Trauma-Informed Care
for Displaced Populations

A Guide for Community-Based Service Providers

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THE NATIONAL CENTER ON Family Homelessness
for every child, a chance

A practice area of AIR's Health and Social Development Program

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Introduction

Displaced children and adults represent a unique subgroup within the U.S. population. While displacement can occur for a variety of reasons - war, natural disasters, extreme poverty, or persecution - individuals, children, and families within this group face complex challenges as they leave their homelands and work to establish a home in a new world. It can take decades to fully adjust (Clark, 2003). Common adjustment issues include adapting to a new culture, language, climate or environment, and learning new customs, while simultaneously maintaining family and cultural traditions.

For many who are displaced, trauma is central to their experience prior to, during, and post-migration (Perez-Foster, 2001; DeCandia, Murphy, & Coupe, 2013). Thus, it is critically important when serving people who have been displaced that providers understand trauma and its impact and design programs and services that reflect the principles of trauma-informed care.

In response to the need to build the capacity of community-based organizations to implement trauma-informed care for displaced children and families, The National Center on Family Homelessness at American Institutes for Research (AIR), implemented the Healing Hearts Promoting Health project (HHPH).

Funded by the W.K. Kellogg Foundation, HHPH was an intensive pilot project designed to address the trauma and related nutrition, health, and wellness issues of recently displaced families and children, with particular focus on Haitian earthquake evacuees in Southern Florida. The goal of this project was to engage providers in Miami in a collaborative learning experience to bring knowledge of trauma-informed care into programs serving populations.

A key component of HHPH was the creation of *Trauma-Informed Care for Displaced Populations: A Guide for Community-Based Service Providers*. Adapted from The National Center on Family Homelessness's original *Trauma-Informed Organizational Toolkit*, this Guide includes as its central component, a *Trauma-Informed Organizational Self-Assessment for Displaced Populations* that provides agencies with a roadmap for becoming trauma-informed.

This Guide can be used by community-based organizations that work with families, children, youth, unaccompanied minors, and individuals in various settings (e.g., outpatient settings, mental health, transitional housing programs, shelters, and schools). Leaders within these organizations who are looking to improve their effectiveness in engaging displaced populations can use this tool to begin the process of integrating a trauma-informed approach.

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

1. Background information on displaced populations, trauma-informed care, and the creation of the *Trauma-Informed Organizational Self-Assessment for Displaced Populations*.
2. The *Trauma-Informed Organizational Self-Assessment for Displaced Populations*.
3. Additional resources.

Section 1

Understanding the Needs of Displaced Populations

Understanding the Needs of Displaced Populations

I. Background

An estimated 45.2 million people in the world have been displaced from their homes and have fled to another country (UNHCR Global Trends, 2012). Some are driven by poverty or persecution, and others are displaced by natural disasters (UNHCR, 2006). They flee their homelands in search of safety and security; however, in their host country, many are confronted with significant challenges.

People who are displaced from their homelands often struggle with ongoing poverty, poor living conditions, economic exploitation, discriminatory treatment, and even homelessness (Reed, Fazel, Jones, Panter-Brick, & Stein, 2011; Smith Fawzi, Betancourt, Marcelin, Klopner, Munir, Muriel, Oswald, & Mukherjee, 2009; Beckerman & Corbett, 2008).

To effectively serve this population, community-based agencies need to demonstrate an integrated understanding of the unique cultural, legal, and mental health needs common among displaced individuals and families. If service providers do not fully understand the special needs of those who have been displaced, their needs can go unmet for years as they struggle to resettle.

Displaced Groups in the United States: Characteristics and Needs

Millions of people migrate to the United States in search of a new home. According to the U.S. Census Bureau, "foreign-born" is defined as "anyone who is not a U.S. citizen at birth," including naturalized citizens, lawful permanent residents, temporary migrants, refugees, and undocumented immigrants (American Community Survey [ACS], 2012).

The U.S. Census Bureau estimates that the number of foreign-born persons in the United States is nearly 40 million or 13% of the total population (DeCandia, Murphy, & Coupe, 2013; ACS, 2012; U.S. Census Bureau, 2011; Bhaskar, Scopiliti, Holloman & Armstrong, 2010). There are a number of different types of displaced groups, each with unique experiences and challenges. For the purpose of this Guide, the following primary categories of displaced populations are highlighted: immigrants, refugees, and environmental or disaster refugees.

Immigrants

The United States is a racially and culturally diverse society. Every state in the U.S. is inhabited by immigrants; they represent a total of 125 countries (DeCandia et al., 2013). For example, the 2008 census counted 546,000 foreign born Haitians living in the U.S., although the number is likely much higher due to lack of participation in the Census process. New York, New Jersey, and California are home to the traditional gateway cities newcomers tend to migrate to; however, other gateway cities are found in Arizona, Colorado, Northern California, and Oklahoma (Matthews & Jang, 2007; Hernandez, Denton, & McCartney, 2007). The majority of Haitians in the U.S. reside in Florida (46%), New York (25%), Massachusetts (7%), and New Jersey (8%).

Immigrants face many challenges as they adapt/acculturate that include learning a new language and customs, creating a home in an unfamiliar place, and maintaining their own rituals, identity, cultural beliefs and traditions while adapting to their new environment (Perez, 2001). It often takes immigrants multiple years to adjust to the United States (Clark, 2003; DeCandia et al., 2013).

Among the most significant challenges for immigrant populations are high rates of poverty and associated stressors. The U.S. Census Bureau (2010) estimates that 19% of immigrants live below the poverty line, compared to 15% of those born in the U.S.. According to the most recent statistics, people who migrated from Mexico are among the highest concentrated poverty group (28%), followed by immigrants from Latin American (24%), and Africa (21%) (ACS, 2012).

People who experience high rates of poverty usually experience more challenges to securing permanent and affordable housing. Most of the time, they live in "doubled-up" housing situations and spend more than half of their monthly income on housing expenses (DeCandia et al., 2013). These groups are less likely to access public assistance as well as private benefits such as private health insurance (DeCandia et al., 2013; ACS, 2012, Matthew & Jang, 2007; Capps et al., 2004).

Children of Immigrants

Children with immigrant parents make up one fifth of the U.S. population. These children bring diverse languages, experiences, and perspectives to the communities in which they assimilate. Children of immigrant families have unique strengths as well as specific vulnerabilities, due to their bicultural heritage.

Twenty-two percent of children of immigrant families are under the age of six (DeCandia et al., 2013; Matthew & Jang, 2007). Of these children, 81% live with one foreign-born and one native-born parent; this is defined as mixed families. For sixty-eight percent of these children, their parents have been living in the United States for more than ten years. Nearly one quarter have one parent who is undocumented, although 93% of the children are U.S. citizens (DeCandia et al., 2013; Hernandez et al., 2007; Matthews & Jang, 2007; Capps et al., 2004; Capps, 2001).

The majority of children of immigrant parents live in bi-lingual households. Most families speak at least one language in addition to English, and nearly 75% of children are fluent in at least two languages, a valuable asset in an increasingly global economy. In contrast, a smaller though significant percentage (26%) live in households with no English speaking parent (Hernandez, 2007). This is the group that is most at-risk for social and cultural isolation, poverty, and homelessness and struggle to fully integrate into the U.S. society.

Refugees

United States has been home to more to nearly three million refugees since 1975. By definition, refugees are people who have had to leave their country of origin due to extenuating circumstances (e.g., war, persecution, political instability). Stressful experiences, such as long periods of time spent in refugee camps may affect them as they arrive in the U.S. (DeCandia et al., 2013; Allwood et al., 2002; Marcella et al., 1994).

During migration, additional stressors may include loss and separation from family members (Perez-Foster, 2001). These experiences may hinder people's ability to fully meet their potential in the host country (DeCandia et al., 2013; NCTSN, 2003). The Office of resettlement has agencies that are designed to meet short-term needs of refugees once they arrive in their new country; however, these limited resources are often insufficient to help people reach their long-term goals.

Compared to the general population, the psychosocial and economic needs of refugees are considered to be much higher (UNHCR, 2011). Refugees who relocate to the United States struggle with unemployment and high rates of food insecurity (UNHCR, 2013; DeCandia et al., 2013). Some refugees relocate again from their original resettlement placement within the host country due to instability, housing, or lack of employment (e.g., moving from one state to another in the United States) (DeCandia et al., 2013).

Policies and public attitudes towards this group remain an issue. Refugees face racial and cultural discrimination as they integrate into the United States (UNHCR, 2011). As previously noted, refugees face many challenges such as unemployment, lack of social and community connection, and poverty as they adapt to western society. These ongoing stressors can impact one's physical, mental, and spiritual well-being. (DeCandia et al., 2013; Chiu et al., 2009; Breslau et al., 2007; Grant et al., 2004). Culture-specific challenges such as stigma related to mental health services and lack of cultural and linguistic competence on the part of service providers, may prevent refugees from accessing critical services to address these stressors (Chanoff, 2002).

Environmental or Disaster Refugees

In the aftermath of natural disasters, millions of families and individuals have been left without their homes. Some remain in their communities and attempt to rebuild or are relocated within their country (e.g., Hurricane Katrina and Sandy evacuees in the U.S.) or to other countries, as in the case of evacuees of the earthquake in Haiti in 2010. In either case, families are often faced with the challenge of developing new routines and support systems in an unfamiliar environment with different cultural norms. For many, the trauma of the disaster itself - earthquakes, flood, hurricanes, mud slides - is compounded by the destruction and of losing their homes, possessions, and even loved ones. This traumatic and sudden loss of everything they have known can be devastating.

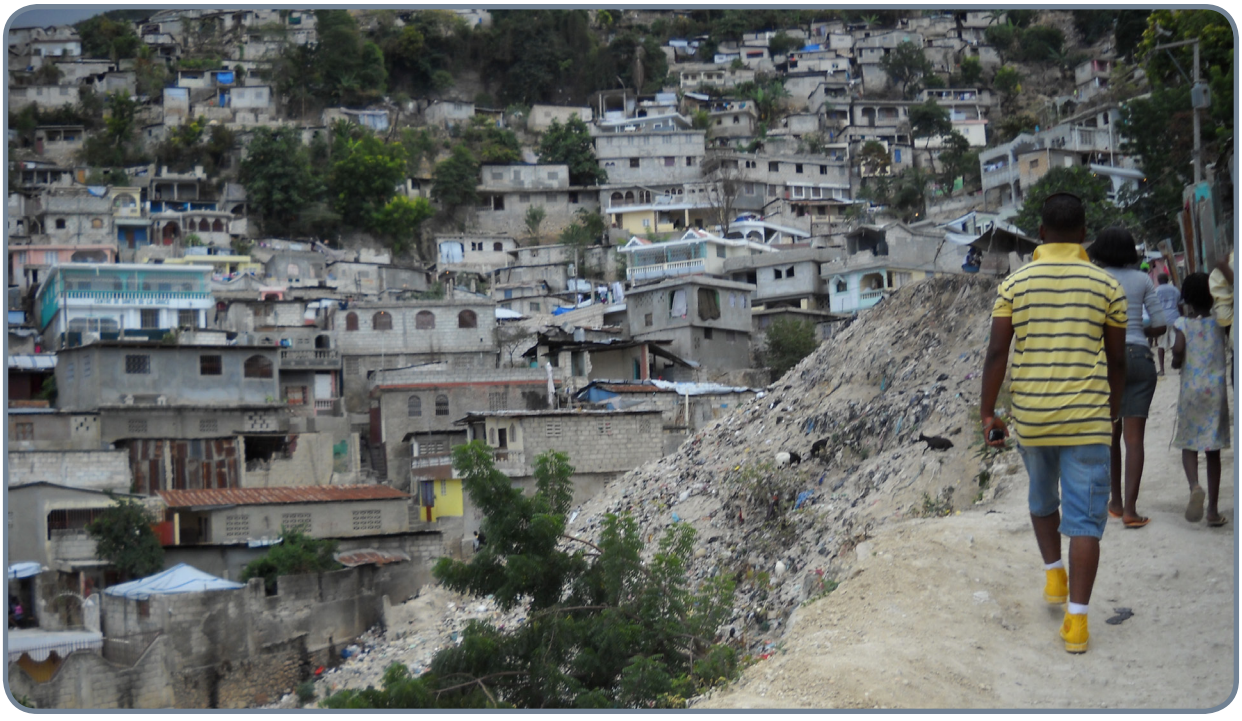
In many parts of the United States and around the world, natural disasters are not a one-time, discrete event but rather, mark the start of multiple, on-going traumatic stresses that are superimposed on other stressors (e.g., poverty, limited social supports and resources, catastrophic loss, economic and political instability) and past traumatic experiences (e.g., violence, abuse, mental health challenges). For example, the pre-hurricane lives of many children affected by Hurricane Katrina were characterized by high poverty rates, community violence, hunger, and educational challenges (Lowe, Chan, & Rhodes, 2010).

For children, these experiences can be particularly impactful, and research conducted after natural disasters shows that children often manifest a range of physical, behavioral, emotional, and cognitive symptoms (Robert, Mitchell, Witman, & Taffaro, 2010). Many children are relocated to other areas within their countries of origin or to other countries and have to start a new life in unknown environments with new routines, cultures, new schools, while trying to keep their cultural identities.

Experiences of Haitian Evacuees: Pre/Post-Earthquake

The Haitian people are resilient and possess the capacity to navigate social, cultural, and physical resources that sustain their well-being while living under stressful life conditions. Haitians draw strength from their strong religious beliefs, cultural and family traditions, and deep sense of community (Nicolas, Schwartz, & Pierre, 2010; World Health Organization, 2010). Haitians allow themselves to see life through a positive lens; collectively most families support each other and negotiate their way to experience their culture in meaningful ways. However, years of conflict and political instability, chronic stress from extreme poverty, and violence in the streets have contributed to ongoing trauma and the suffering of families and their children. The earthquake disaster of 2010 compounded an already troubling situation for many Haitians. Nearly 200,000 or more individuals died in the earthquake, thousands were left without homes/displaced, and many were injured (World Health Organization, 2010).

Although life for most Haitians prior to the earthquake was characterized by deep poverty, food insecurity, political instability, mud slides, and hurricanes, the earthquake created situations that were far beyond the usual range of events these children and their families generally encounter (Nicolas, Schwartz, & Pierre, 2010; World Health Organization, 2010). The earthquake exacerbated existing vulnerabilities for Haitian children, high rates of illiteracy, infant mortality, and extreme poverty. The Haitian earthquake left millions without basic necessities and led to the loss of loved ones, homes, churches, and schools. Many Haitians have relocated to the U.S, coming to a country with new routines, a different culture, and unfamiliar neighborhoods.



II. Trauma in the Lives of Displaced Populations

What makes an experience traumatic?

The experience involves a threat to one's physical or emotional well-being.

It is overwhelming.

It results in intense feelings of fear and lack of control.

It leaves people feeling helpless.

It changes the way a person understands themselves, the world, and others.

(American Psychiatric Association, 2000; Herman, 1992)

In contrast to the usual stresses and strains of our daily lives, traumatic events occur outside the realm of expected daily experiences; threaten one's physical and emotional well-being and basic sense of safety in the world; and leave people feeling overwhelmed, fearful, helpless, and out of control. Some traumatic experiences are one-time events (e.g., natural disasters or accidents), while others are chronic and may accumulate over a lifetime.

The prevalence of trauma in the lives of displaced populations, particularly immigrations and refugees is extraordinarily high. Children and adults may be exposed to a complex array of traumatic stressors across the three phases of the resettlement process that include pre-migration; migration; and post-migration (Perez-Foster, 2001).

Trauma can occur at all stages of an immigrant, refugee, or evacuee's journey (Beckerman & Corbett, 2008; Perez-Foster, 2001). Pre-migration trauma in a person's country of origin may include: extreme poverty, war and political instability, exposure to violence, natural disasters, or persecution. During migration, sadness over what has been lost, accompanied by the uncertainty and fear of what is to come is often compounded by further loss or separation from family members and community.

Once in the U.S., many immigrants face a number of potentially traumatic experiences in their host country. Discrimination, loss of employment, chronic poverty and underemployment, substandard living conditions, and homelessness are common. Alongside the day to day challenges, many undocumented immigrants fear deportation and thus avoid reaching out for support from service systems to avoid detection (DeCandia et al., 2013).

Stages of Migration and Related Stressors

Pre-migration: Stressors may include events that directly precipitate displacement including war, torture, separations, extreme poverty, exposure to violence, natural disasters, forced labor, starvation, or forced combat.

Migration: Stressors include family separations, loss of loved ones, loss of possessions, fear, and lack of food.

Resettlement: Stressors include those related to acculturation such as discrimination, loss of cultural connection and identity, loss of community, social isolation, language barriers, poverty, substandard living conditions, and homelessness.

(Beckerman & Corbett, 2008; Perez-Foster, 2001)

Impact of Trauma

Potentially traumatic experiences are first registered at a physiological level, as the body's stress response system takes over to identify and respond to a threatening situation. The limbic system, known as the brain's emotional control center, plays a key role in identifying incoming sensory information as threatening (Shin, Rauch, & Pitman, 2006; Cohen, Perel, DeBellis, Friedman, & Putnam, 2002; Perry, 2001). Higher, more complex regions of the brain (e.g., the prefrontal cortex) contextualize and evaluate incoming information to determine whether a situation is unsafe (van der Kolk, 2003; Cohen et al., 2002).

In the face of confirmed threat, structures in the limbic system, particularly the amygdala and hypothalamus, activate the body's survival responses: fight, flight or freeze (Saxe et al., 2006; Cohen et al., 2002; Perry, 2001). Neurohormones, including adrenaline and cortisol, prepare the body for action and support a later return to a physiological state of balance once a threat has passed (Perry & Pollard, 1998; Perry et al., 1996). An event becomes traumatic when it overwhelms the stress response system and leaves people feeling helpless, vulnerable, out of control, and overly sensitive to reminders of the event (Brewin & Holmes, 2003; Herman, 1992).

Acute symptoms following a traumatic experience may include nightmares or flashbacks; agitation, irritability, and anxiety; hypervigilance; trouble concentrating; and feeling numb or disconnected (American Psychiatric Association, 2000). People may respond to trauma in different ways based on culture and cultural norms. For example in non-Western cultures, trauma is often expressed somatically (e.g., distress manifesting as physical complains and ailments versus talk of emotions) (Wilson & So-Kum Tang, 2007).

People's ways of understanding, making meaning of, and recovering from trauma are also influenced by culture (e.g., spiritual perspective and rituals, social connection and support, experience with service providers, help-seeking practices/attitudes).

Culture-specific Descriptions of Trauma

Trauma is common across cultures; a particular culture may not use the word "trauma" but instead have other words to describe the impact of stressful experiences.

In the Haitian culture, the term "seizisman" or "seized-up-ness" is used to describe responses (often somatic symptoms such as stomaches, headaches, etc.) brought on by an unexpected event or situation. Common examples include receiving bad news, witnessing trauma, or seeing dead bodies.

(Cook Ross Inc, 2010; World Health Organization, 2010; Nicolas, DeSilva, Grey, & Gonzalez-Eastep, 2006).

Although most people are able to recover relatively quickly from traumatic events, others experience more severe, debilitating, and long-term health and mental health consequences. Whether a person continues to struggle following a traumatic exposure depends on many mediating factors that include: the severity of the event; exposure to other traumatic experiences either past or current; biological traits; individual coping styles and skills; family history; attachment to caregiver; and level of social support (Pat-Horenczyk, Rabinowitz, Rice, & Tucker-Levin, 2009; Brewin, Andrews, & Valentine, 2000; van der Kolk et al., 1996). Each of these factors impact whether an individual is able to recover from trauma without developing more significant challenges, including Post-Traumatic Stress Disorder (PTSD).

The hallmark symptoms of PTSD that impact daily functioning include: re-experiencing the traumatic event (e.g., nightmares or flashbacks); hyperarousal (e.g., difficulty falling or staying asleep, angry outbursts, difficulty concentrating, hypervigilance); avoiding reminders of the event along with constricted behavior and numbing (e.g., diminished interest or participation in significant activities, feeling detached or estranged from others); and dissociation in which behaviors, feelings, physical sensations, and thoughts associated with the traumatic event are fragmented and walled off from other memories (American Psychiatric Association, 2000; Yehuda, 2002).

In children, PTSD symptoms may include fear, worry, sadness, low self-worth, and repeatedly acting out the event through play. In teens, PTSD may manifest as aggressive or impulsive behaviors, out of place sexual behavior, self-harm, and drug and alcohol abuse (United States Department of Veterans Affairs, 2012).

Traumatic events commonly experienced by displaced individuals and families such as exposure to violence, loss, extreme poverty, and long-term instability can have a significant impact over time. As traumatic experiences accumulate, responses become more intense and have a greater impact on functioning. Ongoing exposure to traumatic stress can impact all areas of people's lives, including biological, cognitive, and emotional functioning; social interactions/relationships; and identity formation (Putnam, 2006; Saxe et al., 2006; National Scientific Council on the Developing Child, 2005; Cohen et al., 2002; Perry, 2001; Perry et al., 1996).

Trauma that goes unrecognized and unaddressed in childhood has long-term individual and societal implications. The groundbreaking Adverse Childhood Experiences (ACE) Study highlights the significant connection between childhood exposure to trauma and adverse adult outcomes. Specifically, multiple adverse childhood experiences (e.g., physical or sexual abuse, witnessing violence) are associated with social, emotional, and cognitive impairment; high-risk behaviors as coping mechanisms (e.g., eating disorders, smoking, substance use, self-harm); severe health problems; and greater risk of early death (Felitti & Anda, 2010; Feletti et al., 1998). The cost to society in human and economic terms is significant.

PTSD Diagnosis and Cultural Variations

Current criteria for diagnosing PTSD may not capture all cultural variations. PTSD may be expressed differently across cultures (e.g., some cultures may express only 2 of 3 criteria; others may express different symptoms not currently included in the criteria such as somatic symptoms). Without awareness of these cultural variations, providers may miss critical information that helps them to make an accurate diagnosis.

(Hinton & Lewis-Fernández, 2010; Wilson & So-Kum Tang, 2007; Scheeringa, Wright, Hunt, & Zeanah, 2006)

Post-Trauma Responses in Service Settings

People who have experienced on-going trauma are more likely to view the world and other people as unsafe. Those who have been repeatedly hurt by others may come to believe that people cannot be trusted. Lack of trust and a constant need to be on alert for danger makes it difficult for survivors to ask for help, trust providers, and form appropriate, boundaried relationships. Common stressors in service settings (e.g., completing paperwork, being asked personal questions, strict rules, demands from staff) may be triggering and lead to heightened and seemingly extreme responses that may be misunderstood by providers as purposefully offensive, rude, or aggressive (Hopper et al., 2010; Hodas, 2006).

Post-trauma responses include: difficulty following through on commitments; avoiding meetings and other isolating behaviors; frequently engaging in interpersonal conflicts; becoming easily agitated and/or belligerent; demonstrating a lack of trust and/ or feel targeted by others; continued involvement in abusive relationships; and active substance abuse (Hopper, et al, 2010). Traumatized children may be difficult to redirect, seem emotionally out of control, avoid taking responsibility, appear oppositional and disruptive, and withdraw (Hodas, 2006).

These behaviors can be best understood as adaptive responses to manage overwhelming stress. However, without understanding the connection between trauma and current behaviors, providers may label a teen or adult as "manipulative," "oppositional," "lazy," or "unmotivated," when these behaviors are better understood as survival responses (Prescott, Soares, Konnath, & Bassuk, 2008). Children may be labeled as "hyperactive," "oppositional," "shy," or "spacey," when these behaviors may be fight, flight or freeze responses to on-going stress (Guarino & Bassuk, 2010).

People seeking services may interpret providers' efforts to help as controlling. When that help doesn't yield results, providers' inability to "fix" needs and other stressors may be seen by individuals and families as purposeful and punishing. Agency rules and regulations may be perceived as disrespectful and belittling, and not dissimilar to prior acts of victimization. Survivors who are further traumatized within service systems by unrealistic demands and harsh responses by staff become increasingly wary of and triggered by all people's efforts to help and may drop out of services altogether (Prescott et al., 2008; Harris & Fallot, 2001).

In addition to being perceived negatively by others, trauma survivors also run the risk of being more formally misdiagnosed. To adapt to prolonged traumatic experiences, trauma survivors may develop symptoms that mimic disorders such as anxiety disorders, bipolar disorder, or borderline personality disorder (Luxenberg, Spinazzola, & van der Kolk, 2001). Diagnoses that have been misapplied to traumatized children include ADHD, bipolar disorder, oppositional-defiant disorder, depression, and reactive attachment disorder (D'Andrea et al., 2012; Cook et al., 2005).

When trauma survivors are diagnosed solely on the basis of presenting symptoms, mental health and other providers are likely to miss the underlying traumatic experiences that may be the source of the emotions and/or behaviors and the necessary focus of treatment, which impacts recovery (D'Andrea et al., 2012; Cook et al., 2005). The added layer of complexity associated with cultural differences in post-trauma responses further complicates this process and increases the risk for missing trauma-related impact.

The Need for Trauma-Informed Care

Research and first-hand knowledge tells us that trauma is common in displaced populations. In addition to pre-migration experiences such as a natural disaster or violent conflict, traumas associated with displacement (e.g., separation and loss of loved ones, loss of cultural connection and identity, lack of safety, stability and community) are also profound.

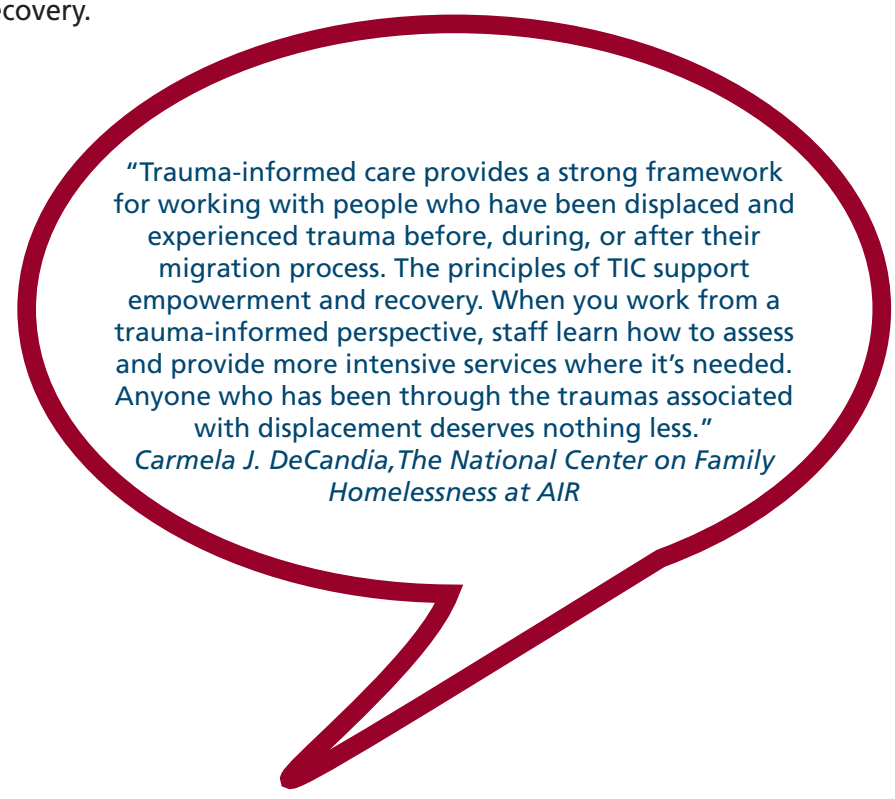
People can and do recover from trauma. Many do so with the help of natural support systems that include family, community, church, and peer groups. Strong social support networks are protective and enhance individual and family resiliency (Center for the Study of Social Policy, 2011) and housing stability (Cohen, 2011; Lubell, Crane & Cohen, 2007). However, for displaced individuals and families, these natural support systems that act to protect us following traumatic events are themselves disrupted, often leaving people with little to nowhere to turn. Newcomers who are non-English speaking are at highest risk of social isolation and lower integration into the host society.

Service providers play an integral role in helping people grieve their losses and adjust to a new life. It is imperative that providers serving displaced populations design services and program environments that best support healing and recovery.

As knowledge and awareness of the prevalence and impact of trauma in the lives of vulnerable individuals and families has increased, there has been a corresponding shift in the way that services are designed and delivered across service systems. This evolution represents a movement away from a traditional approach and towards trauma-informed care.

Using a trauma-informed approach engages agency staff at every level in understanding and responding to the needs of trauma survivors. This includes:

- Understanding the trauma of displacement and assessing for its impact;
- Integrating consumer voice in treatment;
- Case planning that identifies strengths and works to rebuild social support systems; and
- Designing program environments that are safe, welcoming, flexible, and responsive to individual needs, including those of culturally and linguistically diverse populations.



"Trauma-informed care provides a strong framework for working with people who have been displaced and experienced trauma before, during, or after their migration process. The principles of TIC support empowerment and recovery. When you work from a trauma-informed perspective, staff learn how to assess and provide more intensive services where it's needed. Anyone who has been through the traumas associated with displacement deserves nothing less."
Carmela J. DeCandia, The National Center on Family Homelessness at AIR

Types of Displaced Groups

Refugee
"The 1951 Refugee Convention describes refugees as people who are outside their country of nationality or habitual residence, and have a well-founded fear of persecution because of their race, religion, nationality, membership of a particular social group or political opinion. People fleeing conflicts or generalized violence are also generally considered as refugees, although sometimes under legal mechanisms other than the 1951 Convention."

Asylum-Seekers
"Someone who has made a claim that he or she is a refugee, and is waiting for that claim to be accepted or rejected. The term contains no presumption either way - it simply describes the fact that someone has lodged the claim. Some asylum-seekers will be judged to be refugees and others not."

Migrant
"A wide-ranging term that covers most people who move to a foreign country for a variety of reasons and for a certain length of time (usually a minimum of a year, so as not to include very temporary visitors such as tourists, people on business visits, etc). Different from "immigrant," which means someone who takes up permanent residence in a country other than his or her original homeland."

Economic Migrant
"Someone who leaves their country of origin for financial reasons."

Internally Displaced Person (IDP)
"Someone who has been forced to move from his or her home because of conflict, persecution (i.e. refugee-like reasons) or because of a natural disaster or some other unusual circumstance of this type. Unlike refugees, however, IDPs remain inside their own country."

Stateless Person
"Someone who is not considered as a national by ANY state (de jure stateless); or possibly someone who does not enjoy fundamental rights enjoyed by other nationals in their home state (de facto stateless). Statelessness can be a personal disaster: some stateless people live in a Kafkaesque netherworld where they do not officially exist and therefore have virtually no rights at all. Unlike other groups, they may have never moved away from the place where they were born. Some stateless people are also refugees."

(UNHCR Protecting Refugees, 2012, p. 8)

Environmental or Disaster Refugees:
"People displaced as a result of natural disasters (floods, volcanoes, landslides, earthquakes), environmental change (deforestation, desertification, land degradation, global warming) and human-made disasters (industrial accidents, radioactivity)."

(Forced Migration Online, 2012)

Section 2

Providing Trauma-Informed Care

Section 2

Providing Trauma-Informed Care

I. Defining Trauma-Informed Care

Trauma-informed care (TIC) is defined as a *"strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment"* (Hopper et al., 2010, p. 82). Trauma-informed organizations ". . . endeavor to do no harm – to avoid retraumatizing or blaming [clients] for their efforts to manage their traumatic reactions" (Moses, Reed, Mazelis, & D'Ambrosio, 2003).

Adopting a trauma-informed approach means viewing survivors' behaviors, responses, attitudes, and emotions as a collection of survival skills developed in response to traumatic experiences (Guarino et al., 2009; Harris & Fallot, 2001; Bloom, 2000). Accomplishing this requires a commitment at all levels to changing the practices, policies, and cultures of entire organizations using knowledge of trauma and recovery to design and deliver services (Guarino, 2012; Guarino et al., 2009). In the absence of a trauma-informed perspective, the impact of trauma gets lost amid other mental health, substance use, health, employment, and housing issues in the lives of displaced populations.

Trauma-informed care utilizes a "universal design" for addressing violence and trauma in programs serving trauma survivors. Trauma-informed care is provided to all and by all within an organization. A distinction is increasingly being made between trauma-specific and trauma-informed services. The former refers to specific clinical interventions that treat post-trauma responses and tend to require clinically trained staff. Trauma-informed care refers to practices and policies that can be implemented by entire organizations - and involve their structure, culture, values, and principles (Report of the Federal Partners Committee on Women and Trauma, 2011).

Trauma-informed care requires that staff at every level understand and respond to the needs of their clients through the lens of trauma, so that no matter what door a client may go through to receive services - a community health center, transitional program, homeless shelter, or clinic - s/he can be assured to receive a basic level of appropriate care.

Providing trauma-informed care minimizes the possibility of causing additional harm through the use of practices that do not support recovery. Trauma-informed services maximize a person's choice and control over the course of their recovery and focus on safety, strengths, spiritual and emotional well-being, and the development of trusting relationships. Preliminary outcomes of trauma-informed care include: improved functioning and decreased emotional symptoms; decreased use of crisis-based services; enhanced self-identity, skills and safety among survivors; and greater collaboration among service providers (Noether, et. al., 2007; Cocozza, et. al. 2005; Morrissey et. al., 2005).

II. Foundational Principles

The National Center on Family Homelessness has identified eight foundational principles of trauma-informed care that represent the core values of trauma-informed care. These principles were identified on the basis of knowledge about trauma and its impact, findings of the Co-Occurring Disorders and Violence Project (Moses, Reed, Mazelis, & D'Ambrosio, 2003), literature on therapeutic communities (Campling, 2001), and the emerging literature on trauma-informed care (Fallot & Harris, 2002; Harris & Fallot, 2001; Bloom, 2000).

Core Principles of Trauma-Informed Care

Understanding Trauma and its Impact	Understanding traumatic stress and recognizing that many current behaviors and responses are ways of adapting to and coping with past traumatic experiences.
Promoting Safety	Establishing a safe physical and emotional environment where basic needs are met, safety measures are in place, and provider responses are consistent, predictable, and respectful.
Supporting Control, Choice, and Autonomy	Helping people regain a sense of control over their daily lives. Keeping people informed about all aspects of the organization and allowing them to drive goal planning and decision-making.
Sharing Power and Governance	Sharing power and decision-making across all levels of an organization, whether related to daily decisions or when reviewing and establishing policies and procedures.
Ensuring Cultural Competence	Respecting diversity within the program, providing opportunities for consumers to engage in cultural rituals, and using interventions specific to cultural backgrounds.
Integrating Care	Maintaining a holistic view of consumers that understands the interrelated nature of emotional, physical, relational, and spiritual health and facilitating communication within and among service providers and systems.
Healing Happens in Relationships	Believing that establishing safe, authentic, and positive relationships can be corrective and restorative to trauma survivors.
Recovery is Possible	Understanding that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for consumer involvement at all levels of the system; and establishing future oriented goals.

III. Understanding Trauma within a Cultural Framework

Trauma is universal but types of traumatic experiences, responses to trauma, and meaning making associated with traumatic events vary across cultures; and healing takes place within one's own cultural context (Wilson, & So-Kum Tang, 2007; Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003). Families, children, youth, unaccompanied minors, and individuals accessing services come from different cultural backgrounds. Experiences of trauma shape their thoughts, feelings, beliefs, behaviors, and view of the world.

Being culturally aware implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by survivors and their communities (Wilson & So-Kum Tang, 2007). The guiding principles of trauma-informed care are predicated on mutual learning and assistance, respectful interactions, and true partnerships across diverse groups and individuals. Cultural dynamics must be appreciated, and the role of cultural and linguistic differences and their impact on service provision is a critical part of providing trauma-informed care. Helping people stay connected to what is meaningful and relevant to them, within their culture framework, may act as a protective factor from future mental and physical stress-related illness (Wilson & So-Kum Tang, 2007).

It is important for service providers to recognize that each individual's diverse experiences, values, and beliefs will impact how they access services. It is equally important to recognize that the cultural values of providers and service delivery systems have an effect on how services are delivered and accessed. Services for displaced populations need to be provided by culturally and linguistically competent providers who understand different eligibility requirements related to refugee status, immigration status, and how to access legal resources for this subgroup. A culturally competent approach helps to create a respectful environment in which trauma survivors can begin to rebuild a sense of self and a connection to their communities.

"We implemented Electronic Health Records and analyzed how we extract data to inform treatment planning needs. We wanted to look at utility bill requests, number of times clients move, attendance to appointments, and other activities. We decided that this data, without a valid trauma informed assessment, was incomplete. Someone may have high utility bills or not attend appointment because they are staying at home because of their fear of exposure to more traumas."
Manuel Sarria, Citrus Health

Section 3

Developing and Piloting:
Trauma-Informed Organizational Self-Assessment for Displaced Populations

Section 3 Developing and Piloting the *Trauma-Informed Organizational Self-Assessment for Displaced Populations*

I. Healing Hearts Promoting Health Project

In 2011, The National Center on Family Homelessness received support from the W.K. Kellogg Foundation to implement Healing Hearts Promoting Health (HHPH), an intensive, two-year pilot project designed to address the trauma and related nutrition, health, and wellness issues of recently displaced families and children, with particular focus on Haitian earthquake evacuees in southern Florida.

The main goal of HHPH was to improve the health and wellbeing of displaced families and children by 1) equipping second responders with training and concrete tools and strategies; and 2) building the capacity of community-based organizations to implement trauma-informed programs and practices focused on culturally appropriate family health and well-being strategies.

During year one of the project, The National Center on Family Homelessness conducted direct outreach to over 200 agencies in Miami and southern Florida, explored potential partnerships with local providers, and conducted a focus group in Miami with 10 agencies coordinated through a local partner. At the conclusion of this process, it was determined that a web-enabled training format that was the most accessible training mechanism for this community. From June to November 2012, The National Center on Family Homelessness conducted a six-session online training series on trauma-informed care for displaced populations.

Webinars in the series were offered once per month, and each session was 1.5 hours in length and accredited through the National Association of Social Workers to offer 1.5 CEUs per session to eligible participants. The series covered the following areas: understanding trauma and its impact on displaced children and families, with an emphasis on the experience of Haitian evacuees; understanding the principles of trauma-informed care; creating safe and supportive environments; assessing and responding to the needs of the family, caregivers, and children; and addressing self-care and burnout for providers. Participants in the online training series represented 117 agencies across the state of Florida, 27 in Miami-Dade County, and five in Little Haiti.

During year two of HHPH, the focus shifted to targeted capacity building and onsite training to support community-based agencies in Miami to provide trauma-informed care to displaced populations. Year two included the following key activities:

1) Providing onsite training on trauma-informed care for displaced populations and vicarious trauma and provider self-care;

2) Developing the *Trauma-Informed Organizational Self-Assessment for Displaced Populations* to support organizations to build system-wide capacity to integrate a trauma-informed approach into daily practice;

3) Piloting the *Trauma-Informed Organizational Self-Assessment for Displaced Populations* to support organizations to assess current practice and develop goals for incorporating trauma-informed care; and

4) Finalizing the *Trauma-Informed Organizational Self-Assessment for Displaced Populations*, a tool for use beyond HHPH to support organizations to become trauma-informed.

II. Background on the *Self-Assessment*

In 2009, The National Center on Family Homelessness published its *Trauma-Informed Organizational Toolkit* for homeless services, a curriculum to support homeless service organizations to become trauma-informed. The curriculum includes as its primary component the *Trauma-Informed Organizational Self-Assessment* – the first of its kind in homeless services - that contains specific "items" or trauma-informed practices to be incorporated across the following key domains of programming: 1) Supporting Staff Development; 2) Creating a Safe and Supportive Environment; 3) Assessing and Planning Services; 4) Involving Consumers; and 5) Adapting Policies.

The original *Trauma-Informed Organizational Self-Assessment* was developed over the course of several years and included the following key steps: 1) Identifying the theoretical framework and core principles of a "trauma-informed" approach; 2) Developing an organizational framework consisting of key "domains" or areas of focus; 3) Conducting focus groups with experts in the fields of trauma and homelessness, service providers, and families to determine best practices; 4) Preliminary field-testing of self-assessment items and format; and 5) Two-year piloting of the tool in nine Massachusetts area shelters and three programs in California, Iowa, and Georgia.

Based on an iterative process, The National Center on Family Homelessness refined format, response scales, and items to create the final assessment tool. In 2011, the tool was adapted for use by agencies serving women Veterans and highlighted in the White House Strengthening Our Military Families report as a promising strategy for serving women veterans.

The *Trauma-Informed Organizational Self-Assessment for Displaced Populations* was adapted from the previous work described above to include trauma-informed practices within each domain that are specific to serving culturally diverse populations who have experienced trauma and displacement. The *Trauma-Informed Organizational Self-Assessment for Displaced Populations* was piloted with five community-based agencies in Miami. The National Center on Family Homelessness made refinements to this tool based on pilot activities and created a final version of the tool.

III. Understanding *Self-Assessment* Domains

The National Center on Family Homelessness created the *Organizational Self-Assessment for Displaced Populations* to offer service providers guidelines on how to provide trauma- informed care in general and trauma-informed care to displaced populations more specifically. While some trauma-informed practices are essential regardless of the type of population being served, others are implemented in response to the unique needs of people who have been displaced. This section explores the six domains or areas of programming within which to incorporate trauma-informed practices for displaced populations.

Domain 1: Supporting Staff Development

Trauma can impact every aspect of a survivor's life, and its effects can appear in areas directly related to the trauma as well as those that initially seem unrelated. Coping strategies used to survive and manage traumatic experiences may be seen by others as inappropriate or "maladaptive." A lack of awareness of trauma and its impact on adults, children, and youth often leads to misunderstandings between staff the people they serve that can be re-traumatizing and cause people to disengage from services.

Creating trauma-informed services and settings requires organizations to expand on basic, traditional staff development efforts to include a range of trauma-related training and support activities. Training and education on trauma, supervision that includes discussions about trauma, and a focus on self-care for the provider are all key components of a trauma-informed organization.

Training and Education

Staff training and education are crucial to becoming trauma-informed. Training everyone, administrators, direct care staff, case managers, support staff, and other team members of your organization about trauma and trauma-related topics ensures that all staff members are working from the same level of understanding and are capable of providing the same types of trauma-sensitive responses.

Organizations may begin with basic training about traumatic stress and its impact on the brain and the body, and move on to offer more specific information on various types of trauma among displaced populations (e.g., war trauma, torture, gender-based violence, intimate partner violence, acculturation, homelessness). To understand the impact of displacement, it is important for staff to learn about how stressors/traumatic experiences during pre-migration, migration, and post-migration impact displaced populations. Staff education should also include a focus on how working with trauma survivors can impact staff (e.g., vicarious traumatization or "compassion fatigue") to raise staff awareness about their own triggers and level of burnout, and how these issues can impact their work with consumers.

Becoming trauma-informed also involves incorporating education about the cultural backgrounds of the people being served, including how individuals from different cultures understand and respond to trauma and cultural differences in how mental health issues are understood and expressed.

"Trauma-Informed Care is a critical, comprehensive endeavor that positively impacts our entire organization. This cultural shift ensures educating all staff who are involved with the residents we serve; with an organizational emphasis on staff self-care. TIC helps adults and children become more aware of how trauma has impacted their families lives, and increases awareness and hope of overcoming the physical, emotional, and social effects of trauma."
Beth Orr, Metropolitan Ministries

Once staff members are educated on these topics, they require additional training on how to apply this information to their daily work. Skills and strategies for working with trauma survivors may include: using motivational interviewing techniques; providing staff trainings on crisis prevention/management (e.g., how to help people identify triggers, express their feelings safely, and use healthy coping skills); learning how to develop safety and crisis-prevention plans; learning how to support adults and children by providing trauma-specific services; and creating connections with other community-based service providers.

Staff Supervision, Support and Self-Care

Staff support is crucial to providing quality care to trauma survivors. Issues such as poor working conditions, confusion about roles and responsibilities, lack of attention to self-care, inconsistent supervision, and minimal input into programming contribute to high rates of burnout and staff turnover within social service settings. Making staff support a priority sends the message to employees and consumers that all are valued and respected. Elements of staff support include regular supervision and team meetings, an organizational commitment to promoting staff self-care, and opportunities for staff members to have a voice in programming decisions.

One-on-one supervision offers service providers an opportunity to think about their work and how they understand and respond to consumers. It is also an avenue for monitoring job frustration or burnout. Individual supervision by someone who is trained in understanding trauma is an essential follow-up strategy to trauma training.

As a result of the challenges faced by providers who work with trauma survivors, organizations must focus on how to encourage self-care at individual and programmatic levels. Mechanisms for encouraging self-care include: addressing topics related to self-care in team meetings, encouraging staff members to understand their own stress reactions and develop self-care plans, devoting part of supervision to talking with staff members about the impact of working with trauma survivors, and providing trainings about compassion fatigue and self-care strategies.

The program can support staff over the long term by creating a culture of self-care that includes encouraging staff members to take breaks, eat lunch, use vacation time, and develop strategies for creating a balance between their personal and professional lives. The agency may also develop ongoing ways to assess job satisfaction and staff need for additional support.

Domain 2: Creating a Safe and Supportive Environment

Traumatic experiences violate our fundamental belief that the world is a safe place and people can be trusted. Creating a safe, supportive, welcoming, and respectful environment is essential in any service setting. People are not successful in environments where they do not feel physically and emotionally safe, heard, and respected. For people who have experienced trauma, issues of safety become even more prominent. Accessing services requires people to enter into new relationships at a time when this is most difficult. Establishing a sense of physical and emotional safety is essential to relationship-building and recovery.

Establishing a Safe Physical Environment

Creating a safe physical environment is one of the primary components of a trauma-informed organization. Specific areas within the building, such as bathrooms and bedrooms, can be particularly triggering for those who have abuse histories. Poor lighting or building security and a lack of control over personal space and belongings can also trigger past feelings of fear and helplessness. Key safety features include providing adequate lighting inside and outside of the program, making sure people can lock bathroom doors and have locked spaces for their belongings, having a program securing system, and decorating the physical space with materials that reflect diversity.

Establishing a Supportive Environment

In addition to ensuring physical safety, establishing a supportive environment is an essential aspect of trauma-informed care. How consumers are welcomed and how staff responds to their individual needs sets the stage for future success or difficulty. Establishing a safe and welcoming emotional environment requires programs to create a culture of open communication, tolerance, respect, and community. Trauma-informed programming involves providing consumers with as much information as possible; being aware of the impact of culture; demonstrating respectful interactions; maintaining consistency; predictability and transparency; and thinking proactively.

Information Sharing

Experiences of trauma leave people feeling helpless and powerless. To avoid recreating these same feelings, providers must be conscious of sharing detailed information about program rules, expectations, schedules, etc. Providing consumers with information enhances their sense of safety and control. Traumatic experiences can have a significant impact on people's ability to integrate information, particularly under stressful circumstances. This potential difficulty in assimilating information requires providers to be ready to review agency information on a continual basis.

Information about rules and consumer rights needs to be communicated to people verbally and in written form, in a language and reading level appropriate to them, and posted throughout the building. Programs should also post information about trauma and how it impacts people, and available trauma-specific resources. For organizations that serve displaced populations, information sharing should be tailored to address the experiences and needs of this group (e.g., specific benefits and services available for displaced populations, types of stressors common to this group).

Privacy and Confidentiality

Respecting privacy and confidentiality includes: asking permission and outlining clear boundaries before entering consumers' spaces; providing private, confidential spaces to conduct assessments and have conversations with consumers; addressing individual issues in private; avoiding having discussions about consumers in public places; and clearly explaining the limits of privacy and confidentiality.

Open and Respectful Communication

Trauma survivors often enter service settings with past experiences that include being mistreated, abused, ignored, and silenced. Providers are faced with the challenge of encouraging honest communication with consumers and demonstrating an ability to

listen to and accept the range of thoughts and feelings that consumers may share. Open communication with consumers involves using active listening skills such as open-ended questions, affirmations, and reflective listening.

These techniques are designed to demonstrate respect and empathy for the consumer experience at any given moment. Respectful communication also involves an awareness of the language used to talk to or about consumers. This includes using "people first language" such as "people who are displaced" rather than "displaced people" and avoiding negative and derogatory labels that foster disrespect (e.g., referring to the consumer as "manipulative" "illegal" or "lazy"). This type of communication also focuses on a person's strengths and capabilities as opposed to her/his deficiencies.

Consistency and Predictability

Feelings of uncertainty and confusion can trigger intense trauma responses related to past experiences. Maintaining a consistent and predictable environment can help to instill a sense of calm, which in turn allows the consumer to focus on recovery. Consistency at the service level creates trust between the consumer and the provider, and serves as a foundation for building healthy relationships. Ways to establish consistency and predictability with consumers include having regular meetings; keeping and being on time for appointments; clearly defining roles and boundaries; and maintaining empathetic responses to consumers in the face of both successes and setbacks.

Safety and Crisis Prevention Planning

Trauma-informed care includes proactive interventions that address potential safety issues ahead of time. Considering the rates of violence and trauma in the lives of displaced populations, ways to incorporate proactive responses into daily practice include creating plans to keep people safe from others outside of the program (e.g., safety plans) and helping them to recognize and manage potential triggers before they become overwhelmed (e.g., crisis prevention or self-care plans). These plans are most effective when they are in writing, developed before the crisis happens, communicated to all providers working with individuals or families, and incorporated into individual goals and plans.

Recognizing and Reducing Triggers and Re-Traumatizing Practices

Agencies should engage in an on-going examination of potentially triggering or re-traumatizing practices and strategize about how to minimize and eliminate these experiences. Potential triggers for children may include: loud noises; hand or body gestures; confusion or chaos; transitions; change in routine; feelings of anger, sadness or fear that trigger similar feelings connected to past trauma; physical touch; emergency vehicles and police and fire personnel; and separation from caregivers. Potential triggers for adults may include: being misunderstood (linguistically and culturally); feelings of embarrassment and shame about challenges such as lack of housing; mental health or substance use issues; violence in the home; difficulties parenting; authority figures; not having choices or decision-making power; and practices that seem unfair or discriminatory. Keeping in mind potential triggers for trauma survivors, organizations can work to eliminate daily practices, policies, and ways of responding that re-create potentially traumatic situations.

Domain 3: Assessing and Planning Services

In all service settings, completing a thorough intake assessment and referring consumers to appropriate services is essential to providing quality care. Considering traumatic experiences and the impact of these experiences on displaced families should be a routine part of the assessment and service planning process.

Conducting Assessments

People who have experienced trauma have specific needs that may be mislabeled or misinterpreted if their history of trauma is not considered during the assessment process. Assessments should include questions regarding specific types of trauma that are common among displaced populations (e.g., pre-migration, migration, acculturation related stressors including discrimination), as well as questions about spirituality, connections to the community, and individual and group strengths that are critical to the healing process.

How assessments are conducted is as important as what questions are asked. The assessment process requires that a person meet with someone they don't know and share intimate details about his/her life experiences, including experiences of trauma. This process involves sharing information that can be emotionally painful, uncomfortable, and outside of cultural norms.

This experience may trigger many difficult feelings and emotions, particularly someone who is new to the environment and navigating the complex power dynamics associated with asking for a accessing help and support. It is important for providers to be aware of these challenges throughout the intake process. This means creating an environment that is as safe, comfortable, secure, and respectful as possible during the assessment process.

Conducting the intake assessment in a trauma-informed manner includes practices such as: conducting the intake in a private space; offering people options about where to sit, who is in the room with them, and what to expect; asking consumers how they are doing throughout the assessment; offering water and breaks; being aware of body language that may indicate that a consumer is feeling overwhelmed and considering cultural norms and expectations when greeting, engaging, and questioning individuals and families.

Using a strengths-based approach also sets a tone of respect and enhances the process of relationship-building. Consumers should be referred for more in-depth assessments when there is a need for further intervention and more specific types of services that require outside professionals.

Developing Goals and Plans

For trauma survivors, developing goals and plans for obtaining housing, employment, and other types of services may seem intimidating and overwhelming. In these situations, it is easy for the consumer to "freeze" and for providers to take over. This pattern only serves to recreate past traumatic experiences and dynamics, and leaves consumers feeling helpless and powerless. Encouraging and helping consumers to create their own goals allows them to take control of their lives and futures.

For programs serving displaced populations, this means understanding acculturative stress, acculturation differences within a family, different eligibility requirements related to refugee or immigration status, and helping them connect to these resources. Trauma-informed goal planning is individualized; goals and plans are reviewed on a regular basis and updated as needed.

Cultural Considerations When Conducting Assessments

Consider how you greet people...

Greet new people with a handshake. Greet everyone present. Say hello and goodbye in a person's language. Participate in rituals that put people at ease (e.g., ceremony, food).

Consider culture-specific communication styles...

Some examples include: eye contact, integration of food into meetings, touch, body language, pace of conversation, and time.

Consider who you include and how...

Ask if a person wants other family members present. Accept and respect the cultural roles of various family members (e.g., elders, male/female roles, etc.). Understand the role of other family members in an individual's decision-making.

Consider how you explain the assessment process...

Explain why you need to ask particular questions. Use culturally-relevant terms to explain things. Have access to tools/methods of interacting with those with limited English proficiency.

Consider cultural differences...

Acknowledge differences if you don't share a similar cultural background. Express willingness to learn. Take the time to learn more about the culture background of those you are serving.

Be aware of historical distrust of service providers by various populations...

Consider how various populations have been marginalized or stigmatized historically and how that impacts interactions.

Be aware of culture-specific experiences such as lack of freedom to express opinions or dissent...

Be clear about privacy and confidentiality, where information is going/to whom.

Be aware of the stigma or taboo associated with various topics...

Some examples include mental health, sexuality, abuse, and violence. Reporting abuse/interpersonal violence may be seen as bringing shame. Gender roles influence what is/is not acceptable for men and women to discuss, particularly with strangers. Children who are taught to respect elders, never show anger, and be respectful and obedient, may have difficulty answering questions particularly in front of family members.

Consider how the assessment process is perceived...

People may not be used to a practitioner asking a lot of questions. This may feel intrusive or rude. A check-list approach to initial intake or conversations may seem less warm and caring and may be seen as rude.

Consider how people share their story...

Look to understand the culture-specific meaning of life, suffering, and healing. Leave space for people to offer details beyond the presenting problem as part of their story.

(World Health Organization, 2010; Pan American Health Organization, 2012)

Providing Services

Organizations serving displaced populations can play a critical role in educating individuals and families on trauma and its impact, building coping skills, and supporting caregiver/child attachment that is critical during a family's period of adjustment. Trauma-related services include the following:

Non-verbal Interventions

It can be extremely difficult for trauma survivors to verbalize thoughts, feelings, and memories related past traumatic experiences. People who have experienced trauma sometimes disconnect from emotions and physical sensations in an attempt to cope. Body-oriented, non-verbal activities serve as a way for trauma survivors to reconnect to their bodies, manage their feelings, and communicate in non-traditional ways.

It is helpful for programs to provide opportunities for children and adults to express themselves using these types of modalities (e.g. art, theater, dance, movement, and music). For younger children, who have fewer words to express how they feel, the use of play and body-based activities help children to manage stress and strengthen coping skills.

Attachment-focused Interventions

The impact of trauma on adults can severely compromise a parent's ability connect with his/her children and be responsive to their needs. Disrupted parent/child relationships can impact all aspects of a child's functioning, beginning at the most fundamental, neurobiological level. Research suggests that "relationships children have with their caregivers play critical roles in regulating stress hormone production during the early years of life" (National Scientific Council on the Developing Child, 2005).

Strategies for fostering parent/child attachment and parent skill-building include: providing parent education about child development, attachment, and trauma and its impact on children; modeling healthy interactions when you are interacting with parents and their children (e.g., tone of voice, eye contact, asking permission around personal space, asking them about their needs); and strengthening parent/child relationships through activities such as family nights and joint parent-child groups.

Trauma-Specific Mental Health Services

Trauma-specific services are interventions or treatments that are designed to address the impact of trauma on mental health (Hopper et al., 2010). Among vulnerable and displaced populations there is a need for increased access to mental health services such as witness to violence services, mental health professionals who provide culturally relevant and competent services, and agencies who can connect with other providers who provide these types of trauma-related services. Trauma-specific services for children and adults may include individual and family therapy and interventions that focus on helping children and adults to manage traumatic stress and strengthen connections.

Domain 4: Involving Consumers

Recovery and success for trauma survivors is largely based on their ability to regain control of their lives. Displaced families flee their homelands in search of safety and have experiences many events that have resulted in a loss of control over their lives. Organizations can facilitate empowerment by giving all consumers a voice in what happens on a daily basis in the program.

Giving all program participants a voice can begin by facilitating regular meetings where consumers can address questions, concerns, and ideas about the program. Involving consumers also means providing opportunities for them to be directly involved in developing program activities and evaluating program practices. Involving consumers in program development enhances the quality of the services provided and affirms the belief that consumers are the experts in what works best for them.

Former consumers have a unique and invaluable perspective. Consumers who have been displaced in the past are invited to share their thoughts, ideas, and resettlement/acculturation experiences. They know first-hand what was helpful and what was not along their road to recovery. Organizations can make a broader commitment to involving former consumers by recruiting people to their board who have similar experiences to those being served in the program and hiring them as paid program and operations staff.

Mental Health and Culture

Mental health diagnoses are largely based on Western frameworks. The way people describe their distress may not fit into current criteria, leading providers to misdiagnose or not diagnose a particular issue. Within and among cultural groups, there are unique factors to consider when assessing mental health. For example, when working with the Haitian community, consider the the following when assessing mental health:

- Haitian spiritual beliefs and practices vs. psychological problems (common to talk about seeing a spirit, communicating with God).
- Paranoia vs. realistic fear that results from living under oppressive/violent regimes.
- Individual diagnoses vs. empathic family stress (the effect of family members' struggles on an individual's emotional health).
- Understanding the historical, sociopolitical, cultural, and gender experiences related to mental health.
- Haitian meaning of "depression" as discouragement vs. "depression mentale" referring to western understanding of depression.
- Depression and other mental health challenges often expressed somatically (empty, heavy-headed, insomnia, fatigue).

(Pan American Health Organization, 2012; Nicolas, Hirsh, & Beltrame, (n.d.); Nicolas, Desilva, Prater, & Bronkoski, 2009; Nicolas, DeSilva, Subrebost, Breland-Noble, Gonzalez-Eastep, Manning, Prosper, & Prater, 2007).

Domain 5: Adapting Policies

Establishing Written Policies

Establishing policies that protect the safety and well-being of those being served is essential to providing quality care. A trauma-informed organization considers trauma and its impact when creating policies to minimize the risk of implementing protocols that are retraumatizing (e.g., engender feelings of powerlessness, shame, lack of control, etc.). Trauma-informed policies include a formal acknowledgement that consumers have experienced trauma and a commitment to understand trauma and its impact and engage in trauma-sensitive practices. As part of this commitment, programs establish written policies based on an understanding of the impact of trauma on consumers. Agencies focus first on creating policies that address issues of safety, including the program's response to threats made to consumers by others outside of the program. A policy outlining the program's response to a consumer crisis is also important when serving trauma survivors who may frequently feel unsafe within their own bodies. Organizations that serve displaced populations should also have a written commitment to understanding the needs of this population and tailoring services to meet their cultural and linguistic needs. Within a trauma-informed agency, there is a formal commitment to hire staff with similar life experiences to those being served.

Reviewing Policies

As the needs of consumers evolve and the role of the organization changes, policies that were once effective may no longer be helpful. Creating trauma-informed organizations requires continual review of policies to see what works and what may be re-traumatizing to trauma survivors. For policies to be effective, they must be enforced properly, considered helpful, and not cause additional harm. The more an organization's staff learns about trauma, the more modifications it may need to make to their policies and services. A regular review of policies will be required to update practices and guidelines to make them as relevant as possible to the people being served. The effectiveness of policies and the impact of enforced policies on consumers can be accurately assessed only when staff and consumers are part of the policy review process.

Domain 6: Working with Children

The impact of trauma on child development and the parent/child relationship is profound, and it is essential that children receive services as soon as possible to lessen the negative impact of these experiences on their emotional, physical, cognitive, and social development. Traumatic events such as war, natural disasters, and deprivation are common reasons for a child and his or her family to leave their country of origin. Being displaced adds an additional layer of stress in the family.

A word about children...

Traumatized children may behave in ways that are consistent with diagnoses such as attention deficit hyperactivity disorder, bi-polar disorder, oppositional-defiant disorder, or reactive-attachment disorder (Cook et al., 2005). Without a thorough assessment that includes a history of trauma, providers are more likely to diagnosis or label a child based on presenting behaviors and miss the traumatic experiences that may be the source of the symptoms and the necessary focus of treatment.

Programs may consider a number of strategies to support children, that include modifications to both the physical environment and the assessment and service planning process. Programs serving children who have been displaced can incorporate child friendly materials that reflect diversity, as well as play spaces with developmentally and culturally appropriate materials. A child assessment should be conducted for each child in the program and may be framed around risk and protective factors at the level of the individual child, the family, and the community.

Assessments include questions about the following: history of mental and physical health challenges, substance abuse, and traumatic experiences for child and caregiver; educational history for child and caregiver; parenting style, satisfaction/stress, and quality of attachment; strengths and supports; access to resources; and perceived sense of safety within the broader community. It is important to ask about children's experiences prior, during, and post migration, child history in country of origin, and child's acculturation in the host country.

Thorough child assessments allow providers to make immediate referrals for further evaluation, and integrate mental health and early intervention services as needed. Organizations serving displaced children and youth should be prepared to make referrals to agencies that provide the following services: trauma specific therapeutic services, early intervention, mental health, physical health, and education.

Section 4

Implementing:
Trauma-Informed Organizational Self-Assessment for Displaced Populations

Section 4

Implementing the *Trauma-Informed Organizational Self-Assessment for Displaced Populations*

I. Becoming Trauma-Informed

Creating a trauma-informed organization requires system-wide transformation. This type of change is not found at the direct care administrative level only. Becoming trauma-informed requires a commitment to changing the practices, policies, and culture of the entire organization. This type of change requires staff at all levels and in all roles to modify what they do based on an understanding of the impact of trauma and the specific needs of trauma survivors.

This section outlines the steps for using the *Trauma-Informed Organizational Self-Assessment for Displaced Populations* to begin an agency-wide process of becoming trauma-informed. These steps are based on The National Center on Family Homelessness's experiences and lessons learned while working with community-based organizations as they moved through the assessment process and worked to create changes in both individual behaviors and organizational processes. An organization's ability to move through this step-by-step process will depend on several factors including staffing, resources, and time.

Building Knowledge and Gaining Buy-in

Becoming trauma-informed is an ongoing process that begins by raising awareness through education and training about trauma and its impact and gaining buy-in from staff across an agency to make changes based on this knowledge.

Step 1:

The program has a person or group of people who have the desire to help their organization become trauma-informed. At least one of these people has the authority to make system wide changes in the program. This person or group of people is willing to shepherd the program through the transformation process. These are the "leaders" or "champions of change" for the organization.

Tips and Strategies

- It is helpful to have co-leaders to facilitate the change process so that one person is not the sole champion of this process.
- Try to choose trauma-informed leaders who represent different roles in the organization (e.g., the program director and a case manager). This increases buy-in across the organization and assures that many different voices are heard.
- Program leaders must have the authority to institute programmatic change and the support of the broader agency to implement these changes. Program leaders who are dedicated to the change process but have no real authority to make programmatic changes will have a difficult time implementing new practices and creating a new culture. Program leaders also need to be given the time in their work life to devote to the change process. Without the time to devote to the process, change efforts are likely to fall by the wayside.

Step 2:

In order to "set the stage" for trauma-informed organizational change, program leaders introduce the concept of becoming trauma-informed and the need for organizational change. Education and discussions about these concepts can be done in all-staff meetings, in smaller lunch meetings or shift change meetings, or in whatever ways work best in your program to include everyone in the conversation.

Tips and Strategies

- It is important to clarify that this process is not just about increasing individual trauma knowledge, but about setting the stage for organization-wide change.

- Addressing the need for change with all staff is not a one time conversation. Commitment to change is a process that requires ongoing discussions around what it means to be trauma-informed and what it will take to begin the transformation.

- All staff need to have an understanding of how the change process is going to begin and what to expect moving forward. People are less likely to invest in a process if they feel that their feedback will not ultimately be used. Explaining the ways that the program will take all information given by staff into consideration when developing goals is a way to empower all individuals in the program to feel that they are contributing to the change process.

Step 3:

The concept of being trauma-informed involves educating all staff on how to respond in a safe and sensitive manner. Before an organization uses the *Organizational Self-Assessment for Displaced Populations* to develop goals and plans, it is important that all staff receive basic training and education on the following: 1) what trauma is and how it impacts people; 2) the relationship between displacement and trauma; 3) experiences and needs of displaced adults, children, and families; and 4) information about what it means to provide trauma- informed care. Training participants include everyone from the executive director to administrative assistants and maintenance staff. This type of foundational education ensures that everyone is using the same language and working from a similar level of understanding. The National Center on Family Homelessness has included a list of resources on Page 72 that offers programs a variety of possibilities for educating staff on these topics, particularly when more formal in-person trainings by outside experts are not an option.

Tips and Strategies

- When using outside trainers, it is helpful (when possible) to have experts who can also provide ongoing consultation and can be called on for additional help and support during other steps in the change process.

Step 4:

Once staff have completed Steps 2 and 3, it is essential that the program leaders evaluate the organization's interest in and readiness for change. If staff "buy-in" is an issue or if there are conflicting views within the organization about whether this type of change is necessary or helpful, these issues must be addressed before the *Organizational Self-Assessment* is introduced as a tool for change.

Tips and Strategies

- It is important to acknowledge staff frustrations or confusion about the need for change early in the process. Use initial meetings to gauge readiness. If there is an overarching negativity about change, program leaders may want to think about how to begin the process more slowly and on a smaller scale. (For example, start with additional training and conversations before beginning to talk about evaluating and changing program practices.)

- In order to gain buy-in, the process has to identify "hooks" for all participants that address the benefits of becoming "trauma-informed." For some staff, the "hook" may be improved safety due to a reduction in crises, or discussions about the impact of the work on themselves. For others, gaining insight into the effective treatment strategies and approaches for consumers previously thought to be "untreatable" is the value. The possibility of improved outcomes as a result of a trauma-informed approach provides administrators with the potential for new funding opportunities or evidence that this type of work has benefits for the broader system.

- Communication is important to success. If communication between staff is strong, it is easier to lay out a plan and assess people's interest, understanding and readiness. If communication between staff members in various roles is a challenge, it is essential that these issues be resolved before attempting to make system-wide changes that will require ongoing dialogue and peer support.

Step 5:

Program leaders introduce the *Organizational Self-Assessment for Displaced Populations* (Page 44) as a tool to help the organization become trauma-informed. Leaders explain that the tool includes a list of concrete practices that should be incorporated into daily programming in a "trauma-informed" organization that serves displaced populations. Leaders inform staff members that they will begin by evaluating the extent to which the program currently incorporates the practices outlined and, based on the results, develop an action plan for implementing those practices that are not currently being used. Organizations may choose to have their staff complete the entire *Organizational Self-Assessment* at once, or complete it one category at a time (e.g., start with "Supporting Staff Development" or "Creating a Safe and Supportive Environment" and move on to additional categories later).

Tips and Strategies

- It can be difficult for staff members to talk about a program's weaknesses without feeling defensive. It is helpful to present this process as an opportunity for change and growth rather than a judgment on the program.

- It is important to remind people that they are not assessing their behaviors alone, but rather the daily practices of the organization as a whole.

- It is recommended that programs give staff a period of time, whether at a staff meeting or another designated time, to focus specifically on completing the *Organizational Self-Assessment*. There should be a designated box or location where staff can return the *Organizational Self-Assessment*.

- It is helpful for program leaders to be available to offer additional help and support throughout the assessment process. There may be confusion about specific items in the *Organizational Self-Assessment*, and asking clarifying questions increases the likelihood of accurate answers.

Compiling and Understanding Organizational Self-Asssessment Results

Step 6:

Below we provide an example of how to gather responses and examine results: Using an Excel spread sheet, enter each staff member's response to each item.

Example:

I. Staff Development	Staff Member 1	Staff Member 2	Staff Member 3
A. Training and Education			
Staff receive training on the following topics:			
1. Traumatic stress and its impact on the brain and body.	Strongly Agree	Agree	Do Not Know
2. Cultural differences in how children develop.	Agree	Disagree	Agree
3. The impact of transgenerational trauma on family functioning.	Strongly Disagree	Strongly Agree	Agree

Using the information entered above, count the total number of Strongly Disagree, Disagree, Agree, Strongly Agree, and Do Not Know responses for each item. Enter these totals on a blank *Organizational Self-Assessment* that can be copied and distributed to all staff.

I. Staff Development					
A. Training and Education	Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know
Staff receive training on the following topics:					
1. Traumatic stress and its impact on the brain and body.			1	1	1
2. Cultural differences in how children develop.		1	2		
3. The impact of transfenerational trauma on family functioning.	1		1	1	

Tips and Strategies

Compiling the assessment results by hand can be time consuming. Some programs have had success putting the entire *Organizational Self-Assessment* (domains and items) into an online tool such as Survey Monkey, so the staff can complete the tool online and there are a number of mechanisms for tallying and reviewing the results.

Step 7:

Agency leaders bring staff together to begin conversations about the results of this organizational assessment process. These conversations may begin in staff meetings or in smaller group meetings, based on what is realistic and feasible for the program. Community-based organizations may decide to form a smaller multi-disciplinary group that examines results and reports back to the larger staff with ideas for possible program changes. To identify areas for change, the organization leaders and other champions of becoming trauma-informed should look at the following:

- Specific practices in the *Organizational Self-Assessment* that most staff "Do Not Agree" are being done in the program (responses were "Disagree" or "Strongly Disagree")
- Specific areas that many people responded "Do Not Know," which may mean that these things are not being done or that there is a lack of staff understanding about what is being done in the program.
- Items that had a range of responses, with some staff strongly agreeing that this practice is done, and others strongly disagreeing.

Reviewing results can take a considerable amount of time and focus. It may be helpful to examine the results one domain at a time. For example, start with the "Supporting Staff Development" domain and clarify practices that are and are not being done before moving on to the second domain, "Creating a Safe and Supportive Environment."

Developing and Implementing a Strategic Plan

Step 8:

A strategic plan for the program includes the following:

- Identified and agreed upon goals;
- Specific steps to reach each goal;
- Resources needed to achieve each goal;
- A realistic timeframe for achievement of each goal; and
- The names of people responsible for monitoring progress.

When identifying areas of change, the program may choose to focus on one domain at a time or identify specific short-term and long-term goals within several of the domains. Each goal includes the necessary action steps, resources, timeframe for achievement, and persons responsible for monitoring progress towards the goal.

Tips and Strategies

- It is very important that the goals identified are realistic in the current organization. If an organization has a great goal but no time or resources to achieve that goal, it could impact the entire change process. If people begin to feel hopeless that change cannot be made, it may impact their drive to make smaller, more manageable changes. With the creation of each goal, all staff should have a sense that it can be achieved, whether in the short term or in the long term.
- Change is most effective when identified goals reflect the needs of service providers in varying roles, at all levels of the organization. Staff members in different roles often have different perspectives on the program and what needs to change. Becoming trauma-informed involves reconciling these perspectives and including staff at all levels in regular discussions about how to be more trauma-informed.
- Becoming trauma-informed is as much about changing a program's culture as it is about changing program practices. Changing the culture of an organization can be much more difficult, as attitudes and values are often subtle, ingrained, and hard to identify and shift. As an organization begins to incorporate new practices, it is helpful to have continued discussions about the ways that these practices are attempts to shift tone, culture, and atmosphere in the program.

Sample Strategic Plan

The following is a sample strategic plan for becoming trauma-informed in the area of *Staff Development*:

Staff Development Goal #1:
Topics related to trauma are addressed in team meetings.

Action Steps:

Staff generates a list of topics related to trauma that are of interest and would be helpful to their work with consumers. The specific needs of staff in different roles are taken into consideration.

Staff discusses ways that they would like to address these topics (e.g., small group discussions, case presentations, more formal trainings, presentations by program staff and/or outside consultants).

If needed, outside experts are contacted for times that they could come to the program to provide information and trainings.

Program leaders come up with a schedule of topics to be discussed at upcoming meetings.

Resources:

Staff time for discussions and brainstorming sessions.

Sources of funding for trainings by outside providers and professional development opportunities that staff can attend off-site.

Timeframe:

4 months

Persons responsible for monitoring progress on action steps:

Program identifies specific people responsible for monitoring progress towards this goal.

The sample above can be used for all goal-setting that a program does based on the *Organizational Self-Assessment* domains.

Step 9:

Once agency leaders and staff members identify goals for incorporating the trauma-informed practices outlined in the *Organizational Self-Assessment for Displaced Populations*, it is helpful to put structures in place to monitor progress towards goals and keep the commitment to being trauma-informed in the forefront. One way that an organization can do this is by creating a multi-disciplinary "trauma workgroup" consisting of a core group of staff representing all roles in the agency. This group makes a commitment to: 1) making sure objectives are being met for identified short-term and long-term goals related to becoming trauma-informed and providing trauma-informed care to displaced populations; 2) generating new ideas about further changes that may be necessary as the process continues; and 3) looking for additional education and training opportunities for the program at large.

If a community-based organization is small enough (e.g., a staff of 12-15), the trauma workgroup can include all staff. In this case, trauma workgroup topics may be included in regular staff meetings or discussed at a different time. In larger programs, it may be unrealistic to get all staff together on a regular basis to discuss trauma and trauma-informed care in addition to general topics covered in staff meetings. Creating a smaller multidisciplinary group of staff may make things more manageable. This trauma workgroup can report back to all staff in order to give updates on progress towards goals and get staff feedback on how the change process is going. This includes discussions about challenges and barriers to change that inevitably arise. The trauma workgroup should maintain ongoing contact with program consumers, including displaced families, as one key method of assessing whether they are making progress on identified goals.

Tips and Strategies

- Staff at all levels of an organization should have a voice in the trauma workgroup. If all staff roles within a program are not represented in the workgroup, it leads to a sense that some positions are less valued than others.
- Ongoing feedback from consumers provides organizations with essential information about whether daily programming and services actually seem different.

Step 10:

Becoming trauma-informed is a process that involves ongoing growth and development. There is no specific end-date at which point agencies are "trauma-informed" and therefore "finished" with the process. The *Organizational Self-Assessment for Displaced Populations* is one tool that programs can use to become more trauma-informed. As programs begin to incorporate trauma-informed practices, the hope is that they will also begin to generate additional ideas for creating trauma-informed programming that go beyond what is outlined in the *Organizational Self-Assessment*.

Step 11:

As organizations achieve their initial goals and modify their strategic plans to include new ideas for trauma-informed practices, it is helpful to begin to brainstorm ways to document the impact that this type of trauma-informed change is having in the program, specifically as it relates to consumer feedback and outcomes. This may include the use of staff and consumer focus groups, questionnaires, and documentation of information such as number of terminations from the program, number of successful housing and job placements, and rates of staff turnover. Documenting how becoming trauma-informed impacts consumer and staff experiences may be a helpful way for programs to advocate for additional resources and changes in broader systemic policies that may conflict with a trauma-informed approach.

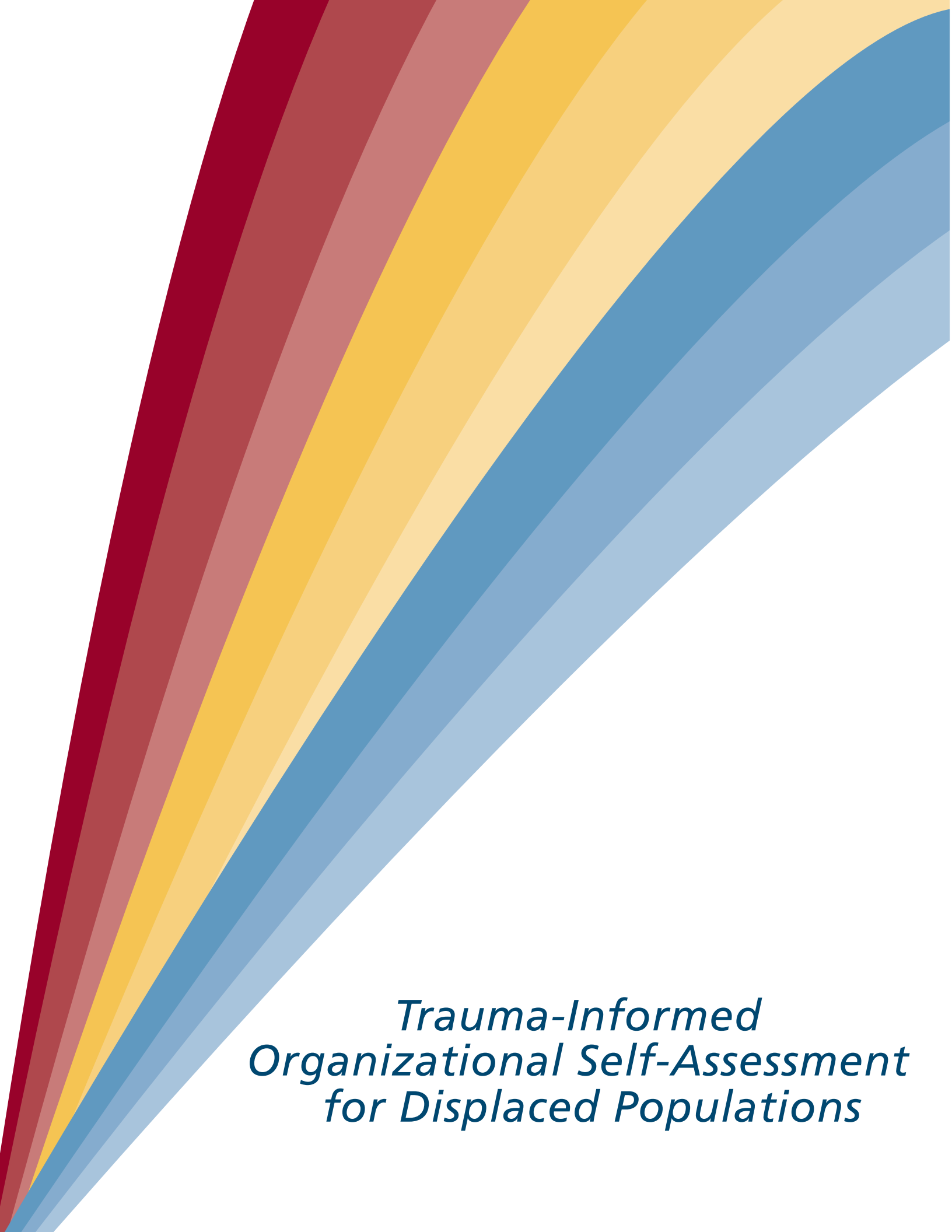
II. Sustaining Trauma-Informed Change

The following are suggested "next steps" for sustaining trauma- informed changes:

- Routinely provide training on trauma and trauma-informed care for all staff across the organization.
- Coordinate and provide cross-trainings across service systems to develop a shared mission, vision, language, and commitment to delivering trauma-informed care
- Conduct periodic reviews of short-term and long-term goals. Agencies can do a yearly re-assessment of their program to identify changes. Utilize various assessment tools including staff and consumer surveys, focus groups, and individual interviews to continually monitor how trauma informed care is being delivered and received by clients.
- Engage consumers in service delivery to meet their unique needs.
- Connect with experts in various areas and agencies that can provide on-going support and consultation.
- Network with other service systems that are incorporating trauma-informed models to build a support system and learning community to help sustain commitment to delivering trauma-informed care.
- Provide trauma training as part of the new hire process and conduct ongoing trainings on trauma-related topics.
- Educate other service systems and providers working with displaced populations on the impact of trauma and trauma-informed care.

III. Conclusion

As the numbers of refugees, immigrants, and those displaced by natural disaster, conflict, persecution or extreme poverty grow, it is incumbent on providers to fully understand the potential impact of traumatic experiences for this special population. There are many opportunities to address the needs of displaced populations, including providing culturally competent, trauma-informed care. While the Healing Hearts Promoting Health project focused attention on the particular needs of Haitian evacuees in Southern Florida following the 2010 earthquake, this guide is a tool that can be used by community agencies serving persons displaced for reasons other than natural disasters. By implementing trauma-informed care through a culturally competent lens, programs serving displaced children and families can develop an organizational model of service delivery to ensure all displaced persons receive a level of care that is attuned to their unique needs.


Trauma-Informed
Organizational Self-Assessment
for Displaced Populations

Instructions for Completing the *Self-Assessment*

The central component of *Trauma-Informed Care for Displaced Populations: A Guide for Community-Based Service Providers* is the *Trauma-Informed Organizational Self-Assessment for Displaced Populations*. The *Organizational Self-Assessment for Displaced Populations* is a tool that community-based organizations can use to evaluate current practices and adapt their programming to respond to the needs of persons who have been displaced. It should be completed by all staff in an organization looking to become trauma-informed. This group may include direct care staff (full-time, part-time, and relief), supervisors, case managers, clinicians, administrators (e.g., program managers, directors, executive directors, etc.), and support staff (e.g., office support, maintenance, kitchen staff, etc.).

The *Organizational Self-Assessment for Displaced Populations* is organized into six main "domains" or areas of programming:

1. Supporting Staff Development
2. Creating a Safe and Supportive Environment
3. Assessing and Planning Services
4. Involving Consumers
5. Adapting Policies
6. Working with Children

Within each domain is a list of trauma-informed practices. For each item, please consider the extent to which you agree that your program incorporates this practice using the following scale:

- Strongly Disagree (This rarely or never happens)
- Disagree (This usually does not happen)
- Agree (This happens some of the time)
- Strongly Agree (This happens most of the time)
- Do Not Know (I don't know if this happens in the program)
- Not Applicable to My Program (This practice is not applicable to what we do in our program)

For example: "Staff at all levels of the organization receive training and education on cultural differences in how people understand and respond to trauma." Staff responds, "Strongly Disagree, Disagree, Agree, Strongly Agree, Do Not Know, or Not Applicable to My Program."

When responding to items, please answer based on your experience in the organization over the past six months. The *Organizational Self-Assessment for Displaced Populations* can be completed in one sitting or in sections and takes approximately 30-40 minutes to complete all at once.

Some items use the term "consumer," which refers to people being served by the agency. The term "staff " refers to paid and voluntary individuals providing services, which include but are not limited to: those working directly with consumers, administrators, policymakers, groundskeepers, maintenance, and transportation specialists.

I. Supporting Staff Development

A. Training and Education

Staff at all levels of the organization receive training and education (e.g., face-to-face trainings, online courses, special presentations) on the following topics:

I. Supporting Staff Development **A. Training and Education** **Trauma and Mental Health**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
1. Traumatic stress and its impact on the brain and body.						
2. Child development.						
3. Cultural differences in how children develop.						
4. Child/caregiver attachment (e.g., types of attachment).						
5. Culture-specific parenting practices (e.g., discipline practices, parent/child interactions).						
6. How trauma impacts child development.						
7. How family trauma impacts child/caregiver relationships.						
8. The relationship between childhood trauma and adult re-victimization (e.g., domestic violence, sexual assault).						
9. The impact of chronic trauma on adults.						
10. The impact of trans-generational trauma on family functioning (how trauma is transmitted across generations).						
11. Experiences of historical trauma among particular groups.						

I. Supporting Staff Development **A. Training and Education** **Trauma and Mental Health**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
12. Cultural differences in how people understand and respond to trauma (e.g., physical symptoms, different words to talk about traumatic experiences).						
13. The relationship between trauma and mental health.						
14. Common mental health disorders associated with trauma (e.g., depression, anxiety - causes, symptoms, treatments).						
15. Individual vs. Empathic Family stress.						
16. Post-traumatic stress disorder (PTSD).						
17. Cultural differences in how mental health issues are understood and expressed.						
18. Cultural norms around help-seeking behavior as it relates to mental health.						
19. Culture-specific experiences with the health and mental healthcare systems (e.g., histories of being marginalized, stigmatized, or abused).						
20. The relationship between trauma and substance abuse.						

I. Supporting Staff Development **A. Training and Education** **Trauma and Mental Health**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
21. Substance abuse disorders (causes, symptoms, treatments).						
22. Suicide (risk factors, red flags, crisis intervention).						
23. Traumatic Brain Injury (TBI).						
24. How working with trauma survivors impacts staff (e.g., compassion fatigue/vicarious trauma).						
25. Factors that help people recover from trauma.						
26. The role of spirituality in the recovery process.						

I. Supporting Staff Development **A. Training and Education** **Displacement-Specific Knowledge**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
27. Types of displacement (e.g. refugees, secondary migration, asylum-seeking, returnees, internally displaced, stateless).						
28. Types of pre-migration trauma experienced by displaced families (e.g., war trauma, torture, gender-based violence, female genital cutting, unstable political systems).						
29. The immigration process for displaced families.						
30. Experiences and challenges related to resettlement and acculturation.						
31. Mental health disorders frequently experienced by displaced families (e.g., depression, anxiety).						
32. Racism, classism, and cultural oppression related to the population being served.						

I. Supporting Staff Development **A. Training and Education** **Skills and Strategies to Support Recovery**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
33. Trauma-Informed Care.						
34. Cultural Competence (e.g., awareness of the cultures served, awareness of staff members own values, attitudes, and beliefs based on cultural background, culturally sensitive practices).						
35. Motivational Interviewing.						
36. De-escalation strategies (i.e., ways to help people prior to, during, and after a crisis).						
37. Professional boundaries and ethics.						
38. Culture-specific strategies for engaging families.						
39. How to recognize and minimize potential triggers for clients.						
40. How to educate trauma survivors about trauma and its impact.						
41. How to work through a translator or cultural broker with clients who are non-English speaking or have limited English proficiency.						
42. How to respond effectively to the services needs of populations with low literacy skills.						

B. Staff Supervision, Support and Self-Care

I. Supporting Staff Development **B. Staff Supervision, Support and Self-Care**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
43. Staff members have regular team meetings.						
44. Trauma-related topics are addressed and reinforced in team meetings.						
45. Staff members have regular opportunities for individual supervision.						
46. Supervisors are trained in trauma and trauma-informed care.						
47. Topics related to self-care are addressed in team meetings and supervision (e.g., vicarious trauma, burn-out, stress-reducing strategies).						
48. The organization has a process for helping staff members debrief after a crisis.						
49. The organization has a formal system for reviewing staff performance.						
50. The organization provides opportunities for on-going staff evaluation of the program.						
51. The organization provides opportunities for staff input into program practices.						
52. Outside consultants or staff members with expertise in trauma and trauma-informed care provide ongoing education and consultation.						
53. Outside consultants or staff members with expertise in cultural competence provide ongoing education and consultation.						
54. Outside consultants or staff members with expertise in working with displaced individuals and families provide ongoing education and consultation.						

II. Creating a Safe & Supportive Environment

The experience of trauma violates one's fundamental sense of safety and security. Establishing and maintaining physical and emotional safety is a core principle of trauma-informed care.

A. Establishing a Safe Physical

II. Creating a Safe and Supportive Environment **A. Establishing a Safe Physical Environment**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
1. The organizational facility has a security system.						
2. Agency staff monitors who is coming in and out of the program.						
3. The environment outside the organizational facility is well lit.						
4. The common areas are well lit.						
5. Bathrooms are well lit.						
6. Bathroom doors can be locked.						
7. When applicable, there are private, locked spaces for belongings.						
8. The organizational facility is clean and well-maintained.						
9. The organizational facility is decorated with materials that reflect diversity.						
10. The organization provides consumers with opportunities to make suggestions about ways to improve/change the physical space.						

B. Establishing a Supportive Environment

II. Creating a Safe and Supportive Environment **B. Establishing a Supportive Environment** **Information Sharing**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
11. The organization reviews rules, rights, and grievance procedures with consumers on a regular basis.						
12. Organizational information (e.g., policies, procedures, services, requirements) is available in the languages of the people served.						
13. Organizational information is easy to read (low literacy, pictures).						
14. Consumer rights are posted in places that are visible.						
15. Material is posted or available about traumatic stress (e.g., what it is, how it impacts people, trauma-specific resources).						
16. Material is posted or available about community resources for displaced families.						
17. Materials are posted in the languages of the people served.						

II. Creating a Safe and Supportive Environment **B. Establishing a Supportive Environment** **Privacy and Confidentiality**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
18. The organization informs consumers about the extent and limits of privacy and confidentiality (e.g., the kinds of records that are kept, where they are kept, who has access to this information, when the program is obligated to report information to child welfare or police).						
19. Staff does not talk about consumers in common spaces.						
20. Staff does not discuss the personal issues of one consumer with another consumer.						
21. There are private spaces for staff and consumers to discuss personal issues.						
22. Consumers who have violated rules are approached in private.						
23. When applicable, the organization obtains permission from consumers prior to giving a tour of their space (e.g., person notified of date, time, and who will see the space).						

II. Creating a Safe and Supportive Environment **B. Establishing a Supportive Environment** **Open and Respectful Communication**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
24. The organization uses "people-first" language rather than labels (e.g., "People who are displaced" rather than "displaced people").						
25. Staff uses motivational interviewing techniques with consumers (e.g., open-ended questions, affirmations, reflective listening).						
26. Consumers are allowed to speak their native language within the organization.						
27. When applicable, consumers are allowed to prepare or have ethnic-specific foods.						
28. The organization provides ongoing opportunities for consumers to share their cultures with each other (e.g., potlucks, culture nights, incorporate different types of art and music, etc.).						
29. Staff shows respect for personal religious or spiritual practices.						
30. Staff shows respect for culture-specific family roles and practices.						
31. Rules are enforced in respectful ways (e.g., expectations about room/apartment checks are clearly written and verbalized and checks are done in a manner that ensures as much control as possible for the family).						
32. The organization is flexible with rules and regulations if needed, based on individual circumstances.						
33. Staff works in collaboration with families.						

II. Creating a Safe and Supportive Environment **B. Establishing a Supportive Environment** **Consistency and Predictability**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
34. The organization has regularly scheduled meetings with consumers.						
35. The organization provides advance notice of changes in the daily or weekly schedule.						
36. The organization has structures in place to support staff consistency with consumers across roles and shifts (e.g., trainings, staff meetings, shift change meetings, and peer supervision).						

II. Creating a Safe and Supportive Environment **B. Establishing a Supportive Environment** **Safety Planning and Crisis Prevention**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
For the following items, the term "safety plan" is defined as a plan for what you and staff members will do if you feel threatened by another person outside of the agency.						
37. Consumers work with staff to create written, individualized safety plans.						
38. Written safety plans are incorporated into consumers' individual goals and plans.						
For the following items, the term "crisis-prevention plan" is defined as an individualized plan for how to help each consumer manage stress and feel supported.						
39. Every consumer in the organization has a written crisis-prevention plan.						
40. Crisis prevention plans include a list of triggers (e.g., situations that are stressful or overwhelming and remind the person of past traumatic experiences).						
41. Crisis prevention plans include a list of ways that the person shows that she is stressed or overwhelmed (e.g., types of behaviors, ways of responding, etc.).						
42. Crisis prevention plans include specific strategies and responses that are helpful when the person is feeling upset or overwhelmed.						
43. Crisis prevention plans include specific strategies and responses that are not helpful when the person is feeling upset or overwhelmed.						
44. Crisis prevention plans include a list of people with whom the person feels safe and can go to for support.						

III. Assessing and Planning Services

A. Conducting Assessment

III. Assessing and Planning Services A. Conducting Assessments **Assessment Questions**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
Assessments include questions about the following:						
1. Primary language.						
2. Language(s) spoken in the household.						
3. Cultural background.						
4. Country of origin.						
5. Cultural Strengths (e.g., world view, role of spirituality, cultural connections).						
6. Personal strengths.						
7. Years of education completed.						
8. Immigration and documentation status.						
9. If displaced, reasons for displacement.						
10. Quality of relationships between family members (e.g., caregiver and child).						
11. Degree of extended family support.						
12. Family management and discipline practices.						
13. Degree of connection to the community and similar cultural groups.						
14. Perceived level of safety in the community/neighborhood.						
15. Current level of threats to safety from other people (e.g. political, domestic violence, stalking, restraining orders).						

III. Assessing and Planning Services **A. Conducting Assessments** **Assessment Questions** (continued)	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
Assessments include questions about the following:						
16. History of trauma (e.g., witnessing violence; physical, emotional or sexual abuse; neglect; loss; intimate partner violence; community violence; past homelessness; torture).						
17. Trauma experienced during the migration process.						
18. Acculturative stress (e.g., isolation, language barriers, challenges adjusting to new environment).						
19. Acculturation differences within the family (e.g., how different family members within the same household adjust).						
20. Post-traumatic stress symptoms (e.g., nightmares, flashbacks, preoccupation with telling story of a traumatic event, avoiding situations that remind someone of a traumatic experience).						
21. Health history.						
22. Any head injuries.						
23. Other previous injuries (cuts, broken bones, broken jaws, torture).						
24. History of substance use/abuse.						
25. History of mental health issues.						

III. Assessing and Planning Services **A. Conducting Assessments** **Assessment Questions** (continued)	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
Assessments include questions about the following:						
26. Suicidal thoughts and behaviors.						
27. Housing history.						
28. Current access to services/ community resources.						
29. Relationship with child's school when applicable.						
30. Degree of cultural and linguistic barriers to accessing services and supports.						
31. Experiences of discrimination.						

III. Assessing and Planning Services **A. Conducting Assessments** **Assessment Process**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
32. There are private, confidential spaces available to conduct assessments.						
33. Assessments are conducted for each family member.						
34. Consumers have the option of doing the assessment individually or with other family members.						
35. Consumers are informed of the limits of confidentiality in ways that they will understand.						
36. Assessments are conducted in the primary language spoken by the consumer.						
37. The organization provides an adult translator or cultural broker for the assessment process if needed.						
38. Staff acknowledges cultural differences and expresses willingness to learn when applicable.						
39. Staff considers culture-specific communication styles when conducting the assessment (e.g., eye contact, touch, body language, and pace of conversation).						
40. Staff explains why particular questions are asked and what is done with the information using culturally-relevant terms and tools for those with limited English proficiency.						
41. When possible, assessment questions are open-ended vs. yes/no answers (e.g., How do you feel? vs. Do you feel sad?).						

III. Assessing and Planning Services **A. Conducting Assessments** **Assessment Process** (Continued)	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
42. Assessment questions are strengths-based vs. deficit-based (what you have done, how you have cared for yourself and your family, what you have experienced vs. what is wrong with you, what you haven't done).						
43. Assessment questions are broken down into specific behaviors and responses (e.g., How have you been sleeping? vs. Are you depressed?).						
44. Assessment questions are designed to capture cultural differences in how people respond (e.g., when talking about mental health, using words that make sense in a particular culture that might not refer to a set of symptoms as "depression").						
45. Staff is aware of culture-specific topics that may be taboo (e.g., mental health, sexuality, abuse, violence).						
46. Throughout the assessment process, staff checks in with consumers about how they are doing (e.g., asking if they would like a break, a glass of water, etc.).						
47. Consumers are given the option of writing down responses to assessment questions when preferred.						
Assessment Follow-Up						
48. Releases and consent forms are updated whenever it is necessary to speak with a new provider.						
49. The assessment is updated on an on-going basis.						

B. Developing Goals and Plans

III. Assessing and Planning Services **B. Developing Goals and Plans**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
50. Staff collaborates with participants to co-create goals.						
51. Consumer goals are reviewed and updated regularly.						
52. The organization helps families identify resources in their community.						
53. Staff offers program participants with step-by-step support as they begin to access community-based services.						

C. Providing Services

III. Assessing and Planning Services **C. Providing Services** **Emotional Support**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
54. The organization educates consumers about traumatic stress and its impact.						
55. The organization provides or refers consumers to agencies that provide trauma-specific mental health services (i.e., mental health interventions that are designed to address trauma-related reactions).						
56. The organization has or refers consumers to agencies that have expertise in providing mental health services to displaced families.						
57. The organization provides or refers participants to agencies that provide substance abuse treatment.						
58. The organization consults with spiritual healers when necessary.						
59. The organization integrates culture-specific practices and terminology into service delivery.						
60. The organization provides opportunities for consumers to express themselves in creative and nonverbal ways (e.g., art, dance, movement, music).						
61. The organization supports a variety of peer-to-peer activities for consumers.						
62. The organization provides opportunities for former consumers to mentor new program consumers.						
63. The program coordinates on-going communication between mental health and substance abuse providers.						
64. The program coordinates on-going communication between early intervention and mental health service providers.						

III. Assessing and Planning Services **C. Providing Services** **Instrumental Supports**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
65. The organization offers child care support/alternatives for people while they participate in services.						
66. The organization has connections with agencies that provide a variety of services including housing, legal and educational advocacy, ESL, job training and placement programs, immigration services, and health services.						
67. The organization considers child care and transportation issues when referring families for additional services.						
Community Outreach						
68. The organization educates community-based providers about trauma and its impact.						
69. The organization educates community-based service providers (mental health, homelessness, law enforcement, employers, schools, etc.) about the unique experiences and needs of displaced families.						
70. The organization educates community-based providers (church, housing, schools) about how to access resources to help displaced families cope with trauma, lost, and separation.						

IV. Involving Consumers

A. Involving Current and Former Consumers

IV. Involving Consumers A. Involving Current and Former Consumers **Current Consumers**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
1. The organization provides consumers with opportunities to express their needs and concerns.						
2. Current consumers have opportunities to identify their treatment needs and goals.						
3. Current consumers are involved in developing agency programming.						
4. The organization provides opportunities for consumers to co-lead/lead activities.						
5. Current consumers have opportunities to evaluate the organization and offer their suggestions for improvement in anonymous and/or confidential ways (e.g., suggestion boxes, regular satisfaction surveys).						
Former Consumers *(refers to anyone who has had similar experiences to those currently served by your organization)*						
6. Consumers who have been displaced in the past are invited to share their thoughts, ideas, and experiences with the organization.						
7. The organization recruits former consumers for their board of directors.						
8. Former consumers are hired at all levels of the organization.						
9. Former consumers are involved in program development.						
10. Former consumers are involved in providing services (e.g., peer-run support groups, educational, and therapeutic groups).						
11. The organization provides support and mentoring for former consumers who are involved in programming.						

V. Adapting Policies

A. Creating Written Policies

V. Adapting Policies **A. Creating Written Policies**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
1. Policies are established based on an understanding of the impact of trauma on the people being served.						
2. Policies are accompanied by explanations of why they are needed.						
3. Policies are strengths-based (e.g., what you can do vs. what you can't).						
4. Policies are available in multiple forms (e.g., written, verbal, pictures).						
5. Policies include a written commitment to provide trauma-informed care.						
6. Policies include a written commitment to provide culturally competent care (e.g., staff training, hiring bilingual/bicultural staff, organizational practices that respect cultural differences).						
7. Policies include a written commitment to hire former consumers with similar experiences to those who are currently served by the organization.						
8. Policies include a commitment to responding effectively to the literacy needs of the people served.						
9. The organization has written policies outlining program responses to consumer crises (e.g., self-harm, suicidal thinking, aggression towards others, violation of restraining orders).						
10. The organization has written policies outlining professional conduct for staff (e.g., boundaries, responses to consumers, etc.).						

B. Reviewing Policies

V. Adapting Policies **B. Reviewing Policies**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
11. The organization involves current consumers in its review of policies.						
12. The organization involves staff at all levels in its review of policies.						
13. The organization reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors.						

VI. Working With Children

VI. Working With Children	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
Physical Environment						
1. The organization incorporates child-friendly decorations.						
2. The organization displays child-friendly materials that reflect diversity (e.g., toys, books, dolls).						
3. The organization provides a space for children to play.						
Intake and Assessment						
4. The organization has a child-specific assessment.						
5. Child-specific assessments are conducted for each child at the organization.						

VI. Working With Children **Intake and Assessment** (Continued)	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
Child assessment includes questions about the following:						
6. Child's cultural background.						
7. Child's relationship with caregiver (caregiver/child attachment).						
8. Child's achievement of developmental tasks.						
9. Child's education history.						
10. Child's support network.						
11. Child's strengths.						
12. Child's history of trauma (e.g., neglect, abuse, exposure to violence, separation, loss, homelessness, migration trauma).						
13. Child's history of emotional health issues.						
14. Child's history of physical health issues.						
15. Child's history of substance abuse issues.						
16. Child's history of hospitalization.						
17. Child's experiences prior, during, and post migration.						
18. Child's history in country of origin.						
19. Child's acculturation issues.						

VI. Working With Children **Child Services and Supports**	**Strongly Disagree** (This rarely or never happens)	**Disagree** (This usually does not happen)	**Agree** (This happens some of the time)	**Strongly Agree** (This happens most of the time)	**Do Not Know**	**Not Applicable to My Program**
20. The organization partners with families to create a service plan for each child in the family.						
21. The organization provides or makes referrals for children based on service plan needs.						
22. The organization provides or refers children to trauma-specific therapeutic services when needed.						
23. The organization provides or refers children to early childhood education programming when needed.						
24. Child service plans are reviewed and adapted regularly.						

Resources

Resource Kit #1: Refugees/Immigrants
Resource Kit #2: Trauma-Informed Care
Resource Kit #3: Homelessness
Resource Kit #4: Cultural Competence

Resource Kit #1: Refugees/Immigrants

1.1

Refugee Council USA (RCUSA)

Website:	www.rcusa.org
Language:	English
Content:	RCUSA provides advocacy on issues affecting the rights of refugees, asylum seekers, displaced persons, victims of trafficking, and victims of torture in the United States and across the world. The coalition also serves as the principal consultative forum for the national refugee resettlement and processing agencies as they formulate common positions, conduct their relations with the U.S. government and other partners, and support and enhance refugee service standards.

1.2

US Committee for Refugees and Immigrants (USCRI)

Website:	www.refugees.org
Language:	English
Content:	USCRI advocates, protects, and provides direct services to persons in forced or voluntary migration worldwide.

1.3

Bridging Refugee Youth and Children's Services (BRYCS)

Website:	www.brycs.org
Language:	English
Content:	BRYCS provides technical assistance to organizations serving refugees and immigrants, focus on youth and children.

1.4

Office of the United Nations High Commissioner for Refugees (UNHCR)

Website:	www.unhcr.org/pages/49c3646c4b2.html
Language:	English
Content:	UNHCR leads and coordinates international action to protect refugees and resolve refugee problems worldwide.

Resource Kit #2: Trauma-Informed Care

2.1

The National Center on Family Homelessness at American Institutes for Research (NCFH/AIR)

Website:	www.familyhomelessness.org
Language:	English
Content:	NCFH/AIR is a leading resource for research, training, consultation, and technical assistance on trauma-informed care. Multiple tools and products are available on the website.

2.2

National Center for Trauma-Informed Care (NCTIC)

Website: www.mentalhealth.samhsa.gov/nctic
Language: English
Content: NCTIC is a technical assistance center dedicated to building awareness of trauma-informed care and promoting the implementation of trauma-informed practices in programs and services.

2.3

The Trauma Center at JRI

Website: www.traumacenter.org
Language: English
Content: The Trauma Center helps individuals, families, and communities that have been impacted by trauma and adversity to re-establish a sense of safety and predictability in the world, and provides them with state-of-the-art therapeutic care as they reclaim, rebuild, and renew their lives.

2.4

Safe Start Center

Website: www.safestartcenter.org/resources/tip-sheets.php
Language: English
Content: The Safe Start Center promotes community investment in evidence-based strategies for reducing the impact of children's exposure to violence.

2.5

Oregon Health Services: Trauma-Informed and Trauma Specific Services

Website: www.oregon.gov/OHA/amh/Pages/trauma.aspx
Language: English
Content: Oregon Health Services provides valuable links to policy samples, screening tools, presentations, publications, and other trauma-related web links.

2.6

National Association of State Mental Health Program Directors (NASMHPD)

Website: www.nasmhpd.org/TA/NCTIC.aspx
Language: English
Content: NASMHPD offers valuable information about the Center for Mental Health Services National Center for Trauma-Informed Care, including resources such as publications, reports, webinars, and other tools.

2.7

Medical University of South Carolina (MUSC)

Website: http://tfcbt.musc.edu/
Language: English
Content: The MUSC offers Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)—A Web-Based Learning Course. TF-CBT is a child and parent psychotherapy approach for kids who have behavioral difficulties that result from trauma. Children and parents learn new skills to manage and resolve distressing thoughts, feelings, and behaviors that result from traumatic life events.

2.8

The Trauma-Informed Response

Website: www.traumainformedresponse.com
Language: English
Content: The Trauma-Informed Response assists organizations in creating Trauma Responsive, Trauma-Informed systems and in particular help organizations adopt trauma-informed care. TReSIA, is a Trauma Responsive System Implementation Advisor suite that includes tools for implementing Trauma-Informed Care.

2.9

The Trauma-Informed Care Project

Website: www.traumainformedcareproject.org
Language: English
Content: The Trauma-Informed Care Project provides education for those that deliver services or have some piece of a family's case, about trauma and how it may impact the system and/or affect the family and trains practitioners in evidenced-based trauma-informed services so that our consumers/community/system can have available resources to send trauma survivors to receive services.

2.10

California Center of Excellence for Trauma Informed Care

Website: www.trauma-informed-california.org
Language: English
Content: The Center promotes trauma-informed practices within California's social service sector.

2.11

State University of New York at Buffalo - School of Social Work

Website: www.socialwork.buffalo.edu/research/ittic/
Podcast: www.socialwork.buffalo.edu/podcast/trauma/
Language: English
Content: The SUNY Buffalo School of Social Work offers the Living Proof Podcast Series - Trauma and Trauma-Informed Care: Free podcasts related to trauma and Trauma-Informed Care, produced bi-weekly by the University.

2.12

The Trauma Informed Care Network

Website: www.traumainformedcarenetwork.org
Language: English
Content: The Trauma-Informed Care Network has a shared community vision that embraces a system of care that views individuals in a way that honors their complicated and traumatic histories by responding with sensitivity and understanding.

2.13
The National Child Traumatic Stress Network (NCTSN)
Website: www.nctsn.org
Language: English
Content: NCTSN's collaboration of frontline providers, researchers, and families is committed to raising the standard of care while increasing access to services. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and dedication to evidence-based practices, the NCTSN changes the course of children's lives by changing the course of their care.

2.14
Florida Department of Juvenile Justice
Website: www.djj.state.fl.us/partners/our-approach/Trauma
Language: English
Content: The Florida Department of Juvenile Justice provides Trauma-Informed Care to continue to be "part of the solution," and so children will be afforded the opportunity to live with more hope than fear.

2.15
Child Trauma Academy
Website: www.childtrauma.org
Language: English
Content: The Child Trauma Academy strives to improve the lives of high-risk children through service, research, and education. Free online learning modules are available.

2.16
National Clearinghouse on Families and Youth
Website: http://ncfy.acf.hhs.gov/tools/exchange/trauma-informed-care/tips
Language: English
Content: The National Clearinghouse on Families and Youth provides web-based information on trauma-informed care and tips for youth workers.

Resource Kit #3: Homelessness

3.1
The National Center on Family Homelessness at American Institutes for Research (NCFH/AIR)
Website: www.familyhomelessness.org
Language: English
Content: NCFH/AIR is a leading resource for research, training, consultation, and tehcnical assistance on family homelessness.

3.2
Homeless Resource Center (HRC)
Website: www.homeless.samhsa.gov
Language: English
Content: The HRC is part of the Homelessness Resource Network (HRN), a collaboration to share a common digital library of over 9,000 resources related to homelessness, mental illness, substance use, co-occurring disorders, and traumatic stress.

3.3

United States Interagency Council on Homelessness (USICH)

Website: www.usich.gov/issue/trauma_informed_care
Language: English
Content: The USICH coordinates the federal response to homelessness and creates a national partnership at every level of government and with the private sector to reduce and end homelessness in the nation while maximizing the effectiveness of the Federal Government in contributing to the end of homelessness.

3.4

The National Association for the Education of Homeless Children and Youth (NAEHCY)

Website: www.naehcy.org
Language: English
Content: NAEHCY is the only professional organization specifically dedicated to meeting the educational needs of children and youth experiencing homelessness. Provides professional development, resources, and training support for anyone and everyone interested in supporting the academic success of children and youth challenged by homelessness.

Resource Kit #4: Cultural Competence

4.1

Child Welfare Information Gateway

Website: www.childwelfare.gov/responding/trauma.cfm
Language: English
Content: The Child Welfare Information Gateway promotes the safety, permanency, and well-being of children, youth, and families by connecting child welfare, adoption, and related professionals as well as the general public to information, resources, and tools covering topics on child welfare, child abuse and neglect, out-of-home care, adoption, and more.

4.2

National Center for Cultural Competence (NCCC)

Website: http://nccc.georgetown.edu
Language: English, Spanish
Content: NCCC provides national leadership and contributes to the body of knowledge on cultural and linguistic competency within systems and organizations.

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