Children’s Crisis Treatment Center (CcTC): Bringing Mental and Behavioral Health Care to Hard-to-Reach Populations

Amy Schlosberg and Mikaela Levons 01 February 2010

Summary

Communities face significant challenges in accessing effective mental and behavioral health treatment for children who have experienced trauma and consequently suffer from mental health issues. These challenges are compounded when the children belong to immigrant, minority, and/or refugee groups that live in low-income areas. Children’s Crisis Treatment Center (CcTC) has developed a model of care that helps meet the needs of these vulnerable children in Philadelphia’s immigrant, minority, and refugee communities by providing high-quality, comprehensive mental and behavioral health services through community integration.

In the last ten years, under the innovative leadership of Antonio (Tony) Valdés, CcTC has grown and become culturally relevant to each ethnic group the organization serves. CcTC’s unique approach has been formalized in

its “Nine Essential Components for Success” in community integration, which include immersing in, interacting with, and soliciting feedback from the target community. Securing organizational buy-in, providing multidimensional services, and hiring staff from the target community are also essential. CcTC integrates itself by establishing programs in key geographic locations, creating high visibility, and collaborating with existing community organizations. The individual strategies are not revolutionary, but CcTC combines them in a way that has given the organization unique access to underserved minority, immigrant, and refugee communities in Philadelphia. CcTC is now viewed as almost indigenous to its client base, and it provides vital mental and behavioral health services to these underserved clients who might otherwise slip through the cracks of the mainstream health and mental health care systems.

CcTC’s successful community integration allows it to effectively serve children all over the city, including those who reside in a West African immigrant and refugee community in Southwest Philadelphia. In this neighborhood, children grapple with serious acculturation issues while suffering the longstanding effects of war-related traumas experienced in their home countries.

Introduction: Mohammed’s Story

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Mohammed relocated to the United States at the age of 6. He and his mother were forced to flee their home in Liberia as a result of an escalating civil war in which his brother and father were killed. They ended up at a refugee camp in Guinea where Mohammed's mother died of dysentery. The little boy had to fend for himself in the refugee camp, which was plagued with disease, no running water, poor sanitation, and little food.

Eventually, a maternal aunt offered to take Mohammed into her home in the U.S. She lived in Southwest Philadelphia in an overcrowded house in a dangerous neighborhood. In addition to the culture shock accompanying an abrupt introduction to different food, attitudes, and school systems, Mohammed was forced to contend with war-related nightmares that plagued his sleep. He had problems focusing in school because he worried about his family in Liberia. He was also teased because of his accent and cultural differences — children at school told him to go back to Africa. He felt too afraid to tell his aunt or teachers what he was going through and, instead, sank into depression, crying when no one was looking.

Who would take care of Mohammed? The adults in his life didn't fully understand the depth of his trauma. Even if they did, his teachers were not equipped to deal with war trauma and acculturation issues. Mohammed seemed destined to join one of the many West African gangs that had sprung up in the neighborhood; at least they offered

protection from bullies and a sense of belonging.

The Problem: Behavioral Healthcare Challenges for Philadelphia’s Minority Children

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In 1999, the U.S. Surgeon General estimated that 21 percent of children in the United States suffer from *mild* behavioral health problems, and an additional 11 percent struggle to overcome *significant* behavioral health issues. This estimate translates into a total of 4 million youth who suffer from major mental illness, resulting in significant impairments at home, at school, and with peers (U.S. Department of Health and Human Services 1999, 123-124).

In the United States, children who are members of minority racial and ethnic groups are about one-third as likely to receive behavioral health treatment as other youth. Much of this disparity relates to poverty levels, as a greater percentage of minorities lack medical insurance and live in areas with little access to health care and other related services. Institutional racism also contributes to the problem, as behavioral healthcare providers may have difficulty relating to their patients and tend to approach problems and interpret behavior differently with these

patients as a result (Holm-Hansen 2006).

In southeastern Pennsylvania, the child advocacy group Public Citizens for Children & Youth (PCCY) projects that of the 950,000 children in the region under the age of 18, at least 200,000 suffer from mild behavioral problems. Another 100,000 struggle to overcome significant behavioral health issues and most, if not all, of these children need mental/behavioral health services and/or care (PCCY 2008). Despite this direct need, in 2007, only about 39,000 children in Southeastern Pennsylvania accessed behavioral health services through the public system (PCCY 2008).

Children who live in low-income communities within Philadelphia face an additional challenge: they experience multiple stressors that exacerbate mental/behavioral health issues. Considering that 33.6 percent of families with children under the age of 18 live below the poverty line in Philadelphia (one of the highest rates in the country), it comes as no surprise that the need for mental health care in the city of Philadelphia is great (U.S. Census Bureau 2008).

To compound the difficulties resulting from insufficient mental and behavioral health service options, there is a shortage of practitioners representing diverse cultures and a lack of culturally appropriate services that reflect families' specific background and values. For this reason, treatment is often ineffective or not accessed.

Furthermore, stigma frequently prevents parents and caretakers of minority children from seeking accurate mental health diagnoses and associated treatment. These adults are more likely to assume personal blame for the child's issues and are, consequently, much less likely to self-refer or respond to someone else's suggestion regarding treatment (Holm-Hansen 2006).

Children and youth struggling with mental and behavioral health issues experience lower educational achievement, and they are more likely to have a low quality of life and become involved in the criminal justice system. Of those suffering from a behavioral health issue (compared to other disabilities), elementary school–aged children are much more likely to be unhappy at school, are frequently absent, and are three times more likely to be suspended or expelled than their peers. Up to 44 percent of high school students suffering from behavioral health issues drop out of school. Also, up to 70 percent of children and teenagers in the juvenile justice system have a diagnosable mental health disorder (Cooper and Masi 2006). Of course, these children are much less likely to lead successful adult lives, hold jobs, and contribute to society.

According to St. John University's Institute for Violence Research and Prevention, juvenile crime results in $6.6 billion in annual costs, including direct medical costs, quality of life and productivity losses, lost earnings and opportunity cost of time, employment and workers'

productivity, psychological costs, and other non-monetary costs (Miller, Fisher, and Cohen 2001). And, as the Adverse Childhood Experiences (ACE) Study demonstrates, children who are abused or neglected or are exposed to other traumatic stressors have a greater chance of becoming users of street drugs or tobacco, or having problems with alcohol abuse as adults (Redding 2003). Thus, preventing juvenile crime is far more cost-effective than any interventions after delinquency has occurred.

The costs to society of juvenile crime, including acts of violence, are borne largely by the public, offset by higher income taxes. The World Health Organization reports that in the United States, 56 to 80 percent of the costs of care for gunshot and stabbing injuries of the perpetrators and the victims are either directly paid by public financing or are not paid at all (Waters et al. 2004).

The Solution: CcTC Fills the Gap in Behavioral Health Care for Children

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CcTC is a private, nonprofit agency that provides high-quality, comprehensive mental and behavioral health services to Philadelphia's children and their families. Its services are geared toward addressing the effects of abuse, neglect, traumatic events, and other challenges to

early childhood development and toward helping children reach their full potential within their homes, community, and society.

In the last ten years, under the innovative leadership of Antonio (Tony) Valdés, CcTC has grown tremendously and addresses the needs of a variety of Philadelphia neighborhoods and diverse populations. Created in 1971 by psychologist Dr. Louise Sandler under the auspices of the Franklin Institute, CcTC offered a first-of-its-kind program for addressing the mental health needs of preschool children. Seven years later, the organization developed into its own nonprofit and expanded programming to serve children in kindergarten and first grade. Over the years, CcTC has continued to grow and develop into a multifaceted organization, utilizing expert staff trained in psychology, psychiatry, social work, and early childhood education. The organization's vision involves providing increased access to a diverse array of mental and behavioral health services to Philadelphia communities with a focus on eliminating cultural, economic, and geographic barriers to their utilization.

Currently, CcTC offers children between the ages of 18 months and 14 years three types of services: center-based, community-based, and school-based. Within these three categories, mental and behavioral health treatment is provided through multiple avenues, including the therapeutic nursery, intensive case management, outpatient and trauma therapy programs, the summer

therapeutic enrichment program (summer camp), and school therapeutic services. CcTC also works closely with families using approaches such as the Filial Parenting Program, which teaches caregivers one-on-one play therapy techniques to improve parent-child relationships at home.

The CcTC Difference: Strong Leadership and Strong Community

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The current Executive Director, Tony Valdés, arrived at CcTC in 1997 — the same year that managed health care started in Philadelphia. According to Valdés, at that time, many behavioral healthcare practitioners acknowledged a "big hole in children's mental health." When presented with the new system, Philadelphia chose not to contract with a private company but instead created Community Behavioral Health (CBH) to manage its own mental health services. Through CBH, families were no longer geographically limited to their local community behavioral health center and, with the creation of HealthChoices, a mandatory managed care program for medical assistance, recipients could choose any provider on the CBH provider list. Health care had essentially transformed into an open market, leading to the commercialization of many healthcare and mental/behavioral agencies and an

increase of child-related services driven by community needs.

Valdés took advantage of new opportunities resulting from the managed healthcare system, and this led to the expansion of CcTC sevenfold, with a staff increase from 45 to 350 employees, an annual budget increase from $1.8 million to $16 million, and a service expansion from 4 to 16 programs. When Valdés joined CcTC, the agency served approximately 250 children and families per year; today CcTC annually works with over 2,300 children and families across the greater Philadelphia community. With close to 20 years of experience in mental and behavioral healthcare management, Valdés is one of Philadelphia's most visible leaders in children's mental and behavioral health services (Children's Crisis Treatment Center n.d.).

Rather than conforming to the bureaucratic status quo that was emerging in the mental healthcare industry, Valdés determined that he would transform CcTC by developing an innovative, functional organizational culture. Valdés' passion for children's mental and behavioral health, combined with his MBA-honed business acumen, helped him to methodically implement a new culture of openness among staff. This culture of openness included transparency from the top down, comprising frank and honest communication in all facets of the agency. When describing what group collaboration looks like at CcTC, Valdés says, "We're fearless about correcting each other and deciding when to say no to

programming if it doesn't truly fit our mission and goals." Valdés is also a firm believer in a holistic approach to staff management. Consequently, the culture of openness is not just relegated to the office, but also involves encouraging staff to interact and socialize in more relaxed settings. Staff parties and social events play an important role in allowing employees to get acquainted.

Valdés also stresses that a culture of openness begins with creating a safe environment for staff to express their opinions constructively. Thus, in 2006 CcTC began the process of implementing the Sanctuary Model® of organizational change. Created by Dr. Sandra Bloom, Sanctuary is a trauma-informed organizational approach geared toward creating a culture of safety within an agency. Dr. Grace Ryder, CcTC's Division Director of Center-Based Services, credits the model with strengthening the communication within the agency because it fosters effective peer-to-peer and departmental interaction (Children's Crisis Treatment Center 2009, 1). During staff meetings, participants build awareness and acceptance of each other's goals and emotional frames, all of which leads to an emotionally safe environment within CcTC and beyond in its work with clients.

In addition to creating a safe environment in the workplace, Valdés has built up a cadre of competent, talented staff members who have internalized the mission of CcTC. Knowing the mission — what CcTC is and what it

is not — gives staff the freedom to take risks and offer their opinions. Valdés also attributes CcTC's success to his staff's overall skill set and ability. Valdés has recruited highly credentialed staff: Of the almost 300 employees, about 125 hold a master's degree or higher. Staff development and satisfaction is also critical to Valdés; approximately 85 percent of expenses are allocated to payroll and benefits. Finally, Valdés is adamant about creating this sense of continuous professional value because he wants CcTC to be "a place where self-actualization matters." The low staff turnover rate is a testament to Valdés' leadership.

How CcTC's Community Integration Works

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Philadelphia is home to diverse ethnic groups; some have lived in the city since the 1800s, while others have only recently immigrated or arrived here as refugees or asylees. CcTC is an innovator in its field because the agency has integrated itself into the melting pot that is Philadelphia by becoming culturally relevant to each ethnic group the agency serves. Indeed, in many communities CcTC is viewed as a home-grown organization. Valdés emphasizes that CcTC's unique approaches might have failed had the organization not created such a concrete ethos of community within itself.

Community integration allows CcTC access to communities that would otherwise have been closed to traditional mental and behavioral health agencies. By hiring staff members who can culturally relate to and speak the languages of the clientele, CcTC gains the community's trust and the opportunity to serve the children who need their services.

To understand the nature and scope of the agency's approach, it is helpful to look at one program that exemplifies CcTC's community integration. Initially an extension of the Trauma Services Department, the Tamaa Program is a community- and school-based program designed to meet the emotional, behavioral, and social service needs of West African refugee children and their caregivers who have relocated to Southwest Philadelphia. Southwest Philadelphia is a refugee/immigrant-dense community, with 70 percent of Philadelphia's approximately 2,500 West Africans resettled there. In Southwest Philadelphia, West African refugees comprise up to eight percent of the total population (Patusky and Ceffalio 2004).

How CcTC became involved with the West African refugee community exemplifies the organization's commitment to accomplishing its mission through community integration. In the spring of 2001, Dr. Anne Holland, CcTC's Trauma Services Director, received a call from a social worker at the Children's Hospital of Philadelphia who was seeking mental health services for a West African refugee child.

The child had been severely beaten by peers at his middle school, and his teacher, who accompanied him to the emergency room, insisted on speaking with Dr. Holland. From this conversation and subsequent investigation, Dr. Holland explains, CcTC discovered that this little boy's case was not an isolated incident. A large number of West African refugee children who lived in Southwest Philadelphia were experiencing significant trauma-related symptoms, facing acculturation difficulties, and being targeted and violently assaulted by non-refugee classmates.

CcTC's response to the need for mental and behavioral health care within this community is what sets the agency apart from its peers. Rather than insisting that the teacher find a way to get the child into the Trauma Assistance Program (which is where most hospital referral clients are provided with trauma-focused evaluation and therapy), Dr. Holland took the case to Valdés, who recognized that CcTC was, in fact, equipped to effectively meet this client pool's needs if the challenge was approached creatively. Dr. Holland stresses that CcTC's Tamaa Program did not develop in isolation, but was "a natural outgrowth that fit into the mission and vision" of the agency. She also cautions, "If you don't have the right foundation, you can't innovate a program like this."

In the case of the Tamaa Program, CcTC worked carefully with the West African community to develop the program, which was developed to consider the entire family's

needs. After careful analysis and research, five essential components were created and serve as the core of the program to provide a variety of services that address both school-and community-based needs. These five components are Caregiver Education/Support Groups, Case Management Services, Multicultural Social Events, Children's Trauma- and Grief-Focused Therapy Groups, and School Trainings. CcTC engaged two Liberian case managers to work with refugee families and refer them to social services, after-school tutoring, job training for parents, and providers of other basic needs of any immigrant. The families opened up to the Liberian case managers about mental and behavioral health issues, which facilitated successful treatment of the refugee children (Scott 2009). Today, the Tamaa Program's offerings reach about 40 children in case management at a given time, and Tamaa works with about 100 students and their families in the community each year.

Nine Essential Components for Success in Community Integration

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CcTC's focus on cultural and community integration is outlined in the Children's Crisis Treatment Center's "Nine Essential Components for Success" (Holland n.d.). Written by Dr. Anne Holland as a way to formalize CcTC's

innovative approach to Tamaa and its other programs, the *Nine Essential Components* summarizes Valdés' vision and showcases why the agency is so successful in treating children residing in diverse neighborhoods all over Philadelphia.

Valdés points out that although some of the components seem like common sense, in reality, they are often overlooked by mental and behavioral healthcare agencies. Organizations that strive to serve minority communities would benefit from formally integrating these components into their operational plans.

1. Do your homework.

When working with any community, CcTC gathers information and reviews relevant research and clinical literature, paying close attention to specialized needs and evidence-based and -informed practices in similar communities. By doing this, the agency can better meet the needs of their clientele and overcome existing barriers.

In the case of the West African community, the staff paid close detail to the literature on West Africans' beliefs about mental health and illness, as well as mental health treatment practiced in West Africa. In order to develop the program, the stigma around mental health had to be addressed since treatment is not traditionally sought out for most mental/behavioral issues, but rather used only as

a last resort for individuals whose mental health issues involve psychosis.

2. Interact with and involve the target population/community in designing programs/interventions.

CcTC empowers communities from the start by involving them in the mental and behavioral health treatment design and process. For example, teachers' committees are established so that educators and other school personnel take an active role in developing school trainings, as is the case for the Tamaa School Trainings.

As an essential component for the Tamaa Program, CcTC hired staff of West African heritage to work within the program, including two Liberian case managers who helped link families to appropriate resources in the community. Currently, the Tamaa Program's School Trainings educate participants in trauma and refugee concerns and allow schools to take an active part in the health and well-being of their students.

Additionally, the Tamaa Advisory Board Committee was created early on in the program to oversee the implementation of the program in the community and to ensure the program was using best practices and that its components were culturally acceptable and accessible. The Committee is composed of various stakeholders, including Southwest Philadelphia school principals and

other administrators, West African community and religious leaders, political leaders serving Southwest Philadelphia, and leaders in Philadelphia's mental and behavioral health and child protective service systems.

3. Create a continuous feedback loop.

CcTC constantly solicits feedback from its consumers and uses that information to modify programs. Valdés recognizes the importance of flexibility and promotes the idea of thinking outside the traditional parameters of how programming and intervention should operate. With this flexibility, staff can more effectively respond to the needs of children and their communities.

In the case of the Tamaa Program's Caregiver Education and Support Group, the group leaders routinely request feedback from participants and alter the program topics to fit the community's evolving needs. CcTC also distributes and utilizes teacher training feedback forms, and children evaluate their own experiences of the Children's Trauma- and Grief-Focused Therapy Groups. In this way, the agency ensures that its programs fit the current and changing needs of its clients and adjusts services as needed.

4. Ensure that programs fit the agency mission and vision, and ensure an organizational commitment to making them work.

Valdés speaks often about CcTC's ability to take risks. The agency and its entire staff are very clear about the mission and the purpose of their work, and programs are developed with the goal of fulfilling this mission. Internalizing the mission enables staff to suggest new initiatives that are in keeping with core values. Furthermore, by getting everyone, including its Board of Directors, to fully understand and buy in to the programs, the agency can take risks and make decisions that might not seem practical at first glance, but ultimately serve the best interests of the children.

5. Make services multi-dimensional, not one-dimensional.

Highly aware of issues of stigma, along with other barriers to the treatment of mental and behavioral health issues, CcTC uses a creative and multi-faceted approach to address communities' needs. By working in schools and communities, offering outpatient services, individual and group therapy, and a host of other options, the agency is more likely to make a positive impact and reach a greater number of children and their families.

For example, some parents and caregivers who are reluctant to allow their children to participate in group therapy might initially respond more positively to assistance from a Case Manager who can provide knowledge of the services and help the family meet some of their basic needs. Once a relationship is established

with a Case Manager whom the family has found helpful, then the family may be more open to allowing their child(ren) to participate and also may be open to other services available.

6. Make careful staffing decisions.

Staffing is particularly relevant when dealing with diverse communities. CcTC considers the language skills and ethnicity of its staff when assigning them to work in specific communities. With employees of various cultures and language backgrounds, the agency is able to connect with communities all over Philadelphia.

The two case managers assigned to the Tamaa Program are Liberian, as most families served by the program are from Liberia. They too have experienced the effects of wars and are able to connect with their clients emotionally, linguistically, and culturally. CcTC also worked closely with West African cultural consultants to help the agency and staff gain knowledge and build trust in the community to enhance the agency's ability to provide effective services. This was important especially when going into the homes of families who were not from Liberia, but from another West African country. Staff would be accompanied to the home by someone from the family's country of origin to help provide a cultural bridge and create a level of comfort for the family. Finally, throughout the Tamaa Program, staff members work in teams to provide certain services. For example, the Children's

Trauma- and Grief-Focused Therapy Groups are co-led by a trauma specialist and a West African mental health worker, so that both the trauma expertise and the cultural competence are present.

7. Locate or co-locate programs in the community.

CcTC always takes into account location when strategizing about providing effective services. The agency itself is located in the center of Philadelphia to avoid affiliation with any one neighborhood or ethnic group. However, specific programs are situated throughout the city, in schools, neighborhoods, and community centers where they are most needed.

CcTC often considers co-locating with another agency that already serves an important role in the community or neighborhood. The agency does not limit itself to working with other mental/behavioral health agencies but rather seeks to partner with those organizations most integrated into communities. So, for example, the Tamaa Program shares its headquarters with ACANA (African Cultural Alliance of North America) in the heart of Southwest Philadelphia where the majority of the children and families served by the program live. ACANA was a natural fit with a partnership because of their high visibility and deep connections to the West African community. With the agencies partnering together, the already existing level of trust helped the Tamaa Program and its

components gain easier access into the West African community, and CcTC helped ACANA with some programming support they needed to better serve the community.

8. Get involved in the community to ensure high visibility and a strong presence.

Although CcTC is a mental and behavioral health organization, the agency has woven itself into the fabric of Philadelphia's ethnic enclaves. Valdés notes that by attending and participating in various community events, including health fairs, religious events, festivals, and more, CcTC becomes an integral part of the community and is able to gain the trust of its members. CcTC can then use this trust to access families that would normally fall outside the reach of traditional children's mental and behavioral health care.

Every year, Tamaa organizes a Community Clean-up Event, in which families (both West African refugees and their non-refugee neighbors), business and community leaders, and many others in Southwest Philadelphia join in to aid in the beatification efforts in the community by cleaning the block where ACANA and the Tamaa Program are located.

9. Collaborate and develop strategic partnerships.

Because Valdés has provided CcTC with a clear sense of mission and purpose, the agency is confident about seeking out partnerships with other organizations, both locally and nationally. Valdés notes that many agencies feel intimidated by the prospect of sharing resources, ideas, and even the credit for innovative techniques. However, CcTC recognizes that it cannot solve all problems on its own, so it seeks out relevant collaborations and partnerships.

For example, many West African refugees arrive in the United States with a variety of problems beyond mental and behavioral health, including lack of job training and access to community resources. Staying true to its purpose as a mental and behavioral health social service agency, CcTC realizes that by partnering with organizations such as ACANA, African community groups, the National Child Traumatic Stress Network, and others, it can offer improved outcomes for the families served.

Outcomes: CcTC's Social Return on Investment

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The mental and behavioral health consequences of traumas experienced by West African refugee children and youth in Southwest Philadelphia do not remain isolated in the refugee community. They are compounded

by the tense relationship between African Americans and the new refugee population. The socioeconomic problems rampant in Southwest Philadelphia and other low-income neighborhoods provide the perfect recipe for juvenile violence; the city has one of the highest murder rates of any major U.S. city, earning it the nickname "Killadelphia" (Gambacorta 2009). The city is also overwhelmed with illegal weapons and, as the District Attorney told journalists in 2007, youth are at risk: "Now we have youngsters as young as 13, 14, 15 with Tech nines and Mac tens, and semi-automatics" (Serrano 2007).

The already traumatized West African refugee children and youth respond to the fear of being attacked by forming gangs, according to Portia Kamara, a Liberian-born director of Multicultural Family Services. "The kids talk about being called African chimps, African monkeys, sometimes being told to go back to Africa," she said (FrontPage Africa 2005).

CcTC has proven to be highly effective in implementing a mental health and social behavioral intervention approach with the high-risk West African refugee population that works by helping individual children and families, while preventing future costs to society. According to Lanfia Waritay, the Tamaa Team Leader at CcTC, the program serves more than 80 clients per year, on average. School Trainings reach between 10 and 50 school staff per training with 8 trainings being held per year; Caregiver Groups serve about 20 individuals; Case Managers serve

20 individuals on a biweekly basis; and approximately 40 attend the Children's Trauma- and Grief-Focused Therapy Groups annually. To evaluate the success of the Children's Trauma and Grief-Focused Therapy Groups, program staff administers three pre- and post-test measures. In addition, on a quarterly basis, Tamaa staff members collect school information on each participant, including grades, attendance, detentions, and suspensions. Finally, Tamaa group therapy leaders administer a satisfaction survey to children at the end of each group therapy cycle (Children's Crisis Treatment Center n.d., 17).

According to Tamaa's Team Leader, within 1 to 1½ years, about 84 percent of the children treated successfully complete the program. The remaining 16 percent will usually need more intensive mental health treatment, or be referred to other agencies for increased services. CcTC estimates that the total cost for running the Tamaa Program for 40 children each year is approximately $340,000, or $9,000 per youth. Compare this with the national average of the costs associated with crime committed by juveniles: $16,600 to $17,700 in costs to each victim, not including $44,000 in costs to the criminal justice system.

Considering the lost economic contribution of incarcerated criminals and calculating the total cost to society of one youth turning to a life of crime (estimating that this individual will commit 68 to 80 crimes during a lifetime), total estimated annual costs to society range

from $2.6 to $5.8 million (Cohen and Piquero 2008). Not all 40 children served at any given time by a case manager in the Tamaa Program would necessarily have become juvenile delinquents. Based on anecdotal evidence we can assume that 70 percent — or 30 children and youth — in each cohort are prevented from becoming juvenile delinquents and incurring $2.6 million in annual costs. If the program has a success rate of 84 percent, we can conclude that 25 West African youth are successfully kept out of the juvenile justice system each year by Tamaa. CcTC is spending just $9,000 per youth to create a social return on investment of approximately **$65 million per year for those 25 youth** — a huge savings by anyone's estimate.

As the ACE study cited earlier found, trauma not only increases the likelihood of criminal activity, but it also heightens addictions. The more traumatic events children experience, the more likely they are to use street drugs or tobacco, abuse alcohol, engage in promiscuity, or even attempt suicide (Redding 2003). Thus, CcTC's effective treatment of at-risk minority youth, normally facing limited access to behavioral healthcare solutions, creates societal benefits that increase and multiply as the children enter adulthood.

Hope for the Future

Hope for the Future

Mohammed, now age 11, participated in one of CcTC's Tamaa Program school-based Children's Trauma- and Grief-Focused Therapy Groups throughout the last school year. During the weekly, one-hour group sessions, Mohammed was initially hesitant to talk about what had happened to him in Liberia. However, after a few weeks, this child's level of participation and attitude toward the group changed significantly. During one group session, while watching a video about children's experiences as refugees, Mohammed joked and laughed about the hardships the children shared in the video, but by the end of the video, he was tearful and quietly murmured, "The same thing happened to me."

In the following weeks, during discussions about the effects of trauma and the experiences of war, as refugees, and in a new country, Mohammed transformed into a positive force within the group. He opened up, sharing many personal thoughts, feelings, and memories. By the end of the school year, Mohammed no longer waited for the CcTC staff to retrieve him from his classroom for group sessions; he eagerly appeared at the group room door on his own. At the group goodbye party, Mohammed said he felt sad because the group had ended, and he noted, "I'll miss this group. It was the best."

Mohammed's experience, while unique to his life, represents the story of every child treated by CcTC and its myriad programs. With their innovative approach to integration and their unrelenting commitment to

understanding the specific situations and points of views of the diverse Philadelphia community, CcTC offers effective solutions to problems associated with children's mental and behavioral health care.

Recognizing the importance of caring for children today to secure the continued health and success of society, CcTC prevents huge future costs to everyone by working to solve difficult problems today. Through the Tamaa Program and every other program designed and implemented to reach infants through older children in Philadelphia, CcTC provides irreplaceable services to the city and a model that can be understood and replicated all over the United States, with enormous individual and societal benefits.

Since 2004, Amy Schlosberg has worked in the nonprofit and education sector. She holds a B.A. in Anthropology/Sociology from Gettysburg College and is currently a candidate for the M.Sc. in Nonprofit/NGO Leadership at the University of Pennsylvania.

Mikaela Levons has worked in the nonprofit sector for the past five years. She graduated from Princeton University with a Bachelor of Arts degree from the Woodrow Wilson School of Policy & International Affairs. She is currently a candidate for the M.Sc. in Nonprofit/NGO Leadership at the University of Pennsylvania.

Recipients of Goldring Fellowships and candidates for the degree of Master of Science in Non-profit/NGO Leadership, School of Social Policy and Practice, University of Pennsylvania.

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