NACCHO[SM]

National Association of County & City Health Officials

Toolkit

Trauma-informed Approaches for Local Health Departments and Non-profit Organizations Working with RIM Communities

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Table of Contents

Purpose of the Toolkit 4

Who Should Use This Toolkit? 4

Background 5

What Is Trauma? 6

6 Key Principles of Trauma-Informed Care Checklist 8

Integrating a Trauma-Informed Approach Checklist 10

Case Studies 15

Resources 16

Purpose of This Toolkit

This toolkit will provide local health departments (LHDs) and non-profit organizations (NPOs) an overview of trauma-informed approaches when working with RIM communities that have experienced traumas across multiple contexts, at the individual, interpersonal, and collective or systemic levels. By leveraging trauma-informed approaches, LHDs and NPOs can engender trust and meaningful engagement with RIM communities, which is crucial to service uptake and improved health outcomes. A case study also will be included.

Who Should Use This Toolkit

This toolkit is intended for LHD and NPO administrators, program managers, and staff delivering direct services to RIM communities interested in learning about and identifying tools and resources to support the facilitation of health and wraparound services supporting RIM populations.

Background

Trauma, stemming from various adverse experiences, is a significant public health concern that disproportionately impacts people in refugee, immigrant, and migrant (RIM) communities.[1] Over the past decade, the number of people fleeing their countries due to conflict, persecution, or violence more than doubled, to over 108 million.[2,3] People in RIM communities have survived these geopolitical, climate, and economic upheavals,[4] adapting their social networks and resources to new countries. Yet they may face challenges to finding culturally aligned care for physical and mental health that may be associated with their unique immigration experiences.[5,6,7] Others may be concerned with punitive immigration policies,[8] as well as past negative experiences with medical providers outside their communities whose lack of linguistic and cultural understanding resulted in ignored requests for clear guidance, discrimination, and/or medical abuse.[9]

Trauma-informed care offers organizations and providers an approach to address individual and community histories of trauma and how it impacts their clinical and behavioral outcomes, beliefs, and engagements with healthcare systems.[10] Instead of asking, “What is wrong with this person?” providers and organizations leveraging trauma-informed approaches ask, “What happened in this person’s environment that harmed them psychologically and/or physically?”[11] With this comprehensive approach, providers can help ensure that interactions with service users are supportive and do not unintentionally cause further harm. This often is particularly important for people in RIM communities who have fled extreme hardship, only to find themselves in a country from which they feel alienated.[12] A vested understanding of these experiences, coupled with buy-in from RIM community leaders and stakeholders, offers LHDs and NPOs an opportunity to create and deliver socio-culturally responsive services grounded in trauma-informed care.

What Is Trauma?

Trauma can occur at distinct levels, having adverse effects on mental, physical, social, emotional, and/or spiritual well-being:

- **Individual traumas:** These are events or circumstances that impact an individual emotionally and/or physically, such as a physical attack or robbery, often by those unknown to them. These events do not involve others in the lives of individuals, potentially manifesting feelings of isolation.
- **Interpersonal traumas:** These include adverse events experienced by individuals that were carried out by those close to them, such as interpersonal violence, human trafficking, and elder abuse. For children, interpersonal traumas often encompass adverse childhood experiences (ACES), which occur to negative events during the first 18 years of a person's life, notably abuse (emotional, physical, and/or sexual); household challenges (violence in the home, substance use); and neglect (emotional and/or physical).
- **Systemic and Collective traumas:** These are cultural, historical, social, political, and structural traumas, such as racism, bias, stigma, oppression, and genocide, that impact individuals and communities across generations. Traumas can manifest differently among groups due to factors such as the social ecology and cultural norms of a group impacted prior to the trauma(s), cultural differences, and the types of traumas experienced.

Effective behavioral health services now recognize addressing trauma as crucial, necessitating a comprehensive public health strategy that includes education, prevention, early detection, and specialized treatment within a trauma-informed framework. Trauma-informed care offers opportunities to understand experiences of stress, trauma, forced migration, and resilience of RIM communities and the social determinants driving their health outcomes. Trauma can be understood through the lenses of what the Substance Abuse and Mental Health Administration (SAMHSA)[13] refers to as the Three Es: event(s), experience of event(s), and effect.

- **Traumatic Events and Circumstances** refer to the actual or threatened physical or psychological harm from neglect, violence, or natural disasters. These events and circumstances can occur once or repeatedly over time. This reflects the concept of trauma in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as "trauma and stressor-related disorders" to include exposure to a traumatic or stressful event as a diagnostic criterion. People in RIM communities who are exposed to months of armed conflict may experience post-traumatic stress yet feel unable to discuss their symptoms with a provider who is not linguistically or culturally with them.
- **Traumatic Experiences:** Traumatizing events and circumstances generate a power differential in which a group, event, or force of nature has power over another. These power differentials often can vary by sociocultural roles. For example, within RIM communities affected by war, individuals' experiences vary significantly across gender and age, with women more likely to be impacted by sexual assault, and men by physical attack and/or forced inscription. Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of such events, and are shaped by cultural beliefs (e.g., the experience of domestic violence), availability of social supports (e.g., access to supportive family or community structure), or to the developmental stage of the individual (i.e., impact and understanding of experience differs at age 5 vs 50). As a result, women in RIM communities may delay seeking gynecological care during pregnancy due to fears of judgment from a provider with no knowledge of their culture, language, or experiences.

- **Effects of Traumas:** Traumatic events and circumstances can result in long-lasting adverse mental and physical health effects – such as ongoing hypervigilance or a constant state of arousal, to numbing or avoidance – can wear a person down, physically, mentally, and emotionally. These effects can last for varied periods of time and manifest immediately or after some time. People who experience trauma may be unable to trust new people and relationships or navigate daily tasks, and experience limitations in their ability to think clearly, remember things, and engage in behavioral and emotional regulation. Impacted individuals and communities may not immediately recognize (or wish to name) the connection between the traumatic events and the effects. Children in families exposed to months of armed conflict may have trouble sleeping and trusting new people, which can impact them in their adopted countries and at school. Their caregivers, and the children, would benefit from the support of culturally-aligned clinical and behavioral providers who understood their lived experiences.

6 Key Principles of Trauma-Informed Care Checklist

Trauma-informed care differs from trauma-specific services or trauma systems, encompassing a program, organization, or system that:

- Realizes the widespread impact of trauma and understands potential paths for recovery;
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively prevent retraumatization.

These tenets are reflected in the 6 key principles fundamental to a trauma-informed care approach, as follows:

☐ **1. Safety:** Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe, and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority. Creating a safe space can be as simple as ensuring that TVs show calm images, and that sound is kept at a minimum to ensure clients dealing with hypervigilance related to traumatic experiences feel calm and secure.

☐ **2. Trustworthiness and Transparency:** Organizational operations and decisions are conducted transparently to build and maintain trust with their clients, family members, staff, and others involved. Clinics may have posters outlining their mission and rules in multiple languages, while clinicians themselves may ensure that they and/or their support speak the language of their clients, ensuring that they understand what is happening in the appointment, what the diagnoses are, and what steps they need to take to address them.

☐ **3. Peer Support:** Peer support is critical to establishing safety, trust, collaboration, and hope among clients as they recover. The term "peers" refers to individuals with lived experiences of trauma; in the case of children, this may be family members of children who have experienced traumatic events and are caregivers in their recovery. Peers have also been referred to as "trauma survivors." Clinics may leverage peers to engage members of the community, such as pregnant persons, who require medical care, but fear seeing a Western provider. They may accompany these persons to the clinic, help them complete paperwork, and answer their questions.

☐ **4. Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. For example, an NPO or LHD may establish a community advisory board comprised of RIM community representatives, such as local business leaders and advocates. The Board can help make recommendations to ensure NPOs and LHDs develop culturally and linguistically appropriate interventions and services. The approach can help engender trust in NPOs and LHDs, encouraging uptake of their programs and services and ultimately improving the health outcomes of people in RIM communities. Trauma-informed care also means ensuring staff know how to protect and care for themselves, preventing secondary trauma.

☐ **5. Empowerment, Voice, and Choice:** The organization centers the experiences of RIM communities and clients while recognizing that trauma may unify those who run the organization, provide the services, and/or come to the organization for assistance and support. Organizational operations, workforce development, and services must empower staff and clients alike, while recognizing the power differentials between them. Organizations must recognize that the RIM communities and clients they serve may have experienced diminished control over their care at home and in the U.S. Trauma-informed care encourages client self-advocacy, with staff facilitating rather than controlling healing. Organizations support their staff, ensuring staff and clients feel safe.

☐ **6. Cultural, Historical, and Gender Issues:** The organization actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, religion, gender identity, geography, etc.); offers access to gender-responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

Integrating a Trauma-Informed Approach Checklist

Developing a trauma-informed approach requires change at multiple levels of an organization that aligns with the 6 key principles described above. The following checklist highlights where you already are integrating these principles, and where you can improve your trauma-informed approach. For each of the three levels of integration, there are several items, each of which can be answered with "Fully Implemented," "In Progress," "Being Considered," "Not an Option," and "N/A." Note: It may be helpful to have several program staff members review the checklist Individually, compare and discuss the results, and brainstorm strategies for improvement.
(REVERSE ORDER)

Staff Level: These items assess the staff's capacity to support RIM community members who have experienced trauma.

Implementation Status

Trauma-Informed Care Characteristics	Fully Implemented	In Progress	Being Considered	Not an Option	N/A
1. Staff are trained on trauma-informed care and how to apply trauma-informed principles in every interaction with RIM communities. They know about/are skilled at working with survivors of domestic violence, sexual assault, stalking, structural violence, and other trauma and demonstrate a respectful, empathic, and collaborative approach toward survivors and their children.					
2. Staff receive annual professional development/continuing ed on trauma-informed care.					
3. Staff performance plans assess their mastery and use of trauma-informed care.					
4. Staff members complete intake/engage clients according to their needs (an interpreter, by offering TTY, video relay, etc.). They ask questions that reflect openness and interest in clients' experiences, cultures, and identities. Process includes optional questions about individual cultural, ethnic, racial, gender identity, sexual orientation, religion, and language.					
5. Staff members deliver care that considers trauma-related histories/symptoms.					
6. Staff model positive, non-shaming communication that supports healing for those in need and promotes health and well-being for everyone. They have the skills, training, and investment to provide information about trauma and its impact in an empowering and thoughtful way, including asking people what is helpful to them when they are in distress.					

7. Staff support healing for those in need through referrals to designated licensed mental health professionals, verified by our organization to be trauma informed.					
8. Staff members can support parents in understanding the impact of domestic violence and other trauma on their children and can offer age-appropriate ways to support children’s healing and resilience.					
9. Staff members assure RIM clients that they will not be excluded based on their intake questions, immigration status, and/or previous or ongoing substance use or abuse.					
10. Staff are trained not to assume clients’ experiences, including cultural, religious, or spiritual beliefs/practices, instead giving them time/ space to disclose (or not disclose).					
11. Staff members continuously model and promote healthy relationships.					
12. Staff promote assertive communication and negotiation with sexual partners to establish and maintain healthy relationships.					
13. Staff listen patiently without interruption, pleasantly provide information and answers, and ensure all participants have opportunities to speak and be heard. They provide warm, non-judgmental, empathic, and genuine interactions while maintaining healthy boundaries.					
14. Staff members demonstrate a commitment to partnering with people accessing services and are comfortable responding to people expressing distress in various ways.					
15. Staff provide an introductory statement defining and explaining trauma cues and the potential for curricula topics to bring up adverse childhood experiences.					
16. Supervision addresses the quality and maintenance of trauma-informed practice, respectfully addresses all staff questions and trauma-related concerns and provides ongoing staff support.					

Programmatic Level: These items assess the degree to which your organization/program leverages trauma-informed practices and materials, which promote skill building, competency development, and behavior change.

Trauma-Informed Care Characteristics	Implementation Status Fully Implemented	In Progress	Being Considered	Not an Option	N/A
1. Programs are facilitated through a trauma-informed lens in a comfortable and accommodating manner that is considerate of all (youth, families, and staff). Emotional and physical safety are taken seriously, with consideration given to privacy, access to outdoor spaces, lighting, noise level, and visibility of exits. Space is flexible, healing, and nurturing, and offers amenities like computer access; youth-centered spaces; art, music, or movement; communal spaces; and privacy spaces.					
2. Programmatic spaces consider the noise, chaos, and					
3. Staff members provide warm, non-judgmental, empathic, and genuine interactions with participants and their families. (This component is also a key for staff training.)					
4. Staff members provide explanations for all rules and requests.					
5. All programs have established agreements intended to protect participants' physical and emotional safety and prevent re/traumatization.					
6. As part of an introductory packet, all programs include information on trauma-informed community resources and your organization's policy on confidentiality, mandatory reporting, and/or other elements to ensure a safe and non-traumatizing space.					
7. Staff are trained and can adapt trauma-informed interventions to ensure fidelity is not compromised. (Fidelity is assessed at regular intervals.)					
8. Participants can exercise choice and consent in determining whether or not working with someone from a shared identity group would be helpful for them.					
9. Program implementation is monitored for continuous quality improvement by applying the trauma-informed care principles.					
10. Programs incorporate culturally-relevant approaches to treatment, such as relaxation techniques.					

Organizational Level: The following questions are meant to help you assess the degree to which your organization provides evidence-based programs and services intended to promote self-regulation and enhance physical and emotional safety.

Trauma-Informed Care Characteristics	Implementation Status				
	Fully Implemented	In Progress	Being Considered	Not an Option	N/A
1. The agency's mission statement, policies, and procedures include a written commitment to providing accessible, culturally responsive, and trauma-informed services for all people, inclusive of a person's race, class, age, disability, language, sexual orientation, gender, gender expression, culture, ethnicity, religion, spirituality, mental health, employment, housing stability, family and important relationships, recovery, use of substances, involvement, immigration or documentation status, access to education, and history with the criminal justice system – and facilitates inclusion in its policies, procedures, and practices.					
2. Your agency's written policies include a recognition of the pervasiveness of trauma in the lives of people participating in services, including historical trauma and structural violence, and a commitment to reducing re/traumatization, supporting healing, resilience, and well-being and working to end abuse, violence, and oppression through community outreach, prevention, and local partnerships with aligned organizations. These policies reflect an understanding of the dynamics of domestic violence, sexual assault, stalking, and other violence and abuse, including racism, transphobia, ableism, and xenophobia.					
3. You use trauma-informed care in programs and services delivered to RIM communities.					
4. Your agency intentionally funds trauma-informed care work and spaces for trauma survivors, families, and staff.					
5. Your board, staff, and other decision-making bodies, such as the organization's steering committee and/or community advisory group, include survivors, leaders, and/or other persons who have formerly engaged in your services reflective of the RIM communities you serve. They should have a full voice in assessing their communities' needs and developing action plans/timelines to implementing trauma-informed care.					
6. You clearly define your board, staff, and other decision-making bodies.					
7. You clearly outline your confidentiality policies and align them with HIPAA compliance, the Americans with Disabilities Act, the Fair Housing Act, the Civil Rights Act, and other Federal accessibility regulations, including the 2016 final rule of the Family Violence Prevention and Services Act (FVPSA), 42 U.S.C. 10404(a)(4). You share this information in writing in the clinic, online, and verbally to all clients.					

8. You have a process to refer and provide access to updated lists/ directories of trauma-informed agencies, providers, and services. (Includes licensed clinical and behavioral health services/providers with documented training in trauma-informed care.)					
9. You partner with RIM organizations that leverage trauma-informed care.					
10. You annually review, establish, and share with staff policies and procedures through a trauma-informed lens.					

Case Study

Public Health – Dayton and Montgomery County's facilities boast a Refugee Clinic that has employed strategic partnerships to deepen and improve the cultural alignment of their trauma-informed care and services for those in the RIM communities they serve. COVID-19 offered unique opportunities to expand their trauma-informed services through collaborations with connections with local RIM-serving communities. This approach enabled them to create a safe, welcoming clinical office environment run by trained staff who understood the needs of their diverse clients. Mutually beneficial partnerships enabled them to coordinate care with culturally aligned organizations, filling any remaining linguistic and wraparound service gaps. Partners, in turn, had access to vetted clinical and behavioral health services they could trust would not re/traumatize their clients.

For example, engagement with Ebenezer Healthcare Access, a community-based organization that supports the health and well-being of sub-Saharan African immigrants and refugees, provided Dayton and Montgomery County access to skilled culturally aligned translators and medical interpreters, scheduling support, transportation provision, and health education for their clients. Staff also tapped into Ebenezer Healthcare Access' cultural orientation training, which provided additional understanding of their clients' needs and lived experiences from RIM communities. Additional partnerships, such as that with Catholic Social Services of the Miami Valley's refugee resettlement program; CrossOver Community Development's resource center for local immigrants and refugees; and the City of Dayton Human Relations Council's immigrant business and economic development program and support program, further expand Dayton and Montgomery County's supportive and trauma-informed care services.

During the COVID-19 pandemic, Dayton and Montgomery County built a reputation for delivering trustworthy and culturally aligned services, and their deep connection with RIM communities. Educational materials, sessions, and vaccine clinics aligned with the needs of the diversity of the languages, cultural backgrounds, and lived experiences of the people in the RIM communities they engaged. This work ultimately speaks to the mission of Dayton and Montgomery County: "to improve the quality of life in our community by achieving the goals of public health: prevention, promotion, and protection."

Resources

Centers for Disease Control and Prevention (CDC). *CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study. 2021.*
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CDC. *Building Trauma-Informed Communities*.
https://blogs.cdc.gov/publichealthmatters/2022/05/trauma-informed/

Office of the Administration for Children, Youth, and Families. *Resource Guide to Trauma-Informed Human Services*.
https://www.acf.hhs.gov/toolkit/resource-guide-trauma-informed-human-services

Office of the Administration for Children, Youth, and Families. *Historical Trauma*.
https://www.acf.hhs.gov/trauma-toolkit/trauma-concept

Office of the Administration for Children, Youth, and Families. *Toxic Stress*.
https://www.acf.hhs.gov/trauma-toolkit/toxic-stress

Office of the Administration for Children, Youth, and Families. *Resilience*.
https://www.acf.hhs.gov/trauma-toolkit/resilience

Office of the Administration for Children, Youth, and Families. *Executive Functioning*.
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Advocates

National Center on Domestic Violence, Trauma, and Mental Health. *Resources for Advocates – Trauma-Informed Domestic Violence Advocacy*.
http://www.nationalcenterdvtraumamh.org/trainingta/resources-for-advocates-trauma-informed-dv-advocacy/

RIM Services and Interventions

Office of Refugee Resettlement. *Refugee Health Overview*.
https://www.acf.hhs.gov/orr/programs/refugees/refugee-health

Promoting Emotional Wellness Through Adjustment Support Groups.
https://hhs.adobeconnect.com/_a1020204752/p1ft0wf8wgx/?launcher=false&fcsContent=true&pbMode=normal

Provider Support

Administration for Children and Families, Office of Refugee Resettlement. *When Helping Hurts: Self-Care Strategies for Refugee Community Leaders and Service.*
https://www.youtube.com/watch?v=3Lo9xMptouQ

Trauma-Informed Care for Displaced Populations: A Guide for Community-Based Service Providers.
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Tools

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Harvard Trauma Questionnaire. Learn more here: **https://hprt-cambridge.org/screening/harvard-trauma-questionnaire**. Available in different languages. Download a copy in English here. **https://onlinematerial.posttraumatic-integration.eu/modules/document/file.php/PTIP111/Handout-M1S3A1_EN.pdf**

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