Stress Studies*, Atlanta, GA.

Ellis, B. H. (2007). Caring for Traumatized Children within the System of Care: a Trauma Systems Therapy Approach. *Pre-Meeting Institute of the annual meeting of the International Society for Traumatic Stress Studies*, Baltimore, MD.

Miller, A. B., Issa, O., & Benson, M. (2015, June). Engaging Different Cultural Communities in Meaningful Ways: Lessons Learned in the Adaptation and Implementation of Trauma Systems Therapy for Refugees. In D. Birman (Chair), *Creative methodologies for addressing the psychosocial needs of immigrant youth*. Symposium conducted at the meeting of the Society for Community Research and Action, Lowell, MA.

Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No

If YES, please include citation:

Abdi, S., Barrett, C., Blood, E. A., Betancourt, T. S., Ellis, B. H., & Miller, A. B. (2012). Multi-tier mental health program for refugee youth. Journal of Consulting and Clinical Psychology, 81(1),129-140. DOI:10.1037/a0029844

Ellis, B.H., Miller, A., Baldwin, H., & Abdi, S. (2011). New directions in refugee youth mental health services: Overcoming barriers to engagement. J Child Adolesc Trauma; 4(1),69-85. DOI:10.1080/19361521.2011.545047

Refugee Trauma and Resilience Center (in development). Trauma Systems Therapy for Refugees (TST-R): A Cultural Brokering Program Supplemental Manual. Boston Children's Hospital, Boston, MA.

Abdi, S. M., & Nisewaner, A. (2009). Group Work with Somali Youth Manual. Unpublished manuscript. Center for Refugee Trauma and Resilience, Children's Hospital Boston, Boston, MA.

Nisewaner, A., & Abdi, S. M. (2010, June). Challenges, strategies and rewards of an adaptation of trauma systems therapy for newly arriving refugee youth: School-based group work with Somali adolescent boys. In V. Roy, G. Berteau, & S. Genest-Dufault (Eds.), Strengthening Social Solidarity through Group Work: Research and Creative Practice. Paper presented at the Proceeding of the XXXII International Symposium on Social Work with Groups, Montreal, June 3-6, (pp. 129-147). Forest Hill, London: Whiting & Birch.

Saxe, G. N., Ellis, B. H., & Kaplow, J. (2006). Collaborative treatment of traumatized children and teens: The trauma systems therapy approach. New York: Guilford.

Saxe, G. N., Ellis, B. H., & Brown, A. D. (2015). Trauma Systems Therapy for Children and Teens, 2nd ed. New York: Guilford.

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Clinical and Anecdotal Evidence continued	**Has the intervention been replicated anywhere?** ☒ **Yes** ❒ **No** **Other clinical and/or anecdotal evidence** *(not included above)*: In our implementation with Somali youth in Boston, community-wide acceptance of the program led to increased parent involvement in the schools and an active family advisory board. The program had 100% engagement in treatment among youth referred for services, and perhaps the best indicator of success was that families and youth started self-referring to the program. In our implementation with Bhutanese youth in West Springfield, MA, we found that youth in the groups demonstrated significant improvements in PTSD symptoms over the course of the group. This held true for both years that we implemented skills-based groups with this population.	
Research Evidence	**Other countries?** *(please list)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**30 **By gender:** 19 males, 11 females **By ethnicity:** 60% Somali ethnicity; 40% Somali Bantu ethnicity	Ellis, B. H., Miller, A. B., Abdi, S., Barrett, C., Blood, E. A., & Betancourt, T. S. (2012). Multi-tier mental health program for refugee youth. *Journal of Consulting and Clinical Psychology, 81*,129-140.
Other Research Evidence	**By gender:** 84 boys, 51 girls **By ethnicity:** 135 identified as Somali or Somali Bantu **By other cultural factors:** 98% of participants endorsed practicing the Muslim religion	Ellis, B.H., MacDonald, H.Z., Lincoln, A.K., & Cabral, H.J. (2008). Mental health of Somali adolescent refugees: The role of trauma, stress, and perceived discrimination. *J Consult Clin Psychol 76*,184-93.
Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** The following clinician-rated measure is recommended for clinical use but is not mandatory: Child Ecology Check In (CECI; as cited in Brown, McCauley, Navalta, & Saxe, 2013).	

Outcomes continued	The following self-report measures have been used for program evaluation purposes: • Depression Self Rating Scale (DSRS; Birelson, 1981) • Language, Identity, and Behavior Acculturation measure (LIB; Birman & Trickett, 2001) • UCLA PTSD RI DSM IV (Steinberg, Brymer, Decker, & Pynoos, 2004) • Psychological Sense of School Membership (PSSM; Goodenow, 1993) The following teacher report measure has been used for program evaluation: • The Strengths & Difficulties Questionnaire (SDQ; Goodman, 1997) **If research studies have been conducted, what were the outcomes?** An evaluation study (Ellis et al., 2012) of the TST-R program implemented in Boston demonstrated the following: *At the community level:* • A decrease in experiences of discrimination *At the school level:* • An increase in sense of school belongingness • A decrease in school rejection *At the family level:* • A decrease in family acculturative hassles • A decrease in resource hardships *At the child level:* • A decrease in symptoms of depression • A decrease in posttraumatic stress symptoms
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** Space: Capacity for the delivery of group and individual services to occur in the home, school, or community setting. Materials: Each TST-R supervisor, clinician, and cultural broker should be provided with a copy of the Trauma Systems Therapy book, the Group Intervention Manual, and the Cultural Brokering Manual. Key service elements: Five types of services should be available to the TST-R team: cultural brokering, skill-based group psychotherapy, home- and community-based therapy, legal advocacy, and psychopharmacology. These elements can be assembled creatively out of resources available in a particular community. **Supervision requirements** *(e.g., review of taped sessions)***?** Weekly individual supervision for TST-R clinicians and cultural brokers is highly recommended. Typically group supervision is provided through participation in a weekly team meeting, a requirement for all TST-R teams. Team fidelity can be monitored at this time. Peer supervision for cultural brokers is optional but may be beneficial.

Implementation Requirements & Readiness continued	**In order for successful implementation, support should be obtained from:** It is highly recommended that agencies complete a TST Organizational Planning form prior to implementation. The planning form guides the interested agency through the planning process, which involves, among other things: identifying a champion; establishing partnerships with schools, community, and mental health agencies; and working with and engaging the refugee community being served. As part of successful implementation, agencies contract with the Refugee Trauma and Resilience Center (RTRC) at Boston Children's Hospital (BCH) for an initial in-person training in addition to ongoing training in the form of weekly consultation (see section below on "how/where training is obtained"). Contact the Refugee Trauma and Resilience Center (RTRC) at Boston Children's Hospital (BCH) for support in implementing the intervention: **Website:** http://www.childrenshospital.org/centers-and-services/refugee-trauma-and-resilience-center-program **Contact information:** RTRC @ BCH 300 Longwood Ave, Mail stop BCH 3199 Boston MA 02115 Email: CenterForRefugeeTraumaAndResilience@childrens.harvard.edu Phone: 617-919-4632 Fax: (617) 730-0759
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Saxe, G. N., Ellis, B. H., Brown, A. (2015). *Trauma Systems Therapy*. New York, NY: Guilford Press. Saxe, G. N., Ellis, B. H., & Kaplow, J. (2006). *Collaborative Treatment of Traumatized Children and Teens: The Trauma Systems Approach*. New York, NY: Guildford Press. TST manuals/books can be obtained Guildford Press and from online retailers such as www.amazon.com and www.barnesandnoble.com. Cultural Brokering/TST-R supplement can be obtained from RTRC @ BCH (see above for contact information). Refugee Trauma and Resilience Center (in development). Trauma Systems Therapy for Refugees (TST-R): A Cultural Brokering Program Supplemental Manual. *Boston Children's Hospital*, Boston, MA. *TST-R Group Work with Somali Youth Manual*. Unpublished manuscript. Center for Refugee Trauma and Resilience, Children's Hospital Boston, Boston, MA. *TST-R Group Work with Bhutanese Youth Manual*. Unpublished manuscript. Center for Refugee Trauma and Resilience, Children's Hospital Boston, Boston, MA. *TST-R Group Work Manual*. Unpublished manuscript. Center for Refugee Trauma and Resilience, Children's Hospital Boston, Boston, MA.

Training Materials & Requirements continued	**How/where is training obtained?** Training is currently available through individual agency contracts. Webinar series in development. Training takes the form of an initial four-day in-person training followed by ongoing training in the form of phone consultation. A typical consultation schedule involves weekly consultation with the skills-based group teams, weekly consultation with the TST clinical teams, and monthly administrative and supervisory consultation. **What is the cost of training?** Variable **Other training materials &/or requirements** *(not included above)*: Benson, M. A., & Abdi, S. (in development). Trauma Systems Therapy for Refugees (TST-R): A Cultural Brokering Webinar.
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)*? TST-R is the only established, evidence-based program that has demonstrated success in reducing risk factors among refugee youth in the diaspora. TST-R is specifically designed to address the barriers to care for refugee youth and families and to provide cultural and linguistically appropriate services to a subset of traditionally traumatized and marginalized youth. More specifically, it addresses distrust of authorities by engaging the community and the stigma of mental health services by embedding services in existing service systems; linguistic and cultural barriers by creating a partnership between providers and cultural experts; and the primacy of resettlement stressors by integrating services. TST-R has been shown to successfully engage refugee youth and families in multi-tier mental health services. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)*? The phase-based nature of intervention may last a long time (e.g., one year). Treatment requires an interdisciplinary team, which agencies will need to assemble through various funding sources. Requires a high level of community engagement, coordination, and flexibility. Some components may not be reimbursable through insurance, and other funding mechanisms may need to be identified in order to implement and sustain the model. **Other qualitative impressions:** When implemented as designed, we have found high levels of client satisfaction.

Pros & Cons/ Qualitative Impressions continued	**From qualitative evaluation with the Somali population:** • 100% said they'd recommend this group to other Somali students • 80% said the group helped them interact with classmates or teachers in school • 91% said the group helped them feel more comfortable or happier with themselves • 85% said the group helped them get along better with their Somali and/or American friends **From qualitative evaluation with the Bhutanese population:** • 94% said they'd recommend this group to other Bhutanese students • 94% said the group helped them interact with classmates or teachers in school • 78% said the group helped them feel more comfortable or happier with themselves • 78% said the group helped them get along better with their Bhutanese and/or American friends • 67% said the group helped them get along better with their siblings/family members
Contact Information	**Name:** Heidi Ellis, PhD **Address:** 300 Longwood Ave, Mail stop BCH 3199, Boston, MA 02115 **Phone number:** 617-919-4791 **Email:** heidi.ellis@childrens.harvard.edu **Website:** http://www.childrenshospital.org/centers-and-services/refugee-trauma-and-resilience-center-program