### Treatment Description
- **Acronym (abbreviation) for intervention:** IFACES
- **Average length/number of sessions:** Sessions are as needed and tailored to the needs of each program participant.
- **Aspects of culture or group experiences that are addressed (e.g., faith/spiritual component, or addresses transportation barriers):** War trauma, refugee trauma, migration and acculturative stress, as well as multiple barriers to treatment that are overcome through outreach and by providing service in participants’ home or other locations.
- **Trauma type (primary):** War trauma
- **Trauma type (secondary):** Migration and acculturation
- **Additional descriptors (not included above):** The IFACES program provides comprehensive community-based mental health services to refugee children, adolescents, and families. Outreach is seen as the cornerstone of the program and occurs throughout the treatment process. It includes identifying refugee children who can benefit from services, engaging them and their families in services, retaining them in services, and supporting them as necessary after the active treatment phase has ended.

### Target Population
- **Age range:** (lower limit) to (upper limit): All ages
- **Gender:** □ Males □ Females ✘ Both
- **Ethnic/Racial Group (include acculturation level/ immigration/refugee history-e.g., multinational sample of Latinos, recent immigrant Cambodians, multigenerational African Americans):** The target population is refugee and immigrant children who have experienced trauma as a result of war or displacement. This includes children who emigrated themselves as well as children of refugees/immigrants. The program is designed to provide services to a variety of ethnic groups, and no one is turned away from services because of their cultural or linguistic background. Racial groups include White (European refugees), Black (African refugees), Asian (including Southeast Asia and South Asia), and Hispanic (Central and South America).
- **Other cultural characteristics (e.g., SES, religion):** All are low SES, various religions
  - **Language(s):** A wide variety of languages are spoken. For example, 66 children and adolescents on whom extensive data is available and who were served in a 2-year time frame spoke 19 languages, including the following: Amharic, Anuak, Arabic, Bassa, Bosnian/Serbo-Croatian, Bosnian/Roma, English, French, Kpelle, Ogoni. During the same time period, staff, including clinicians and ethnic mental health workers, spoke 15 languages among them the following: Oromo, Spanish, Krahn, Romanian, Swahili, Tigreiny, Ukrainian, Urdu. When a language match between provider and participant cannot be made, staff utilize trained interpreters to communicate with the children and families.
- **Region (e.g., rural, urban):** Urban and rural
- **Other characteristics (not included above):** The program is designed to meet
the needs of diverse children and adolescents from a variety of cultural and language backgrounds. Those seeking services are not turned away if the language or cultural competence is not represented among staff; rather, in these situations services are provided through trained interpreters. The goal is to meet the mental health needs of all refugee children seeking services, regardless of their background, by providing flexible and comprehensive services.

### Essential Components

- **Theoretical basis:** Client-centered and community-based, extensive outreach, and openness to problem-solving any barriers to treatment.
- **Key components:**
  - Multidisciplinary team includes psychotherapists; art, occupational, and dance therapists; psychiatrists; and ethnic mental health workers from refugee communities served.
  - Multicultural ethnic mental health workers provide cultural and linguistic competence and work as part of a mental health team.
  - The team shares responsibility for program participants, with multiple providers providing diverse services to a participant and family.
  - Team approach allows for services to be individualized to particular participant’s needs, and for staff to give support to one another.
  - Services are provided at locations that are most comfortable to program participants, including home, school, office and other community locations.
  - Comprehensive services address mental health as part of a range of needs that refugee children and families have as they are adjusting to their new life.
  - Coordination with refugee resettlement services within the same agency allows IFACES to establish relationships with families before they need services, which helps reduce stigma.
  - Ethnic mental health workers provide extensive outreach, often for prolonged periods of time, before a participant is engaged in mental health services.

### Clinical & Anecdotal Evidence

- **Are you aware of any suggestion/evidence that this treatment may be harmful?** □ Yes □ No □ Uncertain
- **Extent to which cultural issues have been described in writings about this intervention (scale of 1-5 where 1=not at all to 5=all the time).** The approach is culturally sensitive, in that staff constantly assess ways in which the participants’ cultural background impacts on their functioning and services. An article describing the approach is currently under review (Birman et al.). The rationale for the program design is presented in the article as well, and is informed by empirical evidence regarding refugee and immigrant mental health. Also reference Mental Health Interventions for Refugee Children in Resettlement: White Paper II from the National Child Traumatic Stress Network Refugee Trauma Task Force (available through the NCTSN web site).
- **This intervention is being used on the basis of anecdotes and personal communications only (no writings) that suggest its value with this group.** □ Yes □ No
- **Are there any anecdotes describing satisfaction with treatment, dropout rates (e.g., quarterly/annual reports)?** □ Yes □ No

Satisfaction with treatment is regularly assessed and the ratings are consistently high. Anecdotes are...
Has this intervention been presented at scientific meetings? □ Yes □ No

If YES, please include citation:


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

If YES, please include citation:


Has the intervention been replicated anywhere? □ Yes □ No

Other countries? (please list)

Other clinical and/or anecdotal evidence (not included above): The program has evolved from decades of providing services to refugees at the agency, and is informed by experience providing resettlement, social and mental health services to this population. Further, the team approach and comprehensive services aspects of the model have been influenced by Assertive Community Treatment and other community-based approaches used by agency programs that work with individuals who are homeless and have a serious mental illness.
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Outcomes

- What assessments or measures are used as part of the intervention or for research purposes, if any?

The Child and Adolescent Functional Assessment Scale (CAFAS, Hodges, 2000), UCLA PTSDRI, and Child Depression Index (CDI) have been used with some participants as well.

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If research studies have been conducted, what were the outcomes?
Children and adolescents receiving services (n=66) improved as a group over the course of treatment, and the amount of improvement was statistically significant.

All but 5 of the children received services in more than one location, with an average of 4.4 locations (SD = 2). On average, each participant received services from 2.7 providers (SD = 1.5). All but 12 of the participants received services from multiple providers.

Language match between the service providers and the program participants was determined from information available on the language capacity of the providers assigned to each case, and the primary language of the participant. In all, out of the sample of 66, 31 participants were matched on language with at least one of the providers from whom they received services during the three-year period, and 35 were not matched. Those who were not matched either spoke English fluently enough to participate in treatment, or were treated with assistance of interpreters brought in from other services. Those matched on language stayed in treatment longer than those not matched.

Dosage of services was not related to outcome.

Participants with greater needs (more trauma, more caregiver trauma, and younger) received more intensive services (at more locations, from a greater number of providers, and more overall).

| Implementation Requirements and Readiness | Space, materials or equipment requirements? Very intensive, requires multidisciplinary treatment team including ethnic workers knowledgeable about the cultures of current refugee groups and the community. |
|                                          | Supervision requirements (e.g., review of taped sessions)? Because ethnic workers are most often trained in mental health treatment through the program, extensive supervision is required. Group supervision has been found to be helpful given the nature of the clinical work and that each client often works with several staff. |
|                                          | In order for successful implementation, support should be obtained from: Heartland Health Outreach IFACES |

| Training Materials & Requirements | List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained. DVD: International FACES: A Collaborative Approach to Healing and the Refugee Experience |
|                                  | How/where is training obtained? No formal training manuals are currently established. Staff provides training in a wide range of community settings on refugee and multicultural issues. |
|                                  | What is the cost of training? Rates vary according to time and location. |
|                                  | Are intervention materials (handouts) available in other languages? Yes ☐ No ☒ |
|                                  | If YES, what languages? |
|                                  | Other training materials &/or requirement (not included above): Interpreter Manual |

| Pros & Cons/Qualitative | What are the pros of this intervention over others for this specific group (e.g., addresses stigma re. treatment, addresses transportation barriers)? The program is very effective at overcoming multiple barriers to service, including |
| Impressions | stigma and transportation. Access to services is enhanced and treatment is highly individualized. Treatment model is effective with an array of cultural and language groups.  
- **What are the cons of this intervention over others for this specific group (e.g., length of treatment, difficult to get reimbursement)?** Services to those in greater need are intensive, and require commitment of time for the transportation, staff meetings, and travel required. Service is provided through grant funds. It would be difficult to collect reimbursement for travel/transportation and other community-based aspects of the service model.  
- **Other qualitative impressions:** |
| Contact Information | Name: Joan Liautaud, Psy.D.  
Address:  
Heartland Health Outreach IFACES  
4750 N. Sheridan, Suite 500  
Chicago, IL 60640  
Phone number: (773) 751-4054  
Fax: (773) 751-4174  
Email: jliautaud@heartlandalliance.org  
Website: www.heartlandalliance.org |