

# School Training: A Strategy for Changing School Climate for Refugee Children



Commissioned by  
Children's Crisis Treatment Center

West African Refugee  
Assistance Program

The Tamaa Program



**Children's Crisis Treatment Center**

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Children’s Crisis Treatment Center earns recognition as an organization for its unyielding response to the needs of the children and families living in the communities it serves. CcTC’s Chief Executive Officer, Mr. Antonio Valdes has spent his professional career fighting to ensure that Philadelphia’s most underserved children and families, including the City’s immigrants and refugees,

receive quality mental health and social services. Without his vision and his ability to secure support of CcTC’s Board of Directors for this new initiative, there would be no Tamaa Program. Another key member of CcTC’s executive team, without whom the Tamaa Program’s development and implementation could not have been possible, is CcTC’s Chief Operating Officer of Center Based Services, Dr. Grace Ryder. Dr. Ryder provided the leadership and commitment needed to develop, implement and sustain the Tamaa Program.

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## Forward

In the Spring of 2001, the Director of Trauma Services for Children's Crisis Treatment Center (CcTC) answered a phone call placed by a social worker employed at the Children's Hospital of Philadelphia (CHOP). The social worker was calling about a child living in Southwest Philadelphia who had come to Philadelphia as a refugee from Liberia, which is a country in West Africa. A teacher at the largest middle school in the City's South Region of the Philadelphia School District had brought the child to CHOP's Emergency Room for treatment after he had been severely beaten by non-refugee children at the school. The teacher made it clear that providing services for this particular child at CcTC's Trauma Assistance Program would not solve the problem; rather, she wanted CcTC to come to the school to help the West African refugee children who were being targeted for violent assault by non-refugee classmates, and were faced with

the challenges of acculturation, as well as the impact of war-related violence and displacement.

This event began the odyssey that led CcTC to establish a new trauma treatment program, the West African Refugee Assistance Program, which came to be called the Tamaa Program, in collaboration with diverse community partners. Since then, CcTC has intervened in the lives of hundreds of children and their families; assisted principals, teachers, and staff in making their schools more welcoming and understanding, which has made a significant impact on the lives of refugees in Southwest Philadelphia.

The Tamaa Program is comprised of five components that were thoughtfully conceived and implemented:

- Children's Trauma- and Grief-focused Therapy Groups
- Case Management Services
- Caregiver Education and Support Group
- Multicultural Social Events
- School Trainings

The initial development of the Tamaa Program was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). When this grant expired, CcTC was able to secure funds to continue all components of the programs, except School Trainings. This was largely due to the strong relationship CcTC has established with the mental/behavioral health funding sources and child welfare system in the City of Philadelphia, and the inclusion of key individuals from these organizations on Tamaa's Advisory Board. These individuals felt a level of ownership over and pride in the Program and wanted the good works to continue once the initial grant funds ended. Thankfully, the only component that remained unfunded, School Trainings, was recognized as critical by the Robert Wood Johnson Foundation, who generously offered three year support to continue, expand, and improve this final component.

This *Guidebook* has been developed to enable others to replicate the School Trainings component.

## Overview of the Guidebook

In 2001, a middle school student was attacked by classmates – the student was a refugee from Liberia whose family had fled war in their native country before re-settling in Philadelphia, Pennsylvania. This event, the resulting call to action by a concerned teacher – and the response of Children’s Crisis Treatment Center (CcTC) to that call – led to the creation of the West African Refugee Assistance Program (Tamaa). After intensive and detailed research, CcTC determined that in order to most effectively address the challenges of the West African community in Southwest Philadelphia, a comprehensive intervention model was essential. Consequently, Tamaa incorporated: treatment for the war-traumatized children to enable them to better cope with their trauma experiences and improve their acculturation to a new environment; trainings for school personnel to enable them to better understand and support their West African students; support, guidance, and information for the parents and caregivers of the West African children; and activities to help the children and their families preserve their West African culture, while concurrently helping them assimilate into the American culture, specifically that of Southwest Philadelphia.

Tamaa’s development and implementation was initially funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Victory Foundation, and the First Hospital Foundation. When this funding ended, CcTC was able to secure funding for the various components through local resources, specifically the Department of Human Services (Philadelphia’s child welfare agency), Philadelphia’s Department of Behavioral Health including Philadelphia’s Office of Mental Health and Community Behavioral Health. As previously noted, this resulted from the positive relationship CcTC had with the abovementioned mental/behavioral health funding sources and the child welfare system in the City of Philadelphia, and the inclusion of key individuals from these organizations on Tamaa’s Advisory Board. Those individuals from these key organizations had a strong relationship with and commitment to the Tamaa Program and wanted the services to the West African children and families to continue after the initial grant funding terminated, and they worked hard within their own organizations to secure the needed funding.

However, local resources were unable to fund the School Trainings component of Tamaa. In 2006, CcTC secured funding for this component from the Robert Wood Johnson Foundation’s Caring Across Communities program. This Guidebook has been written to provide a description of Tamaa – from conception to delivery, with special attention focused on the School Training component, funded by the Robert Wood Johnson Foundation.

Section One includes a description of CcTC, especially its leadership role in creating Tamaa; a description of the challenges that needed to be addressed in the Southwest Philadelphia community and the schools the West African children attended; and some background information on the war-related experiences of the West African refugee children. Section Two describes Tamaa, including CcTC’s extensive and comprehensive efforts to research and design a program based on this research and best practices, as well as the specific components of the program. The School Trainings component is the subject of Section Three, and includes its development and implementation, ongoing modification and impact. Section Four incorporates CcTC’s “Nine Essential Elements for Success” in implementing a community-based, mental/behavioral health program for children and families from ethnically specific populations<sup>1</sup>, a practical and philosophical framework used to create Tamaa, and offers suggestions for replication.

## SECTION ONE

### Children's Crisis Treatment Center

#### Early History of the Organization

Children's Crisis Treatment Center (CcTC) was founded in 1971, as the Center for Early Childhood Services, a demonstration project funded by the United States Bureau of Education for the Handicapped. The project was developed to research and demonstrate the effectiveness of a variety of programs and services for emotionally and socially troubled young children in the community, school, and clinic. The approach was based on establishing a sound and stable environment for the child, and included the involvement of an interdisciplinary staff from psychiatry, psychology, social work, and early childhood education. The Center became a private non-profit corporation in 1978.

#### CcTC Today<sup>2</sup>

CcTC is a private, non-profit agency that specializes in providing high quality mental/behavioral health services to children and their families who are struggling with the effects of abuse, neglect, traumatic events, and other challenges to early childhood. For more than thirty-nine years, CcTC has been committed to helping children reach their full potential within their homes, community, and society in a culturally sensitive environment that embraces all Philadelphia communities while valuing their differences. Currently, CcTC provides services to more than 1,100 children and treats more than 2,300 children and their families over the course of a year. CcTC's main office is centrally located in Philadelphia, and the agency also operates in several satellite sites.

CcTC's interdisciplinary staff provides high quality mental and behavioral treatment to children and their families. CcTC's vision, "all children and families are entitled to the best treatment and service currently available, in an atmosphere of respect and concern," is reflected in the quality of its services and the high esteem the agency has earned in the Philadelphia community.<sup>3</sup>

### A Plea for Help

In the spring of 2001, the Director of Trauma Services for Children's Crisis Treatment Center (CcTC) answered a phone call from a social worker employed at the Children's Hospital of Philadelphia (CHOP). The social worker was calling about a child living in Southwest Philadelphia who had come to the City as a refugee from Liberia, West Africa. A concerned teacher<sup>4</sup> at Tilden Middle School<sup>5</sup>, located in the South Region of the School District of Philadelphia, had brought the child to CHOP's Emergency Room for treatment after he had been severely beaten by non-refugee children at the school.

The teacher recognized that helping this one child would not address the greater need; rather, she wanted CcTC to come to the school to help all the West African refugees who were attending Tilden Middle School. According to the teacher, these children were struggling to cope with their new community and school and were being harassed by non-refugee students. These challenges were exacerbated by their prior experiences with war, displacement, and resettlement. The teacher was persuasive – and CcTC responded to her plea. Representatives from CcTC's leadership team with the support of CcTC's Board of Directors began an intensive exploration of strategies for assisting this population of traumatized children, their families, their school(s), and ultimately the larger community.

This event was the impetus for creating the West African Refugee Assistance Program, or Tamaa. Tamaa, taken from the Swahili root word "hope," is a community- and school- based program designed to meet the needs of the West African refugees in Southwest Philadelphia<sup>6</sup>.

### School Climate

Since the request for assistance grew out of an incident of school violence, logically, the first point of engagement was school-based. Generally, there is a reluctance to invite "outsiders" to participate in, let alone initiate, an examination and airing of serious internal problems. While this is not endemic to educational institutions, the involvement of children requires special and legitimate caution. The initial visits to Tilden Middle School by

the CcTC leadership team<sup>7</sup> were not encouraging. The school principal and the building representative (for the teachers' union) were reluctant to allow CcTC to become involved in the school's internal affairs; some teachers were antagonistic toward efforts to provide services for West African students exclusively – noting that African American students struggling with issues of community violence as well as other socio-economic stressors, also needed help.<sup>8</sup> To further complicate the situation, the refugee community had not been exposed to mental health support in West Africa and were not prepared to accept such care in the United States.

However, as a result of the persistence of the teacher who had first called CcTC, the interest of a small group of teachers, the patience and persuasion of the CcTC leadership team, and the support of leaders in the West African community, especially the leaders of African Cultural Alliance of North America (ACANA)<sup>9</sup>, a dialogue was initiated among stakeholders. This dialogue ultimately enabled CcTC to secure access to the children and families at Tilden Middle School and eventually at Mitchell, Morton, and Patterson Elementary Schools.

Clearly, the vast majority of the West African students had experienced significant war-related trauma, as well as difficulties associated with displacement and resettlement in a new country and culture, and as a result, the children often struggled academically, socially, and behaviorally in school. The majority of the teachers had little knowledge of the children's past histories – including the horrific violence they had experienced and witnessed. While the teachers recognized that many of the children were behind academically, they were unaware of the cause – the children had to flee their homes – literally for their lives. Many children lost years of schooling during the wars/conflicts in their homelands. Others did continue their educations in refugee camps, but the learning environment in the camps was fraught with stress, inadequate facilities and supplies, and uncertainty. Teachers in Southwest Philadelphia were particularly frustrated with their inability to make contact or engage with the caregivers of those West African children with significant school problems – not realizing that the parents were often working multiple jobs trying to support their families here in the United

States, as well as extended families back home in West Africa, and did not have time for school visits. Strategies for disciplining students were also a problem. The West African parents often felt that the schools/teachers were supposed to handle the students' discipline themselves, even physical discipline, as that was the custom they were familiar with back home in West Africa. When the West African families did discipline the children themselves, it was often perceived by school personnel to be in the form of severe corporal punishment or a threat to return the children to Africa, which worried school personnel. Few, if any, of the teachers had ever received any training to assist them in their work with students and families from different cultures and countries, let alone those who had experienced war, so they often felt confused and unprepared to handle the situations that arose with the West African children and families.

The peer environment for the refugee children in their new public school environment in Southwest Philadelphia was contentious, at best. Though many of the children were able to speak English, it was not "American" English, providing an opportunity for teasing. The majority of the other children had no real knowledge of the harsh experiences of the West African children had endured. The West African families were not always aware of American culture – again providing other children with superficial issues that could be used to target/tease the West African children. Ultimately, the teasing led to taunting, and the children formed groups and fought with each other – disrupting the school/classroom environment. Often these fights extended beyond the school environment and affected the larger community.

The West African parents and caregivers faced many challenges themselves. While many had lived in cities equivalent in size to American cities, a great number of the families came from small villages. Refugee parents and caregivers also experienced the challenge of acculturation. Those who held secure jobs or had businesses in their home countries were not able to find equivalent work in the United States. In addition, while government help for refugees is available in the United States, refugee experiences in their homelands led them to distrust government – and the majority either

were not aware of opportunities for help or were uncomfortable with seeking such support – whether due to fear, privacy or pride. Many parents/caregivers held multiple jobs, working long days and often nights, leaving children completely unsupervised or supervised by older children. As a result, parents were unable to respond to teachers’ requests for meetings; they were also unavailable to supervise the children’s school work, exacerbating the challenges for teachers and students.

## The Commitment

Despite these clear and serious challenges, with no firm source of funding and less than a gracious welcome, the Executive Director of CcTC sought Board approval to reach beyond the organization’s traditional work boundaries to provide mental health intervention for the West African community in Southwest Philadelphia – and the Board responded affirmatively. Children needed help – CcTC was committed to providing it.

## Crafting the Response

### *Knowing the Client*

The leadership of CcTC recognized that it would be irresponsible to offer help and solutions without full and current knowledge of the background of the children and their families. CcTC immediately launched an intensive research initiative to better understand not only the history and culture of Southwest Philadelphia’s West African community (to include research specifically related to mental health care), but also the Southwest Philadelphia community itself. This initial research effort provided the information needed to engage the school, the community, and ultimately, the client; ongoing intensive research and evaluation continue to inform and guide the project.

### **Living conditions in Southwest Philadelphia**

Southwest Philadelphia extends west of the Schuylkill River to the City line and south of Baltimore Avenue. According to the census data available at that time, there were more than 79,000 people living in the area.

Seventy-three percent (73%) were African American or African, 19% Caucasian, 2% Hispanic and 5% Asian. Twelve percent (12%) of the families spoke a language other than English in their homes. According to 2005 statistics, the rate of unemployment was 17.3%; 52% were living below 200% and 26.7% below 100% on the Federal Poverty Index.<sup>10</sup> In addition, according to the 2007 Annual Report of Safe and Sound, the crime rates for Southwest Philadelphia significantly exceeded national rates.<sup>11</sup>

### **West African Refugees in Southwest Philadelphia**

African immigrants are the fastest growing immigrant population in America.<sup>12</sup> It is estimated that by 2007, there were more than 1.4 million African-born people living in the United States.<sup>13</sup> From 1989 through 2003, according to the United Nations High Commission on Refugees (UNHCR), approximately 240,000 West Africans came to the United States. Of these, at least 30,000 were reported as refugees.<sup>14</sup>

According to data reported by several sources, there are an estimated 50,000 African immigrants living in the Philadelphia region.<sup>15</sup> In fact, seven percent (7%) of the City’s population was born in Africa. While many have settled in Philadelphia seeking education and employment (economic motivators), some have come to this area as refugees, seeking asylum as a result of war in their native lands. In fact, approximately 65% of the world’s refugees are African, and 80% of refugees and displaced persons are women and children.

The majority of West Africans who have settled in Southwest Philadelphia are from Liberia; estimates range from 10,000 to 15,000, making this one of the largest groups of Liberians in the United States. The West African community also includes approximately 3,000 from Sierra Leone, and a smaller number from Guinea.<sup>17</sup> It is difficult to report accurately how many of the West Africans in Southwest Philadelphia are refugees; while some entered officially as refugees, others entered the United States as visitors or relatives of immigrants already in this country. However, the increase of West Africans in Southwest Philadelphia occurred subsequent to the civil

wars and unrest in Liberia, Guinea, and Sierra Leone. CcTC addressed the needs of the refugees dealing with the trauma of war and the violence and loss associated with it.

The West African community has developed a highly visible presence in their Southwest Philadelphia community. A commercial district serving and sometimes owned and operated by the African community has developed in Southwest Philadelphia – particularly in the area of Baltimore Avenue in West Philadelphia and Chester Avenue in Southwest Philadelphia. The area is home to the African Cultural Alliance of North America (ACANA), established in 1999, a non-profit organization dedicated to supporting African-born residents with social, educational, and immigration issues. (In fact, Tamaa operates from space located in an ACANA facility.)

While not universally the case, many of the West Africans who now live in Philadelphia were educated and had careers, professions, and businesses in their homeland.<sup>18</sup> However, due to the challenges of acculturation, language, loss of documents and certification of knowledge and skill, refugees often find it difficult to secure work that reflects the level and experience of employment in their native countries. This creates economic difficulty as well as issues of self-confidence, exacerbating the already stressful situation the refugee experiences.

While some other African countries have been making progress in establishing peace, adhering to human rights laws, and social and economic stability and growth, these three West African countries continue to struggle with ongoing tensions as well as the aftermath of civil war. Peace-keeping forces remain to provide additional security; lack of food, electricity, clean water, transportation, and jobs impede economic growth. Inadequate health care is an ongoing concern. With the recent recession, on the heels of civil wars, conditions have actually worsened. Thousands of those displaced over the past decade have not returned to their country of birth. Awareness of these realities that impact family and friends is yet another source of stress for the West African community in Southwest Philadelphia.<sup>19</sup> A comparison of demographic and economic data for these countries, with those of the

United States, clarifies the disparity and seriousness of the conditions in West Africa.<sup>20</sup>

## War, Displacement, Resettlement ~ The Children's and Families' Experiences

According to the U.S. Committee for Refugees, West African refugees' homes and communities/villages were destroyed; sexual violence was rampant; children were recruited as soldiers; and civilians were kidnapped, beaten, and killed. In Liberia, for example, there were 15,000 child soldiers – many coerced to participate in violent actions.<sup>21</sup> Young people and children were especially victimized. Many were killed, injured, orphaned, or abandoned – witnessing atrocities during the strife in their own communities and again in the refugee camps where they sought shelter.<sup>22</sup>

CcTC quickly discovered that many of the West African children and families who had resettled in Southwest Philadelphia had faced numerous and repeated traumatic events in their homelands, including witnessing and participating in the armed conflict; witnessing the murder of family members and friends; witnessing torture, including the amputation of individuals' body parts; being forced to perpetrate violence against loved ones; experiencing physical or sexual assault; being separated from family members and being unsure of their whereabouts; and having their home and possessions stolen or destroyed. Many also were forced to travel by foot for days under very dangerous conditions in order to escape the violence.

Many ended up in refugee camps in neighboring countries, where they lived for years under very difficult conditions (e.g., lack of privacy; overcrowding; inadequate food, water, clothing, shelter, sanitation, medical care) before being admitted to the United States. Many faced further trauma and loss while living in the camps. It was not uncommon for the West African refugees to have loved ones die of disease and malnutrition in the camps. The refugees also often experienced tension and violence between rival ethnic or tribal groups residing side-by-side in a given camp. The camps also had inadequate educational facilities and opportunities for the refugee children.

Unfortunately, once the West African refugees arrived in the United States and resettled in Southwest Philadelphia, their challenges did not end. In addition to their complex histories of trauma and loss, they now had to negotiate the difficult acculturation process in a highly stressed urban environment. The resettled West Africans faced significant language and cultural barriers, and they often were the targets of prejudice and discrimination in their new community. The West African caregivers often worked multiple low wage jobs in order to meet their families' basic needs, as well as support family members back in West Africa. The West African children were often teased, bullied, and physically assaulted by their non-refugee peers in school and in the neighborhood; they struggled academically, as many had limited prior formal education; and many were forced to keep difficult family secrets, often being told by caregivers to lie about their real ages and family relationships.

Refugee children and families, such as those West Africans who resettled in Southwest Philadelphia, clearly are exposed to significant stressors, including repeated traumatic events, throughout their pre-migration, flight, and resettlement, that can greatly impact their mental health. Numerous studies have documented, for example, that refugee children experience a wide range of symptoms including anxiety, nightmares, insomnia, enuresis, depression, relationship problems, behavioral problems, aggression, attention problems, academic difficulties, anorexia, and somatic problems (Allodi, 1980; Allwood, Bell-Dolan, & Husain, 2002; Arroyo & Eth, 1985; Cohn, Holzer, Koch & Severin, 1980; Gibson, 1989; Hejrn, Angel, & Hojer, 1991; Kinzie, Sack, Angell, Manson, & Roth, 1986; Krener & Sabin, 1985; Williams & Westermeyer, 1983). Moreover, Lutsig et al, (2004) have reported a high prevalence of posttraumatic stress symptoms in refugee children, with studies showing symptoms in 50 – 90% of refugee children. Knowing the number of traumatic events and stressors that the refugee children and families face and the high levels of posttraumatic symptoms seen in these populations, many refugees clearly are in need of quality, trauma-focused and trauma-informed treatment.

It is important to note that despite their significant needs, most West Africans in Southwest Philadelphia had little to no contact with any mental health or social service agency in Philadelphia before their involvement with CcTC's Tamaa Program, largely due to the fact that traditional mental health and social services were not designed in such a way that they would be culturally acceptable or accessible to the West African refugees. The majority of the services were not available directly in the refugees' community, which they were afraid to leave; and the service providers did not employ staff who were West African, understood the culture, or spoke the languages and dialects of the those West Africans who had resettled in Southwest Philadelphia. Also, very few of the West African families had medical or mental health insurance coverage, even when they were entitled to it, thus adding yet another barrier to service utilization. Those few who sought help were often turned away from service due to lack of insurance. Moreover, the mental health system in this country was not familiar to the West Africans who often held different beliefs about mental health and illness than are the norm in the United States. This would be CcTC's challenge.<sup>23</sup>

## Identifying Partners and Forging Partnerships

The initial core workgroup, drawn together by the teacher whose call triggered CcTC's involvement, was led by CcTC. The working group was comprised of a school committee that included Tilden Middle School administrators, teachers and counselors, leaders from the West African community, and mental health/social service professionals with experience working with refugee populations.

### Teachers and Staff from Tilden Middle School

Despite the initial reluctance of many at Tilden Middle School to support or participate in the Tamaa Program, teachers and staff eventually partnered with CcTC and ACANA. These teachers and staff members recognized that the West African children needed help and that the school climate would not improve without such help. Their participation was invaluable in bringing Tamaa to fruition.

## ACANA

The initiating teacher was acquainted with the African Cultural Alliance of North America (ACANA), and invited their participation in the new efforts to assist the West African students at Tilden Middle School. ACANA, through the leadership of Voffee Jabateh and Alphonso Kawah, had earned the trust of the West African immigrants and refugees who had made their homes in Southwest and West Philadelphia. ACANA not only had established a presence in the community, but also had a building which housed its office and staff, as well as community activities and programs. CcTC clearly recognized that ACANA served as a cornerstone for the West African community and was trusted by and familiar to them. Eventually, the decision was made by CcTC and ACANA to co-locate the Tamaa Program at the ACANA site; this allowed both organizations to provide the services they were best suited to offer, and facilitated CcTC's entrée into the community.

## Funding

Though CcTC was deeply engaged in extensive research to learn about the West African refugee community and possible trauma treatment models for refugees in order to frame a model for services and intervention, they recognized the importance of securing financial support for what would be a critical and substantial intervention initiative. Coincidentally, the Substance Abuse and Mental Health Services Administration (SAMHSA) was leading a nation-wide effort to improve mental health treatment for children and adolescents who had experienced trauma, the National Child Traumatic Stress Initiative (NCTSI). CcTC submitted a proposal to develop mental health services for the West African children and their families in Philadelphia. In 2002, SAMHSA awarded CcTC a three-year grant to fund its development and to support start-up services for this community.<sup>24</sup> Most significant was that the grant included funds for planning – so that CcTC, working with partners, was able to engage in the sophisticated research and planning needed to design and implement an effective model for intervention and treatment.

In addition to the SAMSHA funding, CcTC sought supplemental funding for the Tamaa Program from a number of foundations. The organization was successful in securing two year grant funding in 2003, from both the First Hospital Foundation and the Victory Foundation. In 2005, all grant funding ended, and CcTC was able to secure funding from more traditional and sustainable funding streams, including Philadelphia's Department of Human Services, and Philadelphia's Department of Behavioral Health including the Office of Mental Health and Community Behavioral Health to fund most Program components. The exception to this was the three year funding that the Robert Wood Johnson Foundation provided, in 2007, for the School Trainings.

## Barriers Overcome/Lessons Learned in the Community Assessment Process<sup>25</sup>

- Don't expect easy access! Even though the purpose of the intervention is the well-being of the child, advocacy and support by external groups is not always welcome.
- Don't go it alone! Identify potential partners and create allies who will assist in securing access. Collaborate with those they trust.
- Do your homework – make sure you understand the clients and their community. Make time for extensive research – this helps you avoid being blindsided along the way.
- Recognize and remind others that when you provide special help to one group in a community this support can change the overall climate – and benefit everyone in the community.
- Seek funding that includes support for planning. Thorough planning can make the difference between success and failure.
- Establish positive relationships with your local mental/behavioral health funding streams and include them as advisors. Not only will their knowledge and skills enhance the program, but their commitment to and ownership of the program is critical in assisting with long term sustainability.

## SECTION TWO

### Formulating the Tamaa Model

Tamaa, a community- and school-based program, was established in 2002 to meet the mental health and social service needs of Southwest Philadelphia’s West African refugee children and their parents/caregivers. Designing and implementing such a program required extensive research, brainstorming, planning, and ongoing evaluation and modification; and, this work was done in a climate that inherently demonstrated respect for the clients, compassion and understanding, and willingness to collaborate with others. While the program is an intact unit, it integrates several elements to complete the whole. The Tamaa Program components, while described separately in this guidebook, were developed concurrently. All of the components were and are key to Tamaa’s success. This section describes the components and the processes employed by CcTC in designing and implementing the program.

CcTC’s careful analysis of existing research, their extensive and long-term experience working with children in need of therapeutic treatment for trauma, and their growing knowledge of Southwest Philadelphia’s West African refugee community, led to the decision that a successful intervention model should include both school-based and community-based elements that would:

- Provide appropriate treatment for traumatized children (Children’s Trauma- and Grief-Focused Therapy Groups);
- Provide training for school teachers and staff to ensure greater awareness of the refugee children’s experiences and culture, and enable them to improve children’s learning experience (School Trainings);
- Provide information and support for the parents/caregivers of the West African children (Caregiver Education and Support Group);

- Increase awareness of and access to services and programs available to the families through community and government services (Case Management Services);
- Create opportunities for the refugee families and the residents of the Southwest Philadelphia community to get to know one another and work together for the betterment of their community (Multicultural Community Events).

### School Based Components

The school-based components were considered essential. The school setting forced interaction between West African refugee children and American-born students as well as the teachers and staff. Indeed, negative interactions in the school environment often led to conflicts in the community. Clearly, as reported by school personnel and students, school-based conflict impeded learning in the classroom.

As a result of considerable research, consultation, and strategic assessment, CcTC determined that school-based program components would target two groups: the West African students with greatest need of therapeutic treatment, whose parents/caregivers would consent to their children’s participation; and the teachers and staff who worked with the students and were willing to participate.

### Children’s Trauma- and Grief-Focused Therapy Groups

Before treatment could begin, several questions required answers:

- How might the target population – those in greatest need of therapeutic treatment – be identified?
- Once the children are identified, what strategies would secure parental consent for screening the children and allowing them to participate in a therapy group?
- What screening tools should be employed?

- What group treatment model should be employed to serve these children?
- How might the efficacy of treatment be evaluated?

The target group of West African refugee children had been narrowed to include those who attended public elementary and middle schools in Southwest Philadelphia, who had been exposed to war-related trauma, and who were struggling with acculturation.

CcTC utilized the procedures established by the School District of Philadelphia’s Institutional Review Board (IRB) to secure approval for acquiring complete student rosters for schools which enrolled significant numbers of the West African children. Since the School District did not differentiate among the students in terms of national origin, painstaking review of the student lists was required. The review to identify potential candidates for the therapeutic program included CcTC Case Managers, and consultation with classroom teachers, ESL teachers, and other school faculty and staff. This effort produced a list of possible candidates. However, the process did not always work as intended. – on a few occasions the process “identified” children who were neither refugees, nor from West Africa. And, sometimes, as a result of the challenging identification process, a West African child was “missed” – however, provisions were made to enroll these children as they were identified through referral.

Once the lists were compiled, Case Managers then secured contact information such as parents’/caregivers’ names, addresses, and telephone numbers. The Case Managers – sometimes going house-to-house – sought contact with the identified child’s parents/caregivers to arrange a meeting in the child’s home to review the program and get signed consents to assess the child and to allow the child, if deemed appropriate, to participate in a Trauma- and Grief-focused Therapy Group.

This was an extremely challenging process that did not end with identification of West African children as possible candidates for the therapeutic program. As noted in Section One of the guidebook, the West African parents/caregivers were also coping with the challenges of relocation and acculturation. Many had been victimized

by “officials” in their native countries, and so there was a reluctance to engage “outsiders” in the United States; most of the families did not utilize any social services that were available in the Southwest Philadelphia community. While some families, as a result of referral/introduction by trusted community leaders, were willing to meet with the Case Managers, at least initially, others were reluctant to do so. However, CcTC went to great lengths to ensure that the Tamaa Case Managers, too, were born and had lived in West Africa so they understood the culture and languages/dialects of the West African refugees. Some of the Case Managers had personally experienced the trauma of war and displacement and had come to the United States themselves as refugees. In addition, CcTC employed “cultural consultants” who were from West African countries other than those of the Case Managers, as needed, to better communicate with and serve the diverse population of West African children and their families. Over time the reputation of Tamaa and respect for the Case Managers made access less difficult, but Case Managers continue to work in atypical ways to engage the families of refugee children. For example, they continue to have to approach families directly and offer services, rather than wait for families to self-refer.

During the home visit, the Case Manager explained the purpose of Tamaa and sought consent for CcTC to assess the child and for the child to participate in the Trauma- and Grief-focused Therapy Group, if considered clinically appropriate. The Case Managers often used the opportunity provided by the initial home visit to make other social services available to the West African family, and secure signed consent for the additional services as well. The consent forms presented to the families’ generally included:

- Consent to allow the child to be assessed by CcTC;
- Consent to allow the child to participate in the therapeutic group;
- Consent to allow the child to be photographed, and audio- and video-taped; and
- Consent for the family to participate in Case Management Services.<sup>26</sup>

This was often a difficult step for the parents/caregivers to take – for they had little if any knowledge about or experience with the mental health system back home in the West Africa. Many viewed mental health services as being appropriate only for “crazy” (severely thought disordered) individuals. To get the families to consent to services, the Case Managers had to avoid using the term “mental health” and needed to emphasize how the children’s participation in group could improve the child’s success academically and socially. The fact that the therapeutic treatment would occur at school and during the school day, did contribute to obtaining the parents’/caregivers’ agreement; they had some familiarity with the notion of the child receiving “help at school,” and since the groups were held during the school day participation did not require them to transport the child. As the West African families and community witnessed the positive impact of the therapeutic treatment on the children, there was less reluctance to allow children to participate.

### Developing the Child Assessment Form

The Children’s Trauma- and Grief-Focused Therapy Groups were designed to help the West African refugee children:

- Process war-related trauma, displacement experiences, and acculturative struggles;
- Identify strengths and resources, personal and cultural;
- Develop skills to promote positive interaction with peers; and
- Decrease feelings of isolation.<sup>27</sup>

In order to better understand the experiences of each child identified, as well as ensure that the child needed the therapeutic treatment, an individual assessment/screening was essential. Clearly, the vehicle for assessment had to be carefully selected or designed to address the child’s history of war trauma, displacement, and acculturative stress, as well as the child’s social, emotional, and behavioral functioning in their new school and home environments – in a culturally competent and sensitive manner. CcTC researched and

reviewed existing tools designed to facilitate productive assessment of children suffering from the trauma of war and displacement. One of the more useful models was the War Trauma Screening Scale, developed by Lane and Saltzman.<sup>28</sup> CcTC initially adapted this measure for use with the West African children, but upon pilot testing with the West African children of the Tamaa staff, it was found to be too long, detailed, and intrusive to be used successfully as a screening measure in a school setting.

CcTC therefore decided to design an assessment instrument that would better serve the needs of their clients. The assessment tool was developed with the involvement of the West African staff, to ensure cultural sensitivity, and was pilot tested prior to being used with the West African refugee children. Over time, the assessment form has been modified based on feedback from the clinicians using the screening forms with the West African children in the schools.<sup>29</sup> There are two forms that are now used – one for elementary and one for middle school children.<sup>30</sup> CcTC also developed and utilized a supplemental form which parents/caregivers of elementary school children would complete, since younger children were not always able to provide comprehensive information.

Using the format of the carefully structured assessment interview, the information gathered from the children included:

- Basic personal data
- School experiences
- Home/community life
- Academic/acculturative stress
- War trauma history
- Coping skills, strengths and resilience

### What the Assessment Revealed

The assessments revealed that most children experienced a long, difficult journey from their homelands to Southwest Philadelphia. Virtually all the children’s families were impacted by the death, disappearance, and/or loss of loved ones. Most children experienced dangerous escapes from their homes, some walking many miles on foot to

safety. The majority of children spent several months in over-crowded refugee camps with inadequate food and poor sanitation. In the U.S., they experienced their schools and neighborhoods as unfamiliar and threatening. Because many children did not have formal schooling at home, they often found school work frustrating.

The signs and symptoms of trauma varied among children, and caregivers reported a range of mood and behavioral symptoms including: nightmares and difficulty sleeping, changes in eating habits, inattention, and preoccupation with the war/conflicts in their homelands, isolation, problems in school, anger and aggression, and somatic complaints.

The information gleaned from the assessments was consistent with that reported in the literature on war-related trauma. The assessment substantiated that the majority of children interviewed were in need of trauma- and grief-focused therapeutic treatment. In fact, 86% of the children assessed during the 2003-2004 school year were in need of the proposed support. Information gathered in the assessment provided the underpinning for each child's diagnosis and treatment plan, which was developed by a CcTC trauma therapist.

### **Designing the Trauma- and Grief-focused Therapy Groups**

CcTC committed significant time, research and planning to determine what group treatment model would be employed. Key research areas included:

- The beliefs held by Africans regarding mental health and treatment for mental health;
- The type and availability of mental health treatment and treatment programs in Africa;
- Global issues surrounding the mental health and treatment of refugees;
- Historic evidence of mental health issues of adults and children exposed to war, and;
- Evidence and success of children's group therapy models, especially group treatment models.

It was not until the early 1990s that war-related trauma

and posttraumatic stress disorder (PTSD) was given serious consideration.<sup>31</sup> Much of the early work was based on studies of the impact of war on children in Eastern Europe. As CcTC began the process of developing a therapeutic treatment model for the war-traumatized West African refugee children in the target community, it became immediately obvious that there was no simple empirically-supported treatment approach, which was acknowledged in 2005, by the Refugee Trauma Task Force of the National Child Traumatic Stress Network (NCTSN) in their White Paper Committee Report (2005) which noted<sup>32</sup>:

“...little information exists with respect to what mental health interventions are effective for traumatized refugee children, with no clinical controlled trials conducted with refugee children in resettlement reported in the literature.” (p.3)

In addition, when a treatment approach was found to be effective with one cultural group, it could not be assumed that it would be effective with a different cultural group. Also, while many refugees exhibited symptoms of trauma, few received mental health care. This was true globally, not only in West Africa. Many of the reasons for the absence of care have been noted in other sections of this guidebook – the cultural stigma associated with mental illness and treatment; inadequate finances or lack of insurance, thus making payment difficult or impossible; and a paucity of clinicians able to communicate in the native language of the refugee.<sup>33</sup> Clearly, any treatment model or intervention necessitated that these barriers be addressed.

There was consensus among those providing therapeutic treatment for refugees about the elements that were critical to providing a model for effective therapy. The treatment should be community-based and comprehensive – providing venues for access to other available services for the refugee family, and assisting the acculturation process by helping families cope with the stress and challenges of resettlement. Schools and culturally sensitive trusted community centers were suggested as appropriate sites for treatment and intervention. The importance of ensuring that staff were not only culturally sensitive, but

were able to communicate in the language and dialects of the refugee population to be served, was stressed. Clearly, the consensus model links basic social services to mental health needs of refugees. Basic needs must be met for the refugee families – needs such as food, clothing, shelter, medical care, education and employment, if the intervention is to be successful.<sup>34</sup>

Among the models examined by CcTC during its exhaustive search, the UCLA Trauma/Grief Program for Adolescents, developed by Layne and Saltzman, seemed to be the most appropriate, and there was empirical support indicating significant reductions in PTSD, depression, and complicated grief, and improvements in school functioning.<sup>35</sup> This model was school-based, short-term (16-20 weeks), and used a manualized group treatment model. It had been designed for traumatized and/or bereaved youth (ages 11-18), who had been impacted by accidents, community violence, natural and man-made disasters, terrorist events and war, and had been used domestically and internationally.

While the UCLA model could be used as a starting point, the model did not address the specific cultural or developmental needs of the West African refugee children in Southwest Philadelphia. CcTC made adaptations based on the clients' needs and also based on feedback they received from a focus group held locally, during the summer of 2003. For the focus group, CcTC structured four activity-focused children's sessions, which were facilitated by two trauma clinicians. The group was comprised of several West African children from Tilden Middle School and their younger siblings; ten children participated all together (six girls, four boys). The group provided a great deal of information that assisted in the development of CcTC's Children's Trauma- and Grief-focused Therapy Group Model, including:

- Groups must occur at school during the day, due to parent/caregiver work schedules and transportation needs;
- Groups must include activities such as art, music and movement, to allow the children to express

themselves and reduce tension in a culturally familiar manner;

- Children in groups need to be separated by age; activities, information-sharing, concepts, and discussion appropriate to middle school children may not necessarily be appropriate for children of elementary school age;
- Groups for middle school-age children need to be gender-specific to improve group productivity and to allow a more comfortable setting for discussions of sexual violence that the children may have witnessed or experienced;
- Group facilitation needs to address the many cultural and tribal, language/dialect differences, even for West African children who had lived in the same country; and
- Groups need to find a ways to ensure privacy/confidentiality since group members were peers in the same school setting.

For the Trauma- and Grief-Focused Therapy Groups, prior to beginning each group cycle, every child participant was assessed by a CcTC trauma therapist and the therapist then developed a treatment plan for each child. Each Trauma- and Grief-focused Therapy Group was comprised of 8-10 children. The program continued throughout the school year, meeting weekly, and a new cohort of children was identified to participate prior to the beginning of each new school year.

There were three facilitators for each Group: One lead facilitator, who was an experienced TAP clinician/trauma therapist, and two assistant facilitators. CcTC designed and implemented the model so that one of the assistant facilitators was West African with experience in mental health or a mental health-related field; the other was a graduate student intern. While it was the rule that everyone speak the English language during the Group sessions, from the onset, CcTC engaged West African co-facilitators to assist with language issues that arose, as well as to ensure cultural sensitivity and awareness.

Tilden Middle School was the site of the first Trauma- and Grief-focused Therapy Groups, but in subsequent years other schools serving West African refugee children were identified for providing Therapy Groups. The schools

included Mitchell, Morton, and Patterson Elementary Schools.<sup>36</sup> West African refugee children attending these schools that were identified as appropriate candidates for the Trauma- and Grief-Focused Therapy Groups were served annually from the 2003-2004 academic year through 2008-2009 school year. The Trauma- and Grief-focused Therapy Groups were discontinued in the fall of 2009, as the majority of the West African children we screened were born in this country and had no history of direct war-trauma exposure, as the war has now been over in Liberia since 2003.

### The Trauma- and Grief-focused Therapy Group Curricula

CcTC designed and implemented two distinct curricula for the Trauma- and Grief-focused Therapy Groups – one for elementary school-age and one for middle school-age children. Each consists of five modules, which were employed over a 28 week program. The five modules include:

- Establishing group structure and building group cohesion;
- Enabling the children to understand the responses that can be expected after trauma and loss and to learn about basic coping skills;
- Working through the impact of the war trauma experience;
- Working through loss and grief; and
- Ending the group experience and planning for the future.

The middle school curriculum was first developed during the 2002-2003 school year, and modified for the 2003-2004 school year. In school year 2004-2005, the curriculum was adapted to serve elementary school students. The key components for both the elementary and middle school curricula include the following modules and associated objectives:<sup>37</sup>

#### *Module 1: Establishing Group Structure and Building Group Cohesion*

- Introduce and discuss purpose and goals of the Group;

- Build trust and establish Group cohesion as well as individual identity;
- Establish group rules and emphasize privacy and confidentiality;
- Stress importance of physical and emotional safety in Group;
- Provide guidelines and consequences for unsafe behavior in Group;
- Educate about responses that may result from traumatic experiences;
- Explain the value of trauma-focused treatment, and;
- Assess each group member's current trauma-related symptoms and level of functioning.

#### *Module 2: Education Regarding Expected Responses to Trauma and Loss and Learning Basic Coping Skills*

- Educate – extensively – regarding expected responses to war trauma;
- Provide opportunities to identify personal trauma reminders/triggers;
- Validate group members' stress-related experiences and reactions;
- Teach basic skills for coping with trauma-related stress (e.g., conflict resolution skills, relaxation training);
- Teach to differentiate thoughts from feelings and reactions, and;
- Teach strategies for substituting helpful thoughts for unhelpful thoughts.

#### *Module 3: Working Through the Impact of War Trauma Experience*

- Provide safe ways to share traumatic experiences in Group;
- Expose (gradually) group members to trauma-reminders and practice skills for coping with trauma reminders;
- Describe common trauma-related cognitive distortions;
- Discuss and challenge group members' own specific cognitive distortions, and;
- Develop and practice problem-solving skills for managing difficulties of day-to-day life as commonly experienced by refugee children.

*Module 4: Work Through Loss and Grief*

- Psycho-educate about common reactions to grief and loss;
- Validate group members’ loss-related experiences and reactions (e.g., loss of loved ones, homeland, previous life style);
- Provide opportunities to identify personal reminders of grief and loss;
- Provide opportunities to process anger, sadness, and other emotional reactions to loss;
- Encourage group members to re-build non-traumatic memories to include both positive and negative aspects of loss, and;
- Continue to practice problem-solving skills for day-to-day difficulties.

*Module 5: Ending the Group Experience and Planning for the Future*

- Identify what group members have gained from the group experience;
- Identify what has been learned from being war trauma survivors;
- Examine how trauma experiences have strengthened the group members;
- Emphasize thinking beyond trauma survival to future-oriented possibilities and personal life goals;
- Identify potential sources of post-group support;
- Teach/practice effective ways to ask for needs to be met in the future, and;
- Develop and practice skills for saying goodbye in a constructive way.

**Assessing the Impact of the Trauma- and Grief-Focused Therapy Groups**

A major aspect of planning and designing a therapeutic treatment model requires evaluation of the efficacy of the model. CcTC determined that it was critical to measure the following:

- Was the program able to reduce the child’s self-reported trauma symptoms?
- Did the child report liking the program and was the child able to identify ways the group positively impacted their life and functioning?
- Was the program having a positive impact on the child’s functioning in his/her “world”?

CcTC formulated strategies to secure both formal and informal data to answer these questions to monitor process as well as to determine the overall effectiveness of the program. The UCLA PTSD Reaction Index to measure the presence and frequency of trauma symptoms was identified as a result of extensive research conducted by CcTC.<sup>38</sup> There are three versions of the Index: child (ages 7-12), adolescent (ages 13+), and parent versions. CcTC utilized this Index during the first two years of the program, administering it to the children in the Groups, during sessions 4 and 24. CcTC choose to wait until the 4th session to give the children a chance to better understand and acclimate to the group. CcTC recognized that the UCLA PTSD Reaction Index was not adequate to meet the needs of the West African children – the language was too complex, and it was difficult to use in the school setting, with time limitations. Subsequently, CcTC switched to using the Trauma Symptom Checklist for Children (TSCC) and began utilizing this index during year three of the program.<sup>39</sup> While shorter and less complex than the UCLA PTSD Index, this too proved difficult for the children to complete, even with assistance. Furthermore, neither of the instruments employed was culturally appropriate. However, CcTC was able to glean some information from these evaluative instruments.

To evaluate the children’s satisfaction with the program, CcTC developed the West African Student Satisfaction Survey, which was administered in session 25. On this measure, all participants reported liking and benefiting from group in varying ways.

CcTC also collected and analyzed school data, such as grades, attendance, and suspension, to assess improvements in the children’s in-school functioning. Other measures included securing more informal and subjective, though critical, information:

- Positive outcomes observed by Group leaders
  - o Observable coping skills (e.g., use of feeling words, conflict resolution skills)
  - o Increased pride in the West African culture
  - o Closer peer bonds among group members
- Positive feedback from teachers
  - o Improved language and social skills

- o Increased engagement in the classroom
- o Improved peer relationships
- Feedback from caregivers
  - o Children felt cared about in school
  - o Children had more support and protection
  - o Improved identification of children’s needs and connection made to appropriate resources
- Feedback from the children
  - o Informally shared comments

### **The Impact of the Trauma- and Grief-Focused Therapy Groups on Child Participants**

In analyzing the information gleaned from the UCLA PTSD Reaction Indices and TSCCs, it became evident that more symptoms were reported later in the program than at the beginning. This was not unexpected because as the children responded to the treatment and trust grew, the children were more comfortable sharing accurate information. This has been supported by Dyregrov, et al., (2002), who noted in his research that children often exhibited a denial of trauma and PTSD.<sup>40</sup> In fact, many of the children had been told by caregivers and others to forget about the war. In any event, it quickly became apparent that the impact of the war-trauma on the children was far more prevalent than the parents imagined.

Many of the children entered the group with low self esteem – having been teased in class for being a refugee, for language differences and for sounding different, even if they spoke English. Some children responded to confrontations by forming their own “gangs” to respond to physical and verbal abuse by other students in the community.

Observations and comments by Group leaders, classroom teachers, school personnel, parents/caregivers, and the children themselves reflected positive attitude and behavioral changes. Some of the observations reported include:

- Children “liked” the program, especially enjoying the use of activities that were culturally sensitive and familiar, as venues for the therapeutic work/

- concepts; the use of West African art and music lessened the tension and enhanced the West African cultural experience;
- Children were less angry; there was less fighting between West African refugee children and African American children, and more positive interaction was observed; principals reported significant decrease in the need for disciplinary action;
- Children were able to speak English more easily, even those with little English-speaking ability; this was intentional and attributed to the commitment of the Group co-facilitators who helped those with language skills manage within group;
- Parents expressed gratitude for what was being done to help their children;
- Teachers reported that the West African children who participated in the program made better progress in the classroom.
- Children successfully “bonded” within the group – understanding that lots of “little fish” can sometimes stand up to the “shark”; as a result, they watched out for each other!
- Children exited the program with more self-respect.

CcTC clearly designed and implemented a therapeutic treatment model that enabled the children’s strengths to emerge and encouraged their use.<sup>41</sup> And, while in the Group, the children were encouraged to talk about what could happen to children during war, so that the children were able to share without the need to expose their own stories – though many did. While the numbers of children served by CcTC’s therapeutic sessions were relatively small, the impact was significant.

As found with many refugee groups, the needs of this population have changed over time. Although acculturation issues are still evident, CcTC began to find that the elementary and middle school aged children whose families are from West Africa were largely born in the United States as opposed to West Africa. These children did not directly experience the war-related trauma and associated displacement experiences, and therefore, are no longer in need of the trauma- and grief-focused groups.

This is not to say that these children do not continue to have significant behavioral health and social service needs. The children and families continue to struggle to adapt to their Southwest Philadelphia community, a community that has endemic struggles of its own. Many if not most of the parents/caregivers work multiple jobs to financially support their families. Consequently, the children's afterschool activities are unstructured with limited adult supervision. CcTC is well aware that unstructured afterschool hours place children at high risk, and is therefore developing a therapeutic afterschool program that will be provided in Southwest Philadelphia.

### **School Trainings**

As noted previously, many of the teachers who taught the West African refugee children had little knowledge of West Africa or the trauma of war experienced by the West African refugee children and their families. This was patently clear from CcTC's initial contacts with the school leaders and school personnel, and thus CcTC knew even before they applied for funding from SAMHSA that a major focal point of intervention to assist the West African children and families had to involve the children's teachers and other school personnel. CcTC knew that without the participation of the teachers and other school personnel, any intervention to improve the school experience and climate would be limited. With discussion and feedback from school teachers, counselors, and administrators, the School Training component of Tamaa was developed.

The School Trainings were designed to help school staff:

- Understand the impact of trauma on a child's behavior, school performance and peer relationships;
- Gain insight into the cultural backgrounds of refugee students, and;
- Understand refugee-specific trauma and acculturation issues.

The purpose of this Guidebook is to document the design, implementation and impact of the School Training component of Tamaa, so that the lessons learned may be available to other groups serving similar populations. To that end, this intentional focus of the Guidebook is comprehensively addressed in Section Three.

### **Community-Based Components**

While the initial challenge was identified as residing within the schools, CcTC realized that some interventions needed to take place outside the schools if Tamaa was to provide support for the children's families and connect the children with their history and culture, as well as with the larger Southwest Philadelphia community. The Case Management, Education and Support Group for Parents/Caregivers, and Multicultural Community Events / Community Resource components were designed to serve the West African community beyond the classroom.

### **Case Management**

From the very beginning it was obvious that Tamaa needed to provide Case Management if the program was to succeed. As noted previously, many of the West African refugees had not sought the public assistance that was available. Not only were they reluctant to accept support, they were also suspicious of government – many had suffered at the hands of government officials in their native countries. The majority of West African families needed support but often did not know what was available, nor how to access services or support. CcTC recognized that before the parents/caregivers would let their children participate in mental health services, families' basic needs had to be met – and that Case Management would be the cornerstone of the program, since effective treatment was dependent on securing basic, day-to-day needs for the family.

The Case Manager made initial contact with the West African families of the refugee children identified as possible candidates for the therapeutic treatment program. This was the most critical element if the

program was to succeed – for it is the first step in establishing a relationship of trust between the program and the family. To facilitate this, CcTC worked to ensure that the Case Managers employed had skills and training in social work or the social service field, and were native to the West African countries that were home to the Southwest Philadelphia refugees. The CcTC Case Managers understand and spoke the language(s)/dialect(s) of their clients, and understood the culture and the history of their clients. Some personally experienced the trauma of war. The Case Managers also represented the success that is achievable in the United States. In addition, the Case Managers were aware of the resources and services available to the refugees, as well as strategies for gaining access to them.

The Case Managers were valuable information gatherers. As they visited the families in their homes, they learned about the needs of the entire family – including concerns about the children. And, as visitors in the homes, the Case Managers were often able to observe and/or discern conditions that could contribute to the challenges faced by the children in school.

One of the major challenges the families faced was related to finances. Despite the tremendous need for financial and social service support, the West African parents/caregivers were more inclined to work several jobs rather than accept public assistance. In fact, many of the mothers were forced to find work in jobs that enabled them to be home only on weekends. Consequently, many of the West African refugee children were left without adult supervision, and there was seldom anyone available to assist with homework. And, since the parents/caregivers were working, they were unable to visit the schools for conferences or meetings – since most worked in jobs that paid hourly wages that would be lost during absences. Due to these constraints, the children were not able to participate in events after school hours. They could not even take advantage of – even academic support activities since getting home was a problem when parents were unavailable for transport.

The Case Managers worked persistently to build trust – through letters, phone calls, visits to the home –

sometimes seeking out parents/caregivers late at night or on weekends. As trust grew, the Case Managers were able to address more delicate cultural issues – issues that led to teasing in school, such as the need for washing clothes regularly. The Case Managers often became the families’ advisor for coping with daily events – such as safety (guides to using kerosene heaters), health care, job search, ESL/ABE classes, after school programs, and other community resources.

While the Case Managers work was primarily community-based, they also played key role in helping the children within the school setting. The Case Managers worked with teachers and the schools’ principals to help the West African families of refugee children become more aware of and responsive to the children’s classroom needs. In addition, the Case Managers worked with the teachers to get assignments to the child and his/her family so that missed work could be completed.

### **Caregiver Education and Support Group**

CcTC’s initial interactions with the West African community, as well as the original research done prior to applying for SAMHSA funding, made it clear that the West African parents/caregivers needed significant support. The families were experiencing some instability and confusion due to resettlement, and had little information about life in the Southwest Philadelphia community. Through interviews with the parents/caregivers, CcTC’s mental health professionals identified trauma-related symptoms in many of the parents/caregivers, as well as in the children. Consequently, CcTC designed and implemented a mental health component for the adults called the Caregiver Education and Support Group.

The Caregiver Education and Support Group was designed to help West African refugee parents and caregivers:

- Gain a better understanding of how trauma affects their children’s behavioral, social, emotional, and cognitive/academic functioning;
- Process their own trauma and displacement histories;

- Understand how their trauma histories and current stressors may impact their ability to manage day-to-day responsibilities;
- Explore the difficulties both children and caregivers experience in acclimating to a new and dramatically different environment, and;
- Learn about various community resources and services available to them through topical presentations.

The sessions are scheduled bi-weekly, on Monday evenings, and dinner is provided so that participants can come from work, participate, and still be home early enough to attend to family needs. A member of the Tamaa staff representing the culture of the participants and a Parenting Expert are paired to facilitate the Group; parents/caregivers are asked to assume responsibility for establishing a needs-based agenda, and this has served as a vehicle to increase their engagement in the Group. As a result of the needs and leadership of the parents/caregivers, the format has been altered over time. One of the bi-weekly meetings serves as a support group while the other provides needed resource/topical information for the parents/caregivers.

The support format enables participants to discuss and seek support for personal and family challenges, and share memories of the past – cherished and painful. The Tamaa staff and Parent Expert introduce arts/crafts activities drawn from West African culture to facilitate discussion and reconnect participants with familiar elements of their past. These activities include knitting, embroidery, flower arrangement, and music. Participants have expressed that the Group provides a safe and nurturing environment – they have confidence that none of the information shared will be carried outside the group. The Group is deemed a valuable resource because many participants have no one to talk with at home and often enter the Group unhappy but leave the session feeling less burdened with problems.

The monthly topical sessions were established to address this need. The topics have been selected by staff with input from the participants. Workshops have included topics such as:

- Immigration
- Child Protective Services
- Resume writing and job search
- Employment behavior – targeting issues such as requesting time off for child/school needs and illness; giving notice; seeking recommendations
- Adult education to include ESL, ABE, GED, and college
- Job training
- Housing
- Social Services

CcTC has utilized various strategies to motivate parents/caregivers to attend these special monthly workshops. These have included providing dinner, hosting parties, gift incentives, and a certificate for those who regularly attend.

The topical workshops and the support group have been well-received by the West African community. While they were intended as support for the families of those children participating in the Children’s Trauma- and Grief-Focused Therapy Groups, participants have also come from the broader West African community.

### **Multicultural Community Events**

CcTC realized immediately upon connecting with and researching the West African community that the West African refugees needed assistance with acculturation and that interventions were needed to build connections between the West African refugees and the African-Americans living in South West Philadelphia. Some of the activities and events included:

- Annual neighborhood clean up and community barbecue, hosted by Tamaa;
- Tamaa and ACANA co-hosted a community fashion show – open to all residents of Southwest Philadelphia.
- Tamaa co-sponsored Philadelphia’s World Refugee Day;
- Tamaa co-sponsored Philadelphia’s Africa and Haiti Health Fair; and

Tamaa co-sponsored Philadelphia’s Annual Celebration of African and Caribbean Culture.

## Other Key Aspects of Program Development

### Staffing

CcTC well understood that Tamaa required careful staffing, in fact, its very success has depended on the selection of staff. CcTC's own experience, as well as research, made it clear that in addition to recruiting and engaging staff members who possessed the critical professional credentials, experience and skills in mental health and social services, several other characteristics were critical. It is important to employ staff who embody certain characteristics. CcTC sought to engage a team that was:

- Multilingual and literate in the languages/dialects spoken by the refugee community, as well as in English;
- Experienced and successful in adapting to American society;
- Knowledgeable about the culture, history and experiences of the refugee community;
- Respected the West African refugee community and was respected by the community;
- Previously resided in one of the countries from which the refugee community originated.

CcTC was successful in identifying a team of individuals that met their self-set criteria. To ensure involvement of staff selection by the West African community, the leaders of ACANA were invited to participate in the selection of the first team leader of Tamaa, leading to the hiring of Kwame Asante. From the beginning, CcTC and the Tamaa staff have been committed to helping the refugee children heal and develop productive strategies to succeed in life. To that end, CcTC has employed full-time professional staff and cultural consultants with West African roots.

### Advocacy

The leadership role assumed by CcTC in addressing the needs of the refugee children, led to the agency being sought to play a leadership role in the City's efforts to serve the broader African community in Philadelphia. As a result, CcTC contributed to the establishment of the Mayor's Commission on African and Caribbean Affairs,

and the agency continues to be called upon for their expertise with these communities.

### External Advice/Community Connections

Once Tamaa was operating in the community and schools, CcTC determined that it would be useful to establish an Advisory Board, to engage additional partners and to create a group that would provide guidance and support. Careful attention was given to identifying participants and membership has included individuals representing education, government, social services, arts and culture, health care including mental health, community organizations, and the West African community. This effort has been critical in ensuring the sustainability of the services for the West African children and their families. The members of the Advisory Board have been instrumental in securing ongoing support for Tamaa's program components through more traditional funding channels, once grant funding has ended.

Currently, the Advisory Board meets quarterly at the Tamaa office in Southwest Philadelphia. CcTC has worked diligently with the Advisory Board, providing orientation, seeking advice and ensuring full and open communication about Tamaa; this has led to a sense of ownership by members. Advisory Board members take great pride in their affiliation with the Tamaa Program.

### Location

From the onset of this effort, CcTC's goal was to co-locate at a site that would provide easy access, familiarity and security. As noted previously, ACANA had established offices at 5521-21 Chester Avenue in the center of what had become a vibrant business community that served the City's African population. Some of the businesses are African-owned. The West African families that would be served by Tamaa were familiar with the ACANA offices; ACANA offered space for meetings and social gatherings, educational activities and events, and community support and information. Consequently, when Tamaa needed to establish a local identity, CcTC entered into an agreement with ACANA to rent space in their nearby building; Tamaa is located at that site.<sup>42</sup> Staff offices are located at

this location, and the parent/caregiver meetings are held on site.

## Barriers Overcome/Lessons Learned in Program Development

- Do the research and develop a plan first – the product will be better and you will save time in the end.
- Be prepared to develop your own materials and tools, especially when serving a unique population – it is often more effective in the long term.
- Employ a continuous feedback loop – seek feedback, modify, then seek feedback again. This will ensure that the program and services are dynamic – responding to the changing needs of the clients.
- Stay focused on your mission/goals – do not try to do what others do better or engage in activities that would impede achieving your primary goal. Select partners in your community that can provide needed adjunctive services that are outside of your mission.
- Involve community members in the process of identifying and hiring staff – this will eliminate many potential problems.
- Invest in your staff – it builds skill, knowledge and loyalty

## SECTION THREE

### School Trainings

#### Why School training?<sup>43</sup>

From early visits to the Tilden Middle School, it became clear to CcTC that in addition to providing the on-site therapeutic treatment for the West African refugee children, some intervention would be needed for the teachers and other school personnel (e. g., counselors,

nurses, administrators, librarians, other non-classroom personnel). For example, while many of the teachers had West African children in their classrooms, the majority had little real knowledge of the civil wars and unrest that had wracked West African countries. However, the teachers, when consulted, expressed real concern about the behavior of the West African refugee children, which included fighting, verbal harassment, early sexual behavior, inattention, and significant problems with schoolwork. The teachers did not know that the children had been forced to flee their homes, and in most cases, lost years of schooling. The teachers were also concerned and frustrated with the apparent lack of responsiveness of the children's parents, who did not attend parent-teacher conferences or teacher-requested meetings. They did not realize that the parents were often working multiple jobs trying to support their families here in the United States, as well as extended families back home in West Africa, and did not have time for school visits. Few, if any, of the teachers and other school personnel had ever received any training to assist them in their work with children and families from different cultures and countries, let alone those who had experienced war, so they often felt confused and unprepared to handle the situations that arose with the West African children and families. Several of the Tilden Middle School leaders felt that the lack of awareness and appropriate training led to the perception that the teachers and other school personnel were not sensitive or responsive to the children's special needs. Clearly, without the involvement of the teachers and other school staff, any intervention to improve the school climate and experiences for the children would be limited.

With the funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) from 2002 to 2005, CcTC developed an initial school training curriculum, working with a group of Tilden Middle School teachers who were nominated by the school principal. The research conducted by CcTC on West African culture, therapeutic treatment models for refugee children, and school training models as well as thoughtful dialogue with teachers and staff, provided the foundation for curriculum development. The curriculum included topics that focused not only on West African refugee-specific trauma and acculturation issues, but also on educating

teachers about childhood trauma in general. The training sessions were designed to help teachers understand the impact of trauma and violence on children and how to assist traumatized children in the school environment. The initial school training curriculum was offered at Tilden Middle School (during the 2003-2004 school year). CcTC invited and used feedback from these first participants to modify the school training curriculum and then offered the training at Morton Elementary School (during the 2004-2005 school year). In the first two years, the school training served sixty-seven (67) teachers from Tilden, Morton, and other area schools.

The School Trainings were specifically designed to help teachers:

- understand the impact of trauma on a child's behavior, school performance, and peer relationships;
- gain insight into the cultural backgrounds of the West African refugee students; and
- Understand refugee-specific trauma and acculturation issues.

CcTC's proposal to SAMHSA included an evaluation model that incorporated internal and external evaluation. The continuous feedback loop enabled CcTC to modify the school training curriculum and its delivery on an annual basis. Philadelphia Health Management Corporation (PHMC), a neutral third party, was contracted to conduct an external evaluation of the school training initiative through the use of key informant interviews. The evaluation indicated that the participating teachers and school personnel found the sessions on trauma and the West African refugee experience most useful, and requested additional training on strategies that could be employed to increase staff and student empathy for West African students. In addition, participating teachers suggested that better publicity was needed to increase awareness of the trainings, and that greater incentives, such as increased food and the addition of stipends, might increase participation.

As noted earlier, the initial development of the Tamaa Program was funded by SAMHSA. When this grant expired in 2005, CcTC was able to secure funds to continue

all components of the program, except the School Trainings. Consequently, the School Trainings were not provided during school years 2005-2006 and 2006-2007. The Robert Wood Johnson Foundation, recognizing the importance of this training, provided three year support to continue, expand, and improve this component.<sup>44</sup>

### **School Trainings: 2007-2010**

The new and secure three-year funding from RWJF enabled CcTC to re-introduce the training component, as well as expand the trainings to reach more Southwest Philadelphia schools, and therefore more and new teachers and school staff. In addition to Tilden Middle and Morton Elementary, several other schools in the Southwest Regional School District served significant numbers of West African Refugee children. These included:

- Mitchell Elementary School
- Patterson Elementary School
- Pepper Middle School
- Shaw Middle School
- Bartram High School

Each year, a different school hosted the School Trainings, though school personnel from any of the identified schools above could participate. This would allow broader participation, and not burden any one school in terms of long-term space needs.

#### *Recruiting for the School Trainings*

The South Regional School District Superintendent, in collaboration with the area principals, agreed to work with CcTC to recruit participants. CcTC worked with the principal at the host school to identify an advisory committee of school personnel who would work with Tamaa to review the curriculum, the schedule, and any other elements of the Tamaa Program that might impact the school and the West African refugee children. The Tamaa staff was scheduled to meet with school personnel to introduce the Tamaa Program, emphasizing the School Trainings, and invite those interested to participate.

CcTC, in response to suggestions made by early participants, and with the support of the South Regional

School District, was able to provide stipends to participants, as well as credit under Act 48 – enabling teachers to earn continuing education credit for their participation in the School Trainings. CcTC also realized that continuing to provide food/refreshments was essential, if school personnel were to participate in late day trainings that often extended into the dinner hour.

### *The Curriculum*

The curriculum, which was based on the original school training curriculum, was modified by CcTC based on feedback from school personnel. The review and modification process was done annually at the end of each school year, and as noted earlier, each fall the host-school advisory group had the opportunity to adjust/expand the topics and schedule. The School Trainings were offered in seven to eight (7-8) two-hour seminars. The seminars were scheduled throughout the entire school year, usually beginning in October and ending in May. The spacing provided several advantages:

- participants had time to absorb and apply the information from each seminar;
- participants had time to share ideas and network between seminars, building a “class” of learners; and
- Participants’ experiences/questions/concerns could be presented and addressed in subsequent sessions.

The School Trainings funded by RWJF began during the 2007-2008 school year and continued through the 2009-2010 school year. The seminars included:

- Understanding and Responding to Traumatized Children in the School Setting,
- Overcoming Barriers to West African Parental Involvement and Engaging Families in Their Children’s School Experience,
- Understanding the West African Refugee Experience and Its Impact on School and Family Life in the United States (Part I),
- Understanding the West African Refugee Experience and Its Impact on School and Family Life in the United States (Part II),

- Responding to Children with Different Learning Styles and Learning Backgrounds in the Classroom,
- Managing Conflict and Diversity-Related Challenges that Arise in the School Setting (Part I),
- Managing Conflict and Diversity-Related Challenges that Arise in the School Setting (Part II), and
- Understanding and Managing Sexually Reactive Children in the School Setting.

### *Staffing*

CcTC recognized the importance of providing a well-informed, diverse, and culturally informed team of trainers for the School Trainings seminars. The seminars were conducted by CcTC trauma therapists, ACANA staff, mediation trainers, university professors, and Tamaa Program “cultural consultants.” Although the primary criteria was for the trainer to have professional expertise in the topic area, special attention was also given to including trainers familiar with and to the Southwest Philadelphia community, as well as trainers from countries in West Africa – so that participants would have the opportunity to learn about the complexities of the West African experience from those who had direct knowledge and experience.

The Tamaa program staff attended every School Training to lend support, be available to answer questions individual teachers/participants might have about securing help for a particular student or family, and ensure that participants “knew” them and what services were available to the West African refugee children. This served as another means to ensure that the participants were informed about all of the services available within the Tamaa Program.

### **What the School Trainings Were to Accomplish ~**

The School Trainings were considered an integral component of the Tamaa Program. The School Trainings were intended to impact the lives of the children and the school environment, which could be measured through a variety of observable behaviors and outcomes. These included:

- increased utilization of mental health services by West African refugee students and families;
- incorporation of culturally sensitive practices and

interventions in the classroom, such as conflict-resolution or cultural awareness, which would result in reductions of incidents of harassment and violence against West African children;

- increased awareness of the trauma histories and cultural backgrounds of the West African students by teachers, school counselors and nurses;
- increased number of referrals of West African children and/or their parents, to Tamaa or other CcTC's services;
- increased demand by school professionals for additional and more specific training as they developed a greater ability to intervene on behalf of the West African students; and
- application of the information about trauma and culture acquired through training to the general student population.

### *Evaluation*

As with the other components of the Tamaa program, CcTC established protocols for evaluating the School Trainings component. In addition to collecting traditional information, such as numbers of participants from year to year as well as the number of seminars each attended, CcTC utilized a variety of other means for evaluating the impact of the School Trainings.

Initially, CcTC was interested in utilizing pre- and post-testing to determine what the participants knew about the subject matter prior to the School Trainings and what they subsequently learned. However, this plan was never implemented, as the first teacher advisory group gave the Program feedback that this would be insulting to the teachers and likely deter their participation in the trainings. Thus, the CcTC changed their evaluation plan, to only use a trainer created post-test to ensure that each trainer's learning objectives were met by the participants.

In addition, after each School Training, participants were asked to complete the Department of Education's Continuing Professional Education Learning Experience Evaluation Form. These assessments provided immediate feedback that was used to guide the Tamaa staff and the teaching team with regard to content, quality of instruction, and any need for modification or follow-up

for a particular topic. These evaluation forms were used at every seminar during the 2007-2008, 2008-2009, and 2009-2010 school years. Most participants completed this form following training, answered items critically, and appreciated the opportunity to critique the seminar.

CcTC also developed their own questionnaire that participants were asked to complete after each School Training, the Tamaa School Training Evaluation Form. This questionnaire asked more detailed questions about the quality and usefulness of the information presented, the quality of the instructors/team, suggestions for modification, and the anticipated impact the School Training might have on their own interactions with the West African refugee children and their families.

CcTC also recognized the importance of external evaluation and engaged the Public Health Management Corporation (PHMC) to conduct in depth Key Informant Interviews, in June, 2008 and July, 2009. The key informants were identified from those who participated in the majority of the trainings at the host-school – Patterson Elementary School during the school year 2007-2008, and Morton Elementary School during the school year 2008-2009. The purpose of the interviews was to obtain information about the participant's perceptions of the usefulness of the trainings and the impact the trainings may have had on them and on the school climate as a whole. The findings from these two studies have been documented in summary reports.

Additional anecdotal information was acquired in the process of gathering information for the *Guidebook*. This information was gleaned through discussions with CcTC and Tamaa staff, the Tamaa Advisory Board, principals of two of the host-schools, and participants in the focus groups.

### **Impact of the School Trainings**

The participants clearly valued the School Trainings – numbers increased dramatically each year. During the school year 2007-2008, an average of 31 participants attended each seminar. By 2008-2009, the increase was so dramatic that facilities had to be expanded to

accommodate the participants (average attendance was up to 73). This number dropped to 23 during 2009-2010, as the Tamaa program set limits on the number of participants to maximize the learning environment. CcTC limited participant to new teachers who had not previously attended the training and had the teachers sign up in advance on a first-come, first-served basis, with a cut off in attendance of 30.

The Professional Education and Learning Experience Evaluation Form proved extremely useful in enabling CcTC to respond immediately to concerns; in one case, several participants complained about a particular trainer’s presentation and why it was problematic. This information was shared with the trainer, and he made immediate adjustments prior to his next presentation; the next set of evaluation forms noted his improvement – with appreciation.

The PHMC Summary Reports of Key Informant Interviews have provided the most useful and detailed information about the program’s impact. The majority of those interviewed at Patterson Elementary School and all of those interviewed at Morton Elementary School indicated the Tamaa School Trainings seminars were excellent or very good. They noted that the presentations were professionally conducted, extremely informative and according to one interviewee: “...the topics were important ...if we are going to find ways to help the students.” The respondents indicated their appreciation of the Tamaa staff, and noted their presence at each of the seminars. It was the consensus that their new awareness helped them better understand the family dynamics and its impact on school visits by caregivers and completion of homework assignments by students. Several of those interviewed criticized the program – but even the criticism was positive because they were seeking even more support and involvement by Tamaa. For example, those interviewed were concerned that some of the West African children did not participate in the Trauma- and Grief-focused Therapy Groups – they felt that all the children needed the therapy, including African-American students who were exposed to violence in their lives. They also wanted Tamaa to conduct school-wide assemblies at all the schools in the South District – to

address issues of culture and school violence in general. Many of the informants noted that as a result of the trainings they were better able to identify students who needed help and referred them to Tamaa. According to the PHMC Summary (2009), “One of the most telling of the informants’ comments about the trainings is their request that the Tamaa Program return next year.”

The focus groups and interviews that were conducted during the development of this *Guidebook* provided additional evidence of the School Trainings successes. The principals at Morton and Patterson Elementary Schools were strong proponents of the Tamaa program in general, and the School Trainings in particular. The principals reported they observed significant improvements in the school environment subsequent to the School Trainings: there was a dramatic decrease in the number of West African children who were sent to the principal’s office for classroom disciplinary problems, which the principals attributed to the teachers’ increased understanding of the challenges the children faced, their improved ability to manage classroom behavior and conflict, and the children’s behavior change linked to participation in the Trauma- and Grief-focused Therapy Groups; teachers were more likely to seek support from Tamaa staff in communicating with parents/caregivers when needed, and the teachers had a greater understanding of the challenges the parents/caregivers faced; the school climate changed, with less taunting/fighting between West African and African American students, due in part to the tone set by the teachers in the classroom. The principals felt that once the teachers and other school personnel understood what the West African refugee children had experienced, they saw the children and their behavior differently, and were more willing to help the children overcome the barriers to learning. The principals also thought that it was important for the school administrators to endorse participation by attending the School Trainings themselves– which both did. As one principal noted, the success of the Tamaa School Trainings can be measured by the increasing numbers of participants, until limits were set, with many traveling to other schools in order to attend the seminars (many of the School Trainings participants in 2008-2009 which was hosted at Morton Elementary School, worked at Patterson Elementary School). The principals

noted that the support for West African children and the School Trainings had an impact on the entire school environment; nonparticipant teachers learned from those who did participate, and the changed classroom environment had a positive effect on the entire school. They also reported that the children who attended the therapy groups were less aggressive, almost immediately. The principals indicated that subsequent to the School Trainings, there were fewer parent/ teacher conflicts, and fewer parent complaints.

During the focus groups with School Trainings participants, strengths and concerns were shared. The participants' valued the School Trainings experience, citing their increased knowledge and awareness of West African history and culture, as well as their improved understanding of the challenges faced by their West African refugee children. They also noted their regard for the work of the Tamaa Case Managers who assisted them in their efforts with the children and their families. Many indicated that it would be useful for Tamaa to offer a follow-up training/workshop for those who had participated in the School Trainings seminars; they sought ongoing opportunities for shared problem-solving and techniques/strategies beyond what was provided in the seminars. Some participants noted that they had not been trained in recognizing or addressing classroom issues related to mental health and acculturation challenges – until Tamaa. The participants also valued Tamaa's responsiveness to concerns; for example, concern was expressed that too many participants were repeating the training, causing some conflict/crowding for first-time participants. Tamaa staff modified the guidelines to register only first time participants. Most notable, the participants wanted "more" – more training for themselves, more workshops for the children, and expansion of Tamaa to all the schools' students. Clearly, the school community has valued their Tamaa program experience.

Interviews with Tamaa staff provided special insight, because of their relationship with the children, their families, and the school communities. Initially, the teachers were reluctant to allow Case Managers to intercede with the students or families. Once teachers participated in the School Trainings, they welcomed the

assistance of the Case Managers, often referring children to Tamaa services, including consideration for the Trauma- and Grief-focused Therapy Groups. The staff reported that subsequent to the School Trainings teachers offered children extra help and made a point to sit next to the children while they were working on assignments in class. One of the more rewarding outcomes noted by staff was that the children became more comfortable, secure, and self-confident, which was manifested as children expressed less fear in going to class, and made more positive comments about the classroom experience, such as "...I like Ms. \_\_\_\_\_. She listens to me and helps me with my work." Ms. \_\_\_\_\_ participated in the School Trainings! Several staff members also recommended that a therapist be available at least several days a week in the school to provide not only group treatment services, but to meet with individual students as well.

### **School Trainings as Integral to the Comprehensive Tamaa Program**

When the Tamaa Program was conceived by CcTC, while several components were developed and implemented, the components were intended to operate as an integrated whole. The services provided at the individual, family, school, and community levels not only were designed to overlap, but also to build a network of support for the West African refugee children. Tamaa intentionally encounters the children and their families in multiple settings – in the home, the school, and the community. Examples of this integration are evident throughout the Guidebook, and some examples are noted here:

- School personnel who have had West African students enrolled in the children's Trauma- and Grief-focused Therapy Groups and/or receive Case Management services often requested information about Tamaa which led to their participation in the School Trainings;
- The Tamaa parent/caregiver groups provided critical information that contributed to the School Training on Parent Involvement, as well as facilitating family participation in the schools. School personnel who participated in the School Trainings, in turn, referred West African parents/caregivers of their students to Tamaa services;

- School Trainings led to the identification of additional West African children in need of mental health services, which led to expansion of the child therapy groups into more schools. In turn, providing the child therapy groups in Morton Elementary and Tilden Middle Schools created an ongoing demand for school professional training, information and technical assistance from Tamaa staff;
- Tamaa influenced school-wide efforts to reduce community violence in Southwest Philadelphia schools. This, in turn, influenced the curriculum for school professional training; and
- Best practices developed through the National Child Trauma Stress Network and other well-regarded groups, and contributed to by CcTC professional staff, have permeated all components of the Tamaa Program, including the School Trainings. The information gathered through Tamaa contributed to the broader body of knowledge on providing innovative mental health treatment for child refugees.

### Barriers Overcome/Lessons Learned for School Trainings

- Remember - teachers and school personnel are key to reaching the children; without their participation and support, impact will be limited;
- Make certain that you have a feedback loop in place – it enables you to learn from mistakes and make ongoing essential modifications – and better ensures that the participants get value for their effort;
- Invite external independent evaluation – it keeps you honest, provides feedback for modifying the program, and recognizes funders’ expectations and needs;
- Be present – it will be noticed and appreciated;
- Don’t be afraid to use incentives – participants often view this as recognition of their effort and commitment to the cause;

- Remember – you may learn more from what doesn’t work than what does. Don’t fear making mistakes - they can be valuable learning experiences!

## SECTION FOUR

### Reflections ~ Moving Forward

The foundation for Tamaa, its creation, implementation, and success, has been the evolution and adoption of the *Nine Essential Components for Success*.<sup>46</sup> This framework for program development has guided the work of CcTC in creating the Tamaa program. It is a tool that can inform and guide development and operations for a myriad of new and existing programs.

The *Nine Essential Components of Success*, and some examples of its use with Tamaa, are:

#### 1. Do your homework:

- a) Gather information about the population/community of interest; for example, the “type and scope” of the problem and the barriers to engagement that are present in already existing services;
- b) Review the research/clinical literature on relevant topics; for example, research the literature on the specialized needs of a given population/community to include evidenced-based, evidence-supported, and promising practices for similar populations/communities.

CcTC put this strategy to use immediately, launching intensive research to gather information on: the West African homelands of the Southwest Philadelphia refugee population that was the focus of the effort; the refugee experience including issues of acculturation; other programs developed to serve refugee children, globally; assessment and curriculum models; evaluation protocols; and more. The extensive knowledge base enabled CcTC to develop Tamaa with greater insight and information.

#### 2. Interact with and involve the target population/community in designing the program/intervention:

- a) Empower the targeted population/community from the beginning.

From the moment the plea for help was made, CcTC was engaged with and by the West African community. The plea was transmitted by a teacher with strong personal ties to the West African community. CcTC, utilizing the Nine Essential Components of Success, sought the support of West African community leaders and organizations, such as ACANA. This resulted in an added benefit – early access to the larger West African refugee community.

**3. Create and employ a continuous feedback loop:**

- a) Solicit continuous feedback from consumers and use this feedback to make modifications in all project components over time;
- b) Be flexible, do not become wedded to your initial ideas as to how programs/interventions should look and operate.

CcTC made sure that a continuous feedback loop was in place and utilized in all aspects of program development and implementation. This enabled CcTC to make timely modifications in the assessments, curricula (for child therapy groups and School Trainings), the School Trainings structure, the Education and Support Groups for Parents/Caregivers, and overall Tamaa operations.

**4. Ensure that the program fits the agency’s mission and vision, and that the organization is committed to making the program work (Board of Directors, management, and staff):**

- a) Recognize that risk is often involved;
- b) Recognize that strong commitment to the cause will enable the initiative to move forward, despite the risk.

The strong support of the organization was made evident with the Executive Director’s commitment to providing help for the West African children, and the subsequent support of the CcTC Board of Directors. This commitment enabled the administrative staff to take the risk of developing a program without secure funding in hand.

**5. Conceive of services as multidimensional, not one-dimensional; do not look at a problem with tunnel vision, think about multiple ways to**

**approach and address consumers’ needs:**

- a) Engage consumers in multiple ways;
- b) Address consumers’ problems/issues from multiple angles, making it more likely to have an impact because the consumer may be willing to try to use the service and not drop out prematurely.

CcTC employed this strategy in several ways. Not only did CcTC develop a comprehensive program that provided multiple lures to connect the West African refugee families to Tamaa, but also utilized multiple venues for reaching into the target community, including community organizations, churches, and the schools. Eventually, the “clients” became the most effective promoters of Tamaa and its services.

**6. Commit to appropriate staffing:**

- a) Engage staff who are similar to the consumers for whom the service is being designed; this should include characteristics such as language and ethnicity;
- b) Employ a team treatment (partnership) approach in the delivery of services when appropriate.

CcTC expended considerable time and effort to ensure that the staff was comprised of representatives of the West African community. Those initially employed to lead Tamaa had the approval of West African community leaders. CcTC sought and hired educated and skilled West African professionals to serve clients in the School and Community-based Tamaa program components. Cultural consultants were also employed as needed to reflect the language/cultural needs of clients. This sensitivity to and respect for the West African community played a major role in gaining the confidence of the target community.

**7. Be mindful of location/geography:**

- a) Provide program services in the community/neighborhood where consumers reside;
- b) Consider co-location with an already established agency in the community, particularly one already seen as a resource for your target population; this should not necessarily be another mental health or social service agency but rather an agency that provides an adjunct, but equally needed/important service.

CcTC established Tamaa in co-location with ACANA, an organization well-known to and trusted by the West African community in the Southwest Philadelphia neighborhood. ACANA, which incorporated in 1999, helps refugee and immigrant families make the transition to life in Philadelphia; helps mobilize African cultural artisans, performing and recording artists to create an awareness of the African Culture; promotes the preservation of cultural values as well as supports artists' efforts to promote their own vocations in their new environment. CcTC has utilized space with ACANA since the beginning of the Tamaa program.

**8. Ensure high visibility and create a strong presence in the larger community, not only at mental health events. Be seen as part of the fabric of the community.**

- a) Identify those events and places that are frequented by your clients, and visit those places to meet the clients and support the local efforts.

Tamaa staff have continued to visit, speak at, and participate in activities and events in the community, to include churches and mosques, health fairs, social events, and special events, such as Philadelphia's Echoes of Africa celebration. As noted earlier, Tamaa staff attend all scheduled events for every component of the Tamaa program, which has been applauded by participants.

**9. Engage in collaboration and forge partnerships:**

- a) Recognize your own limitations and that you cannot solve problems on your own. Seek partners/ collaborators locally and beyond.
- b) Recognize the role of advocacy by being aware of opportunities to advocate for the population served.

CcTC has collaborated with and forged partnerships with diverse and broad-based individuals and groups, to include those at a national level, such as NCTSN, and community- and City-focused groups such as Southeast Asian Mutual Assistance Associations Coalition, Inc. (SEAMAAC), the Mayor's Commission on African and Caribbean Affairs, the South Region School District and ACANA. CcTC has played a strong advocacy role regarding the West African community in various ways

since the inception of the Tamaa Program. For example, CcTC was called upon to testify at a Public Hearing sponsored by the Philadelphia Commission on Human Relations on School Violence.

**Potential for Replication and Recommendations**

The Tamaa Program developed and implemented by CcTC provides a strong example of an intervention model for a targeted population. However, the common-sense framework that informed the evolution of the Tamaa Program makes it particularly useful for replication. The Nine Essential Components of Success provide a comprehensive framework for devising interventions to meet the needs of any group or community.

The Tamaa Program has had such a positive impact on the lives of the West African refugee children, their families and the school community, and many of those interviewed have suggested that this model be employed throughout the School District of Philadelphia as a vehicle for addressing school violence and the trauma of children who have experienced or witnessed violence in their homes, schools, and/or community.

Participants in the School Trainings component of the Tamaa Program have recommended that this model be utilized to provide District-wide professional development training for school personnel. The acknowledged absence of information on child development and mental health must be addressed, particularly as a growing number of children manifest behaviors that are influenced by an increasingly violent society.

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- <sup>2</sup> A complete listing of CcTC’s Center, School and Community Based Program Services is included in the Appendix.
- <sup>3</sup> Vision Statement, CcTC.
- <sup>4</sup> Ms. Makuda Keita-Doe, teaching staff at Tilden Middle School.
- <sup>5</sup> At this time, Tilden was the largest middle school in the School District, and had a history of being identified as one of Philadelphia’s persistently dangerous schools.
- <sup>6</sup> Holland, Anne; personal communication and various documents. The selection was considered particularly appropriate to the initiative and to the West African refugees who were to be served; the term reflected the community’s aspirations to adapt to a foreign culture while simultaneously transforming past challenges into strength and healing.
- <sup>7</sup> The team initially was comprised of the Executive Director of CcTC, the Director of Trauma Services, the Coordinator of Parent-Caregiver Services and later, the Director of Community-based Services.
- <sup>8</sup> It should be noted that the general student population at the target schools, in fact, did have access to many of the services that were to be provided by the West African students (Source: Advisory Board member). Some of these issues are discussed in *Partnership for Wellness: Addressing Stress and Violence in Southwest Philadelphia*. A report of the Robert Wood Johnson Clinical Scholars Program at the University of Pennsylvania School of Medicine 2008-2010 Cohort.
- <sup>9</sup> A more detailed description of ACANA appears later in this section.
- <sup>10</sup> These figures vary by neighborhood, but overall, the community faces major challenges.
- <sup>11</sup> Safe and Sound Philadelphia, Annual Report, 2007. City of Philadelphia and the Robert Wood Johnson Foundation.
- <sup>12</sup> African Immigrant & Refugee Foundation. May 6, 2009; and U.S. Census Bureau, 2000.
- <sup>13</sup> Frazier, Martin. New dimensions – African immigrants in the U.S. *People’s Weekly World Newspaper*, 5/19/2005. <http://www.pww.org/article/articleprint/7095/> ; Terrazas, Aaron. Migration Policy Institute Brief, 2/09.
- <sup>14</sup> Victor, Ciata. Statistics on West African Immigrants in the United States. *TLC Africa*, 2/21/2005; Based on data from UNHCR and the U.S. Citizenship and Immigration Services (USCIS), 1989-2003; <http://www.tlcafrica.com>
- <sup>15</sup> Project SHINE, Temple University Center for Intergenerational Learning. <http://www.projectshine.org/philly/liberians>; Immigrant Communities: Africa. Welcoming Center for New Pennsylvanians. <http://www.welcomingcenter.org/immigrationPA/africa.php>; Katz, Michael B. and Creighton, Matthew J., Philadelphia Migration Project. Penn Institute for Urban Research and University of Pennsylvania Research Foundation, 2009.
- <sup>16</sup> González Willis, Angela. Refugee Mental Health 101. Refugee Mental Health Program, CMHS, SAMHSA, 4/4/2003.
- <sup>17</sup> PA Welcoming Center.
- <sup>18</sup> Swigart, Leigh. *Extended Lives. The African Immigrant Experience in Philadelphia*. The Balch Institute for Ethnic Studies, 2004.
- <sup>19</sup> A more detailed description of Liberia, Guinea and Sierra Leone is available in the Appendix.
- <sup>20</sup> US Data: infant mortality, 6.3/1000; life expectancy, 78 years; adults with AIDS/HIV, 0.6%; literacy, 99%; GDP, per capita, \$46,000; living below the poverty level, 12%; unemployment, 4.6% (currently, 8.9%). [www.indexMUNDI.com](http://www.indexMUNDI.com), 2005.

<sup>21</sup> Refugee Reports: Liberia. U.S. Committee for Refugees/World Refugee Survey 2004.; [www.refugees.org/wrs04/countryupdates/africa](http://www.refugees.org/wrs04/countryupdates/africa)

<sup>22</sup> Global Security. <http://www.globalsecurity.org/military/world/war/>

<sup>23</sup> This situation continues to impact children and adults in West Africa, according a report of the Family Health International (FHI)/Plan West Africa. Morgan, Jenny and Behrendt, Alice. Silent Suffering: The psychosocial impact of war, HIV and other high-risk situations on girls and boys in West Africa and Central Africa. FHI-Dakar Ponty, Senegal: Plan West Africa, 4/20/2009.

<sup>24</sup> CcTC was awarded a \$1 million grant to fund Tamaa's development and implementation for the funding period 2003-2005.

<sup>25</sup> Barriers Overcome/Lessons Learned, which appears in each section of the *Guidebook*, is based on the CcTC authored and copyright document, Nine Ways of Knowing. For additional information on this document, contact CcTC.

<sup>26</sup> CcTC developed Consent Forms for these permissions, as well as Child Assessment Forms, appropriate to elementary and middle school age children. These will be discussed in greater detail in Section Two of the guidebook. Copies of the Consent Forms are included in the Appendix.

<sup>27</sup> CcTC, 2002.

<sup>28</sup> Developed by Christopher M. Layne and William R. Saltzman, 1999. CcTC consulted with Layne, and Anne Holland has provided resources/information to the ongoing body of work.

<sup>29</sup> The assessment tools were pilot tested with the children of the West African staff, and modified based on feedback from the staff and their children. Additional modification occurred over the first three years based on feedback from the clinicians using the screening forms.

<sup>30</sup> For more information about the Tamaa Child Assessment Forms, contact CcTC, Philadelphia, PA.

<sup>31</sup> Kanyangale, MacDonald and MacLachlan, Malcolm. Critical Incidents for refugee counselors: An investigation of human refugees. *Counselling Psychology Quarterly*, 1995, Vol. 8, Issue 1, p.89.

<sup>32</sup> Refugee Trauma Task Force, White Paper. NCTSN, 2005

<sup>33</sup> Refugee Trauma Task Force, White Paper. NCTSN, 2003; Rousseau, C. The place of the unexpressed: Ethics and methodology for research with refugee children. *Canada's Mental Health*, 41: 12-16, 1994.

<sup>34</sup> Refugee Trauma Task Force. White paper, NDTSN, 2005.

<sup>35</sup> Saltzman, W., Steinberg, A., Layne, C., Aisenberg, E. and Pynoos, R. A Developmental Approach to School-Based Treatment of Adolescents Exposed to Trauma and Traumatic Loss. *Journal of Child and Adolescent Group Therapy (the Netherlands)*: Volume 11, No. 2-3, 9/2001.

<sup>36</sup> Profiles of these schools are included in the Appendix.

<sup>37</sup> For more detailed information about the Tamaa Curriculum, contact CcTC.

<sup>38</sup> Pynoos, Robert et al., UCLA PTSD Reaction Index. CA: Los Angeles: National Center for Child Traumatic Stress, 1998.

<sup>39</sup> Briere, John. Trauma Symptom Checklist for Children. FL: Lutz: Psychological Assessment Resources (PAR).

<sup>40</sup> Dyregrov, A., Gupta, L., Gjestad, R. and Raundaleu, M. Is the Culture Always Right? *Traumatology*: Vol. 8, No. 3, 9/02.

<sup>41</sup> Lustig, et al., 2003.

<sup>42</sup> Tamaa is located at 5521-23 Chester Avenue, in Southwest Philadelphia, 19143. During 2009, a serious fire in the building necessitated a move to CcTC offices, at 8th and Callowhill Streets; creating some operational challenges. Tamaa was able to return to the Southwest Philadelphia office during the summer of 2009.

<sup>43</sup> Initially, the school training component was referred to as the school training; this was broadened to School Training when the training was modified and resumed with funding from RWJF.

<sup>44</sup> As noted in Section I, project development and implementation was first funded through SAMHSA. When this funding ended in late September 2005, CcTC was granted bridge funding by the City of Philadelphia through the Department of Behavioral Health and Mental Retardation Services Reinvestment Funds. Ultimately, various funding sources were identified and some have been continued: the Trauma- and Grief-focused Therapy Groups were funded through Philadelphia's Community Behavioral Health (CBH); Case Management services are funded through the Office of Mental Health (OMH); the Caregiver Education and Support Group and the Multicultural Social Events are supported by the Department of Human Services (DHS). However, this funding was not able to support the School training, a critical component of the Tamaa Program. The Robert Wood Johnson Foundation supported the School Training component since 2005, through the Caring Across Communities grant awarded to CcTC. This funding ended in 2009. The Caring Across Communities initiative was designed to address the mental health needs of diverse children and youth; 15 communities were funded. Caring Across Communities seeks to re-engineer traditional mental health services to provide better and more sensible care for immigrants and refugees, especially children.

<sup>45</sup> Project Tamaa – West African Refugee Program, KEY INFORMANT INTERVIEW REPORT SUMMARY, June 2008; Tamaa – West African Refugee Assistance Program, KEY INFORMANT INTERVIEW REPORT SUMMARY, July 2009. Additional information about these Summary Reports is available through CcTC.

<sup>46</sup> Developed by CcTC; copyright pending.

<sup>47</sup> Ranard, Donald A., ed. *Liberians – An Introduction to their History and Culture*. Washington, DC: Center for Applied Linguistics, April 2005.

<sup>48</sup> Profile: Liberia. BBC News Channel, 11/26/2008. [http://news.bbc.co.uk/1/hi/world/africa/country\\_profiles/1043500.stm](http://news.bbc.co.uk/1/hi/world/africa/country_profiles/1043500.stm)

<sup>49</sup> Country Profiles: Liberia. 2009; World Health Organization, 2004.

<sup>50</sup> Johnson-Sirleaf, Ellen. *This Child Will Be Great*. New York: Harper Collins, 2009.

<sup>51</sup> Country Profiles: Sierra Leone. BBC: 6/18/08.

<sup>52</sup> Country Profiles: Guinea. BBC: 1/1/2009.

<sup>53</sup> Guinea. indexMUNDI, 2008.

<sup>54</sup> Country Profiles: Guinea. BBC: 1/1/2009.

<sup>55</sup> For additional information about these materials and other materials developed by CcTC, please contact Children's Crisis Treatment Center at 215-496-0707 or [CcTCKids.org](http://CcTCKids.org).

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Deborah Majeed, Teacher  
Carol McCarthy, Nurse  
Christine McKeown, Teacher  
Amy McLaughlin, Teacher  
Regina Perrulli, Counselor  
Sara Smith, ESOL Teacher  
Al Soler, Patterson School Principal\*  
Steven Solomon, Teacher

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## APPENDICES/RESOURCES

### List of those interviewed:

#### *CcTC Leadership*

Anne M. Holland, Ph.D., Director, Trauma Assistance Program\*  
M. Grace Ryder, Ph.D., Director of Center-Based Services\*  
Anthony Valdes, Executive Director\*

#### *CcTC Tamaa Staff*

Mency Breeze, Care Coordinator\*  
Julie Campbell, Coordinator of Trauma Focused Projects, Trainer  
Richard DeGourville, Trainer (at Trainer meeting)  
Majorie Fogbawa-Robinson, Co-facilitator Children's Therapy Group and Lead Facilitator, Caregivers Group\*  
Twaleh Geply, Care Coordinator (TBA)  
Tamika Iseley, Administrative Specialist\*  
Claudia Spiller-Jargbah, Trainer (at Trainer meeting)  
Lanfia Waritay, Tamaa Team Leader\*

#### *School Personnel*

##### Morton Elementary School

Chi Cao, BCA  
Aimee Davis, ESL Teacher  
Jacqueline Lofton, S.S.A.  
Hilary Morris, Special Education Teacher  
Jean Young, Noontime Aide  
LaJuan Young, Food Service Manager  
Zena Sachs, Morton School Principal\*

##### Patterson Elementary School

Beatrice Adigwe, Teacher  
Celeste Byar, Teacher  
Bernice Century,  
Cecilia De Shields, Teacher

#### *Advisory Board Members/Community Partners*

Patricia Doe, Teacher, Tilden School  
Deborah Ferrell, Department of Behavioral Health, City of Philadelphia  
Voffee Jabateh, ACANA  
Vincent Ngadi, AFRICOM  
Emeka Nwadiora, Temple University (briefly, at AFRICOM)

### Discussion with Groups/Individuals\*

#### *Teacher Training Sessions*

#### *Caregivers Topical Sessions*

#### *Caring Across Communities Team from RWJF*

#### *School-based Advisory Group/Morton School*

### Children's Crisis Treatment Center

Children's Crisis Treatment Center (CcTC) is a private non-profit agency that specializes in providing mental/behavioral health services to Philadelphia's children and their families. CcTC's staff is dedicated to addressing the impact of childhood abuse, neglect, traumatic events and other challenges that can affect childhood development.

For close to 40 years, CcTC has developed and implemented innovative ways of helping children as young as 18 months old and their families cope with obstacles that interfere with their emotional, social and emotional growth. Services and programs are provided at the Center as well as in the home, community and schools. CcTC services have expanded in recent years and currently operate in many Philadelphia Public Schools using four different program models. Further, our community-based programs provide individual services to children in more than 100 Philadelphia elementary, middle, high and charter schools.

With a staff of more than 300, CcTC serves more than 2,300 children and families annually. Our success and reputation for excellence have gained CcTC recognition for our expertise in the areas of trauma, school-based services, community integration and early childhood treatment. Such acknowledgements reflect CcTC's leadership role in the children's health services community.

### **Mission**

To passionately serve the emotional needs of children and families beginning in early childhood. We meet children where they are and help them reach their full potential regardless of their challenge.

### **Vision**

CcTC will be the region's leader in providing quality children's mental health services, training, education and advocacy for best practices. We will be the first choice for children and families as well as potential employees. We will grow through strong collaborative relationships and community integration.

### **Core Values**

CcTC is:

- Committed to providing high quality, comprehensive mental and behavioral health services to all Philadelphia children and families;
- A leader in providing trauma and evidence informed services that address the effects of abuse, neglect, traumatic events and other challenges to development; and
- Providing services in a culturally sensitive, trauma informed environment that embraces Philadelphia's communities while valuing their differences.

### **History of Children's Crisis Treatment Center**

In 1971, psychologist Louise Sandler, Ph.D. outlined an innovative plan to deliver mental health services to preschool aged children with emotional and behavioral health difficulties. Federally funded by a grant from the U.S. Bureau of Education and one of the first of its kind, this program solely focused on addressing the mental

health needs of young children who had experienced trauma. Under the auspices of the Franklin Institute, this therapeutic program for young children would eventually become known as the Children's Crisis Treatment Center (CcTC).

In 1978, CcTC moved out of the shadows of the Franklin Institute and into its current location, just beyond the border of Philadelphia's Art Museum area. It was here that CcTC established itself as a non-profit organization and expanded its original preschool project to fill the needs of children who required assistance from the mental health system, including children in kindergarten and first grade. Supported by City Council members and contributions from concerned groups and individuals, CcTC developed into a multifaceted service provider with an interdisciplinary staff from psychology, psychiatry, social work, and early childhood education. The original CcTC program, the Therapeutic Nursery (TN), remains open today.

Throughout the 1980's and 90's, CcTC slowly began to mark its distinction among mental health providers for children by opening the first children's outpatient Trauma Treatment Program in Philadelphia. Additionally, CcTC ensured that children received the services they needed by establishing community programs to reach families in their own neighborhoods.

In the late 90's the combination of a new management team and an expansion in fundraising and volunteer involvement ushered in a new era and the agency's unprecedented growth. During this time, CcTC diversified its models of service, increased the number of families served and heightened the response to community needs. As former "giants" in Philadelphia's mental health arena for children began to dissolve, CcTC emerged to solidify its place as a leader in the field by meeting the increasing demands for highly regarded programs and services. With a stronger community presence throughout the city, CcTC began to broaden its reach and provide services to those who formerly lived in isolation. These services which reach children in the natural settings of their home, school, and community included trauma treatment services, outpatient services, caregiver programs, home-based treatment and school-based services.

Now in its fourth decade, CcTC's vision of comprehensive care still drives a dynamic organization that adapts and refocuses to meet the challenges of serving Philadelphia's most at-risk young citizens and their families. Today, CcTC remains a cutting edge organization that provides care where the needs are greatest—in the home, in the community, and in our schools thus realizing the agency's vision of aiding children and families wherever they need a helping hand.

## Children's Crisis Treatment Center's Programs

### Center Based Programs

CcTC's Center-Based Programs provide services to children and their families presenting with significant emotional/behavioral issues. They include:

The **Therapeutic Nursery (TN)** is an early childhood day-treatment program for children ages 2 1/2 through 5 who present with significant emotional / behavioral challenges. The TN provides a full array of emotional / behavioral health services in a therapeutically structured, full-day program including psychiatric services, group therapy, and educational activities. Providing individual treatment in a group setting, the TN focuses on emotional and educational readiness skills for a successful transition to a school environment.

CcTC's **Outpatient Department** provides evaluations, individual therapy and family therapy for children ages 2 1/2 through 13 who present with an array of emotional/behavioral health challenges. The Outpatient Department serves as the gateway to other services at CcTC by conducting initial assessments and developing initial treatment plans. Services include child/family therapy, clinical case management, psychiatric evaluations and medication monitoring.

The **Trauma Services Department** at CcTC includes the Trauma Assistance Program (TAP) and Sexual Trauma Treatment Program (STTP). The Trauma Assistance Program provides specialized treatment in the clinic and in the community to children ages 18 months through 13 years and their families who have recently witnessed/experienced a traumatic event (e.g., homicide, suicide, physical abuse, house fire, catastrophic accident,

domestic violence, community violence). The Sexual Trauma Treatment Program is a specialized treatment program within the Trauma Services Department focusing on victims of sexual abuse/assault.

As an extension of the Trauma Services Department, Tamaa is a community and school-based program designed to meet the emotional / behavioral health and social service needs of West African Refugee children and their caregivers who have relocated to Southwest Philadelphia. The program serves those who have witnessed and experienced war-related trauma in their homelands and in refugee camps and who are in the process of acculturating to their new communities.

### School Based Programs

CcTC's School Based Services help children achieve their potential as well as academic and social success through comprehensive behavioral health services within schools throughout Philadelphia. These services help children succeed by working within the school environment, preventing them from missing out on their educational experience. With an array of programs offering preventative services, specialized classroom environments and growth programs, School Based Services focus on academic and social success as well as reintegrating children back into a traditional classroom environment. They include:

CcTC's **School-Based Behavioral Health (SBBH)** program focuses on providing comprehensive behavioral health services within the school setting to children who display serious emotional and behavioral challenges. Services are provided on-site and skills for success are reinforced directly within the school environment.

The **Children Achieving through Re-Education (CARE)** program uses the Re-education Model in the classroom, which is based on an ecological philosophy that a child's challenges is related to the stress placed on him/her by his/her environment. This program develops a better fit between the child and the environment through the use of positive behavioral support aimed at teaching cognitive and behavioral skills while providing individualized instruction. CcTC's CARE program is

currently located at Julia de Burgos Elementary School in North Philadelphia.

CcTC's **Consultation & Education Program (C&E)** program provides short-term preventative care coordination services in Philadelphia public schools. The C&E specialists serve children who suffer or are at risk of suffering from behavioral health challenges. The staff ensures that natural supports as well as traditional and non-traditional resources are being used for the children. The C&E program currently operates in 10 elementary and middle schools in Northeast Philadelphia.

CcTC's **School Therapeutic Services (STS)** program provides group and individual therapy along with comprehensive behavioral health services within the school setting to children with serious emotional and behavioral challenges. Services are provided on-site and skills for success are reinforced directly within the school environment. CcTC's STS services are currently located at two schools in Philadelphia – Bache Martin Elementary School in the Fairmount Section and Reynolds Elementary School in the Sharswood Section.

### Community Based Services

CcTC's Community Based Services provide services to children and their families throughout Philadelphia by assisting them in learning to achieve success with the natural resources that are available to them within their communities.

CcTC's Community Based Services actively engage neighborhoods and become a positive influence within communities. CcTC is committed to helping children and their families utilize local resources that are available to them and to creating opportunities for children and families to achieve long-term success with interdisciplinary behavioral health services, care coordination services, intensive family support and summer camp programs. Working directly within communities is vital to CcTC's vision and assists in understanding different communities' cultural, geographic and economic barriers in order to provide

services in a culturally sensitive manner. Programs include:

CcTC's **Behavioral Health Rehabilitation Services (BHRS)** program provides emotional and rehabilitative support for children. This service places support into the child's community, school and home by providing individualized Therapeutic Support Staff (TSS) Services, Mobile Therapy (MT), Behavioral Specialist Consultation (BSC) and Care Coordination Services.

The **Intensive Case Management (ICM)** program provides direct services to children who display serious emotional challenges. ICM works to ensure that children and their families utilize natural supports as well as traditional and non-traditional community resources to develop appropriate relationships with family and caregivers. Services include assessment and evaluation of medical needs; family and educational history; support network and resource building for the child and family; and child and system advocacy.

The **Summer Therapeutic Enrichment Program (STEP)** is a therapeutic/recreational summer camp for children. The camp provides children with a safe environment where they can develop and practice needed social skills while school is not in session during the summer months. Most of the children have been denied access to other summer camps due to behavioral and emotional difficulties in the past. In STEP, all children successfully complete the summer-long program, learn valuable skills and explore community options. Most importantly, they have the opportunity to enjoy childhood activities as others do while receiving art, dance/movement and recreational therapies.

The **Family-Based Program** offers team-delivered services rendered in the home and community. These short-term, intensive services are designed to integrate behavioral health treatment, family therapy and support services and routine care coordination services. By taking this approach, the program aims to enable families to continue to care for their children with serious emotional disturbances at home and therefore reducing the need for out of home placement.

## Selected Background and History of the West African Refugees:

### *Liberia ~*

While Liberia is known for two violent and damaging civil wars (1989-1996; 2001-2003), it is in fact, the oldest republic in Africa.<sup>47</sup> This West African nation was founded by freed slaves from the United States and the Caribbean, but this group represents only 5% of the population, with indigenous Africans comprising the majority.<sup>48</sup> The long-time dominance of the freed slaves under William Tolbert, led to his overthrow by Samuel Doe in 1980. Doe was executed by followers of Charles Taylor, after several years of economic disaster fueled by poor and arbitrary leadership. Civil war ensued until a peace agreement was signed in 1996; the peace was short-lived for another civil war began in 2001. More than a quarter million people lost their lives and 1.5 million were displaced as a result of these two civil wars. In 2006, following a national election, Ellen Johnson-Sirleaf was inaugurated as Africa's first female elected head of state. She faces real challenges: life expectancy at birth is 41.1 years; Gross National Income (GNI) per capita is \$150 with 80% living below poverty level; unemployment is at 85%; the literacy rate for adults over age 15 is 41.6%. The under-five mortality rate is 25%.<sup>49</sup> The 3.5 million people comprise 16 ethnic groups and 16 indigenous languages plus English.<sup>50</sup> Fifteen-thousand peace-keeping forces remain in Liberia.

### *Sierra Leone ~*

Sierra Leone continues to struggle in the aftermath of a decade-long civil war (1991-2001). The country's population is home to 16 ethnic groups, and tensions among the larger groups, the Mende, Temne and Limba, are largely responsible for the civil strife. During the war, 750,000 people were displaced (many to Liberia and Guinea) and 50,000 were killed. Peace-keeping forces have been needed to control the unrest and reestablish peace. In September of 2007, Ernest Bai Koroma became the country's president.<sup>51</sup> Sierra Leone, home to the first university in West Africa (1827), has a literacy rate of 24%. The infant mortality rate is 156/1000 births; the life expectancy is 41 years. Seven percent (7%) of the adult population has AIDS/HIV. The GDP is \$800 per capita and 70% of the population lives below the poverty rate. Despite laws mandating education for children, approximately 67% of school age children are not in school.

### *Guinea ~*

In 1958, Guinea became the first French colony to gain independence. Unfortunately, all French support to the country ended simultaneously. Guinea is comprised of 24 ethnic groups; the three largest groups are the Fulan/Fula (40%), the Mandinka/Mandinga (30%) and the Soussou (20%). The official language is French.<sup>52</sup> Infant mortality is 87/1000 births and the life expectancy is 49.8 years. While the percentage of adult AIDS/HIV is lower than in other West African countries (3.2%), the World Health Organization fears dramatic increases (2009). The literacy rate is 18% for women and 42% for men. The GDP is \$1000/capita with 47% living below the poverty level.<sup>53</sup> Many fleeing civil wars in Sierra Leone and Liberia sought refuge in Guinea; according to the World Health Organization, some 1 million of those displaced crossed the borders into Guinea. In addition, Guinea's own instability has led to more than 80,000 Guinean displaced persons. As recently as December 2008, the current leader, Moussa Dadis Camara, took over control of the country in a coup d'etat and suspended the constitution.<sup>54</sup>

## List of Documents/Forms Developed for Tamaa by CcTC.<sup>55</sup>

- Child Screening Form, Elementary School Version
- Child Screening Form, Middle School Version
- West African Student Support Group Satisfaction Questionnaire
- Caregiver Intake Form
- Case Management Intake Form
- Consent Form for Child Assessment
- Consent Form for Participation in Children's Group
- Consent Form for Participation in Caregiver Group
- Consent Form for Participation in Case Management Services
- Consent Form to Obtain/Release Confidential Information – Child
- Consent Form to Obtain/Release Confidential Information – Adult
- Child Photography, Audiotape, and Videotape Consent Form
- Caregiver Photography, Audiotape, and Videotape Consent Form
- Tamaa School Training Evaluation Form

### Tamaa School Training Evaluation Form

Topic: \_\_\_\_\_

Date: \_\_\_\_\_

#### **Ratings**

*For each of the following statements, please indicate your opinion by circling one of the five rating numbers: (5 = STRONGLY AGREE)*

Statement	Strongly Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Strongly Agree
1. My expectations for this workshop were met.	1	2	3	4	5
2. This information is important for educators to know.	1	2	3	4	5
3. This workshop addressed a need in our schools.	1	2	3	4	5
4. Implementation of workshop content will be beneficial to me professionally.	1	2	3	4	5
5. The content of the workshop was appropriate for the time allowed.	1	2	3	4	5
6. The presenter was knowledgeable about the topic.	1	2	3	4	5
7. The presenter was easy to understand.	1	2	3	4	5
8. The presenter was engaging.	1	2	3	4	5

#### **Feedback**

1. What strategies/techniques presented at this workshop did you find to be **most** useful?
  
2. Do you have any suggestions and/or ideas that will assist us in future workshops on this topic?
  
3. What other training topics would you suggest as follow-up to this workshop?

### **Degree of Change**

For each of the following four types of change, please indicate the degree of change you have experienced as a result of this workshop by circling one of the four rating numbers:

Type of Change	None	Slight	Moderate	Much
<b>1. Informational Change:</b> an increase in your awareness and understanding of the subject matter of the training program.	1	2	3	4
<b>2. Behavioral Change:</b> an increase in your ability to apply the subject matter of the training program.	1	2	3	4
<b>3. Attitudinal Change:</b> a modification of your beliefs and perceptions related to the subject matter of the training.	1	2	3	4
<b>4. Motivational Change:</b> an increase in your desire to be involved with activities related to the subject matter of the training program.	1	2	3	4

### **Demographics**

Please complete the following four items by marking the appropriate box or writing on the provided line:

1. Gender:  Male  Female

2. Education:  Less than a High School Diploma  Master Degree  
 High School Diploma or equivalent  Specialist Degree  
 Bachelor Degree  Doctorate Degree

3. School: (Please write in what school you work at or your child attends)

\_\_\_\_\_ School \_\_\_\_\_

4. Role:  Special education teacher  Parent  
 General education teacher  Nurse or Health Professional  
 Paraeducator  Other \_\_\_\_\_  
 School counselor  
 Administrator

**Optional** May we contact you for additional information about this workshop, if needed?

Name: \_\_\_\_\_ Day telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail address: \_\_\_\_\_

