illinois childhood trauma coalition
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The Illinois Childhood Trauma Coalition's Ad-Hoc Committee on Refugee and Immigrant Children and Trauma (ICTC-RIC)

Needs Assessment Informing Policy and Capacity Building Initiatives: Trauma-Informed Services for Refugee/Immigrant Children and Families

Reports and Executive Summary

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Ad-Hoc Committee for Refugee/Immigrant Children & Trauma

EXECUTIVE SUMMARY

Needs Assessment of Trauma-Informed Services for Refugee & Immigrant Youth and Families

May 2017

Using a public health framework for addressing the negative health effects of psychological trauma, the Illinois Childhood Coalition's Ad-hoc Committee for Refugee/Immigrant Children (ICTC-RIC) sought to assess service needs in refugee/immigrant communities and inform workforce development and system-wide capacity building activities that would enhance culturally competent, trauma-informed care for refugee/immigrant children in Illinois. As such, ICTC-RIC sent two separate surveys to providers whose member organizations were expected to have some contact with refugee/immigrant youth and families.

METHODS

Self-report surveys were completed online by professionals (N=73) from various agencies serving immigrant and refugee communities. Participants included service providers in the sectors of mental health, legal aid, housing, education, employment, medical care, spiritual guidance, domestic violence, and case management. Two subsets of participants were surveyed: individuals from agencies whose mission is specifically aimed at serving refugee and immigrant youth and families (n=36; referred to as Cohort 1) and individuals whose agencies serve the general population, (n=37; referred to as Cohort 2). Surveys inquired about unmet service needs for refugee/immigrant clients, current level of trauma-informed services available at their agency, staff trained in cultural competency and trauma-informed care, workforce development interests, and mental health referral practices.

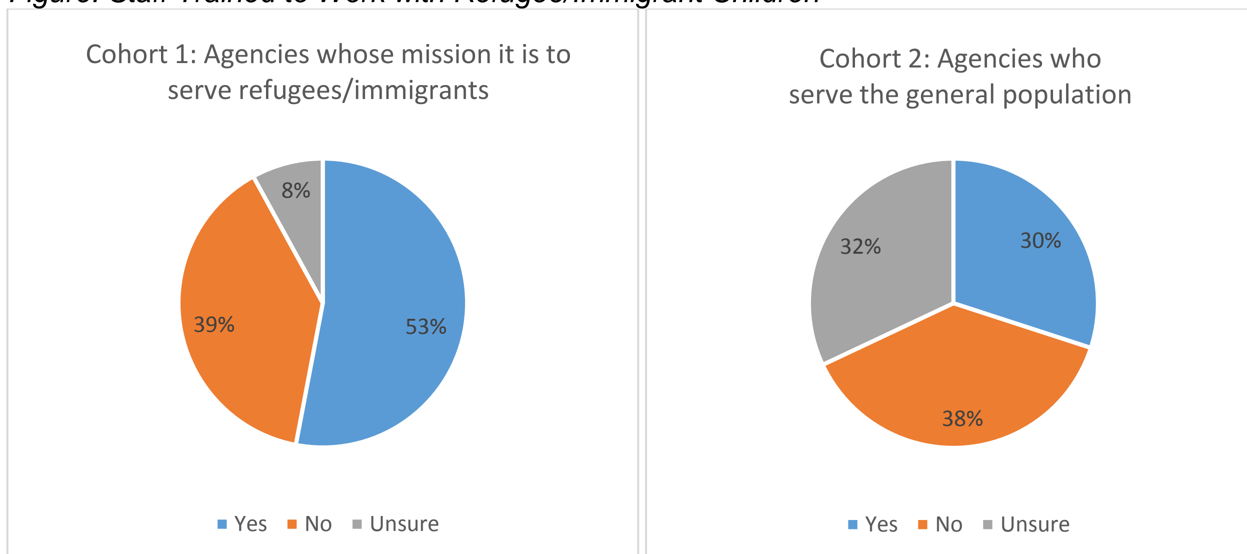
FINDINGS

- **Mental health services was the most frequently identified unmet need impacting the clients served by respondents (both in their agency and in the community) from agencies whose mission it is to serve immigrant/refugee communities.**

- **Training in cultural competency when working with immigrant/refugee children and families and in trauma-informed practices were needs clearly identified across both cohorts.**

  Notably, the percentage of staff who had received cultural competency training to serve immigrant and refugee children was only slightly higher (52%) among staff working at Cohort 1 agencies compared to 30% for staff at Cohort 2 organizations serving the general population. It may be that staff is trained in working with refugee/immigrant adults, but not specifically with children/adolescents. Of note, some respondents in both survey cohorts reported being unsure of whether staff at their agency received training specific to serving immigrant and refugee families.

Figure: Staff Trained to Work with Refugee/Immigrant Children



Both cohorts had significant variability in the portion of staff (both direct service and support staff) trained in trauma-informed practices. Among Cohort 1 respondents, at least some respondents from all types of programs (with the notable exception of mental health programs) endorsed that ***none of their staff*** had received this training. Across both cohorts, the most frequently endorsed item was that ***some agency staff had received this training***.

- **Training-Informed Needs per Program Type**
  We learned from Cohort 1 survey respondents that the 3 audiences with the greatest training needs for providing trauma-informed care were:
    - Educators
    - Case managers
    - Mental health service providers

  This appears to be supported by the Cohort 2 survey data. Even though education, mental health, and case management were among the top 4 services offered by Cohort 2 agencies (along with domestic violence), most agencies reported that only some staff were trained in this area.

- **Perceived Training Needs**
  Interestingly, both cohorts of respondents agreed that their top 3 training needs included:
    - Special considerations when treating/serving refugee/immigrant youth,
    - Culturally sensitive practice information specific to particular refugee/immigrant groups coming to Chicago/Illinois
    - Mental health issues for refugee/immigrant youth and families.

- **Training Modality Preference**
  Readings was the least preferred method to receive training, but the most commonly reported method of previous training. In terms of preference for what type of training would be the most preferred, the top 3 choices were:
    - On-site training at specific agencies
    - Local workshop
    - Webinar

SUMMARY

The results of the ICTC-RIC survey initiative provided essential information to guide ICTC-RIC workforce development and capacity building efforts. The data not only identified gaps in training and area for development, but also allowed for a focused effort on creating training materials that can be delivered in preferred in-person and web-based platforms. This effort comes at a critical time to influence the policies in Chicago as the city defines itself as a "sanctuary city" in the current sociopolitical climate. City-wide efforts are focused on the development of trainings, while ongoing coalition and workgroup collaborations will continue to provide an opportunity to disseminate and evaluate the impact of these trainings.

FUTURE DIRECTIONS

1. **Increase access to mental health services for refugee youth and families**

   Action Item 1: Develop a comprehensive resource guide that is made publicly available to increase awareness of existing resources.

   Action Item 2: Train providers to make informed and effective referrals to increase the likelihood of refugee/immigrant families' receipt of needed mental health services.

2. **Workforce development opportunities are needed to help increase provider capacity to serve refugee/immigrant youth and families in a trauma-informed manner, for both agencies identified as serving the immigrant/refugee and those that serve the general population.**

   Action Item 3: Develop and deliver in-person and webinar trainings to increase provider knowledge and awareness of the mental health context of immigrants and refugees as well as trauma-informed care strategies for work with vulnerable populations.

   Action Item 4: Prioritize training areas of workforce development to target:

   i. Providers with expertise in culturally responsive service provision to refugee/immigrant populations (educators, case managers)

   ii. Providers with expertise in trauma-informed, evidence-based care (mental health service providers)

3. **Increased investment in promoting workforce development in trauma-informed care for refugee/immigrant children and families is needed.** Funding was identified as the biggest barrier to expanding/improving programming for these families.

   Action Item 5: Identify and pursue funding streams for improvements in trauma-informed services for refugee/immigrant children and families.

4. **Education and consultation should be provided to community organizations in order to raise awareness about the immigrant and refugee youth and families they serve, and how they can begin to better track which programs/services are accessible to these families.**

   Action Item 6. Prioritize organization leadership trainings to raise awareness about the needs of refugee and immigrant families and the ways in which community organizations can minimize barriers to services and provide welcoming environments.

   Action Item 7. Foster networking and coalition-building activities to facilitate resource-sharing and collaboration between organizations serving the general public and local partners serving the immigrant and refugee communities.

Report 1:

Needs Assessment of Trauma-Informed Services for Refugee & Immigrant Youth and Families October 2016

From April through June 2016, the Illinois Childhood Trauma Coalition's Ad-Hoc Committee on Refugee and Immigrant Children and Trauma sent an electronic survey to personnel at a variety of agencies whose mission it is to serve refugee/immigrant youth and families. The goals were to (1) learn more about existing refugee/immigrant children's services and needs, (2) facilitate connections among service providers, and (3) inform workforce development and system-wide capacity building activities that would enhance trauma-informed care for all those who come in contact with refugee/immigrant children.

A pilot survey was completed by 8 respondents in March 2016 which contained some questions that were later excluded from the final survey (Wave 2). The Wave 2 survey was completed by a total (including pilot respondents) of 36 respondents. Whenever possible, pilot data was combined with Wave 2 survey data, but at times pilot data has to be reported separately due to different versions of questions included in the survey.

Definitions

TRAUMA: When the term TRAUMA is used in this survey, we are referring to the experience of an event by a child that is emotionally painful or distressful which often results in lasting mental and physical effects. The *National Institute of Mental Health* notes that trauma includes an*:*

- Event – One time or chronic
- Experience – whether the event is experienced as scary or threatening
- Effect - long-lasting and life altering

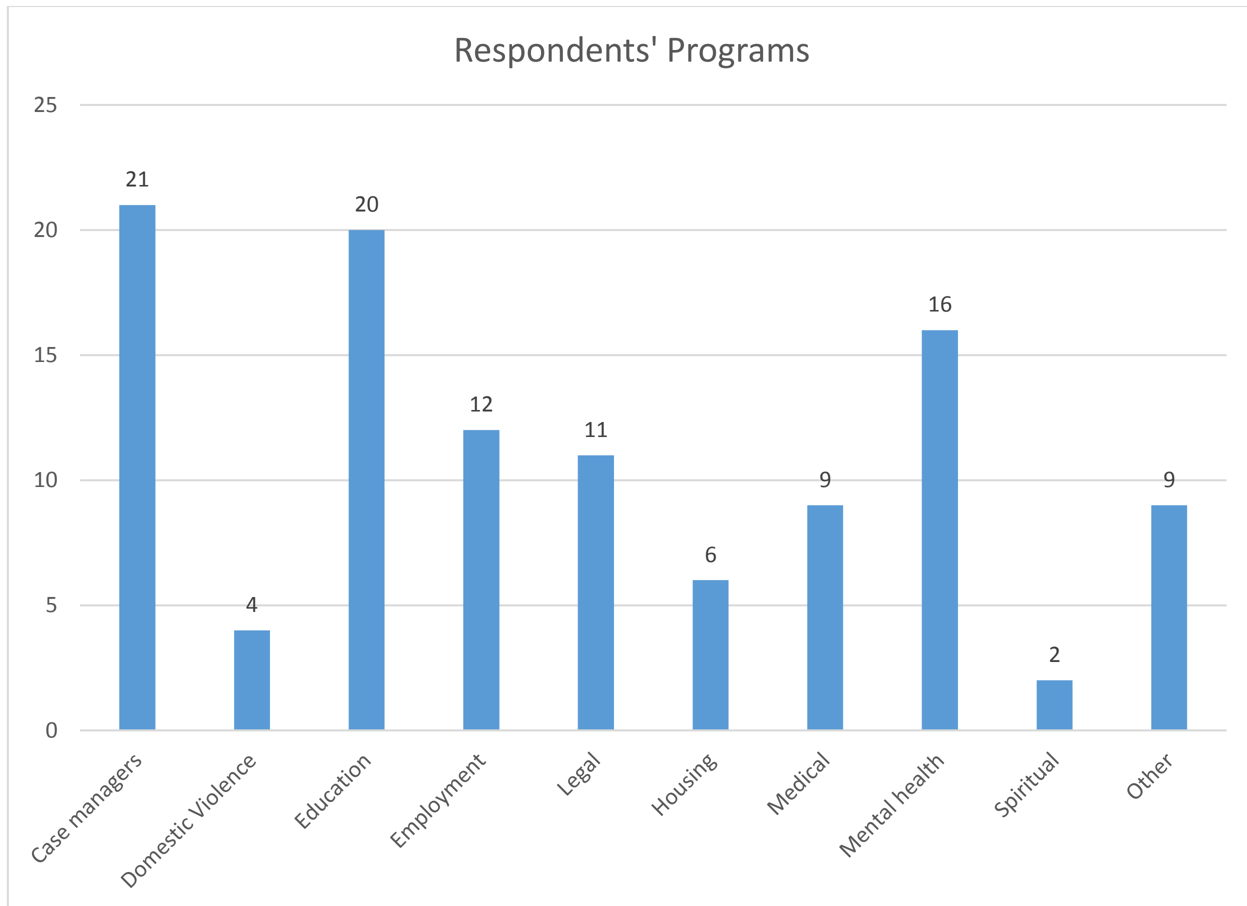
TRAUMA-INFORMED: A trauma informed organization is defined by the 4 Rs:

1. REALIZE the widespread impact of trauma & understand potential paths for healing;
2. RECOGNIZE the signs & symptoms of trauma in people; and
3. RESPOND by fully integrating knowledge about trauma into practice, settings, procedures, policies & laws; and
4. Try not to RE-TRAUMATIZE children and families seeking services.

Respondents

The 36 respondents reported on a variety of programs. Some reported on more than one program at their agency and sometimes multiple people from the same agency responded. For this reason, most data will be reported in terms of total respondents instead of percentages. The largest number of respondents reported on case management, education, and mental health services.

Figure 1



Evidence-Based Treatments in which Mental Health Providers Serving Refugee/Immigrant Youth & Families are Trained

A subsample of mental health provider respondents from the pilot (n = 7) reported in which evidence-based treatments their mental health providers had received training. Of note, although these treatments are recognized as evidence-based, little research has been done to translate and validate their use with refugee/immigrant populations.

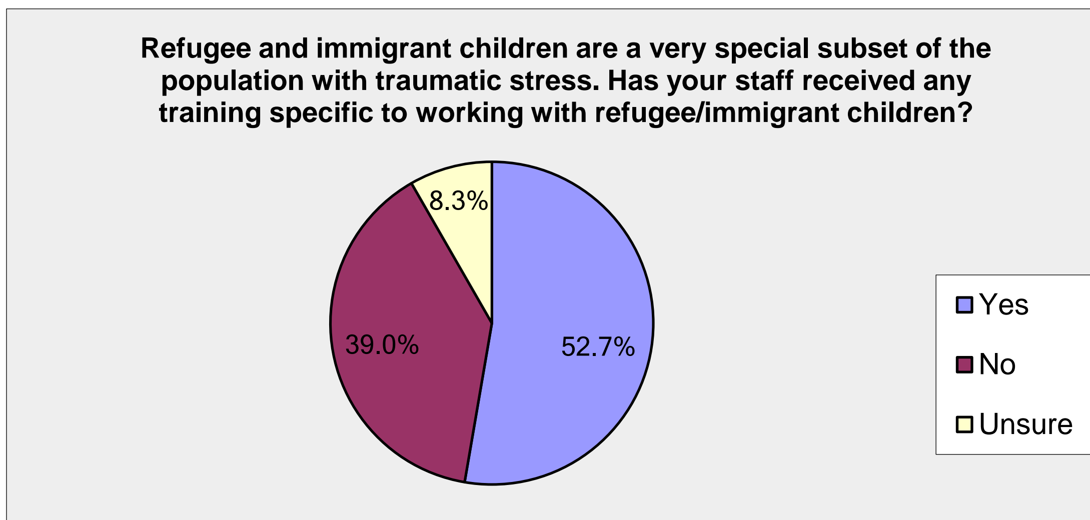
Table 1

EBT	*n*	%
Trauma-Focused Cognitive Behavioral Therapy (CBT)	5	71%
Cognitive Behavioral Therapy (CBT)	5	71%
Motivational Interviewing (MI)	4	57%
Narrative Exposure Therapy	3	43%
Parent Management Training (PMT)	2	29%
Interpersonal Therapy for Adolescents (IPT-A)	2	29%
Child Parent Psychotherapy (CPP)	1	14%
Attachment Regulation Competency (ARC)	1	14%

Training Specific to Work with Refugee/Immigrant Youth and Families

Respondents were asked whether their staff had received training specific to working with refugee/immigrant children. Notably, only slightly more than 50% of respondents from agencies whose mission it is to serve refugee/immigrant youth reported having received such training. Simply because staff have not received training does not necessarily mean that they are not providing high quality services, but it does point to the need for professional development opportunities in this area.

Chart 2



Type of Training Received

Of those who responded that their staff was trained, readings appeared to be the most common form of training received across different types of programming. Domestic violence workers, housing assistance providers, attorneys, and spiritual guidance leaders appeared to have the most restricted training backgrounds (mostly readings, workshops and internship/clinical practicum, and/or webinars). Case managers, educators, employment assistance providers, and mental health practitioners seemed to have the most varied training background including graduate studies, internship/clinical practicum, workshops, webinars, and PLCs.

Chart 3

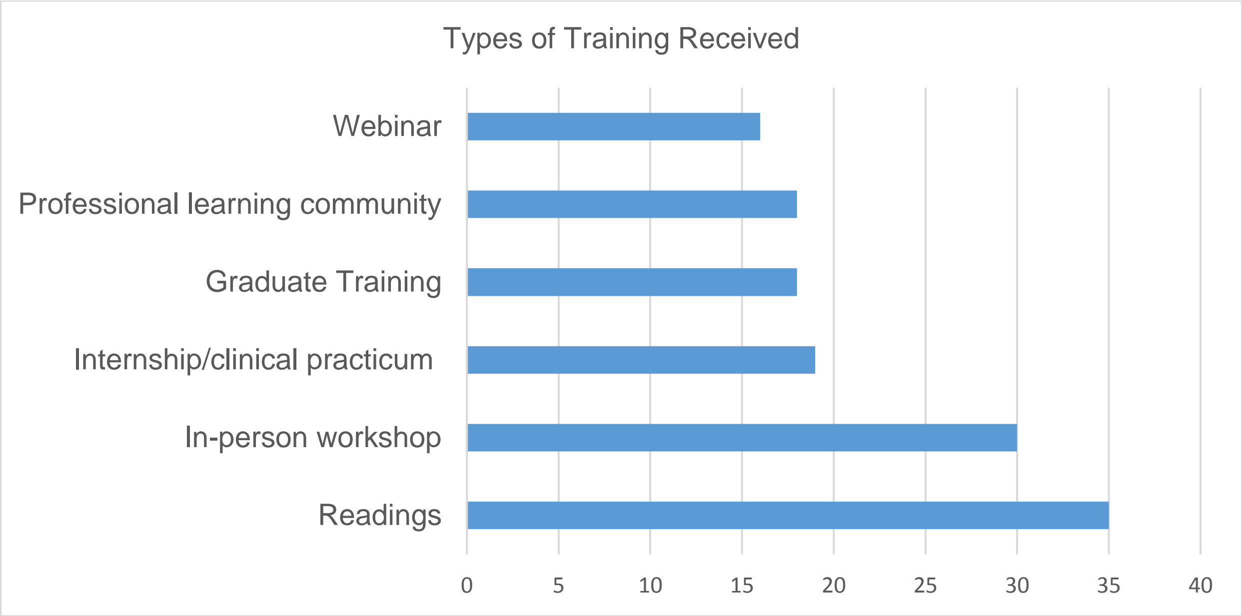


Table 2: Types of Training Received by Program Type

Program Type	Graduate Training	Internship/ Practicum	In-person workshop	Webinar	Readings	PLC
Case Management (21)	4	4	7	6	8	5
Domestic Violence (4)	0	1	1	0	1	0
Education (20)	3	2	7	3	6	5
Employment (12)	1	1	3	2	3	2
Housing (6)	0	1	1	0	1	1
Legal (12)	0	1	4	2	4	0
Medical (8)	1	1	2	1	2	1
Mental Health (15)	9	8	5	2	9	4
Spiritual Guidance (2)	0	0	0	0	1	0
Total	**18**	**19**	**30**	**16**	**35**	**18**

Notes: Total number of respondents in each category noted in parentheses; PLC= Professional Learning Community;

Trauma-Informed Practice Integration

Respondents were asked to describe level of staff training in trauma-informed practices across their agency, ranging from none of staff trained to all staff (direct service and support staff). Respondents were able to mark more than one response. Twelve respondents noted that all staff were trained in trauma informed care, and most respondents noted that some program staff were trained. However, besides mental health services, at least some respondents from other program types (total *n=28)* noted that none of their other program staff had been trained in trauma-informed practice.

Chart 4

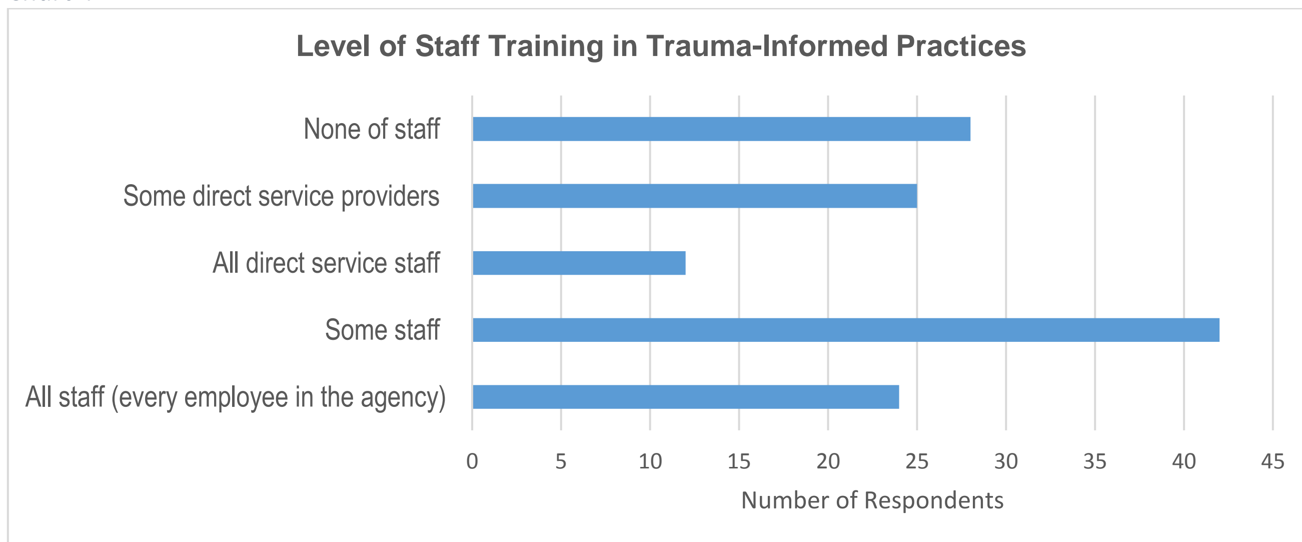


Table 3: Level of Staff Training in Trauma-Informed Practices by Program Type

Program Type	All staff Trained	Some Staff Trained	All Direct Service Staff Trained	Some Direct Service Staff Trained	None of Staff Trained
Case Management	6	9	4	6	4
Domestic Violence	2	3	1	0	4
Education	3	7	1	8	4
Employment	2	3	1	2	3
Housing	2	4	0	2	4
Legal	*0*	5	0	3	5
Medical	2	3	1	2	2
Mental Health	7	7	4	6	0
Spiritual Guidance	0	1	0	2	2
Total	24	42	12	25	28

Trauma-Informed Practice Across Programs

Trauma Screenings: Few respondents noted that trauma screens are performed as part of routine practice. Only the following providers endorsed routine trauma screening:

- 40% of mental health providers
- 14% of case managers
- 14% of housing services providers
- 13% of medical providers

Physical Environment Characteristics. Only the following providers endorsed that physical environment characteristics are aligned with trauma-informed practices. No other providers endorsed this.

- 50% of domestic violence services
- 47% of mental health services
- 18% of case management services
- 14% of housing services
- 13% of medical services

Crisis Response Protocol. Similarly, only the following providers indicated that their crisis response protocol integrates trauma-informed practice:

- 60% of mental health services
- 50% of domestic violence services
- 29% of housing services
- 18% of case management services
- 9% of educational services
- 8% of legal services

Table 4: Endorsement of Trauma-Informed Care and Practices by Program Type

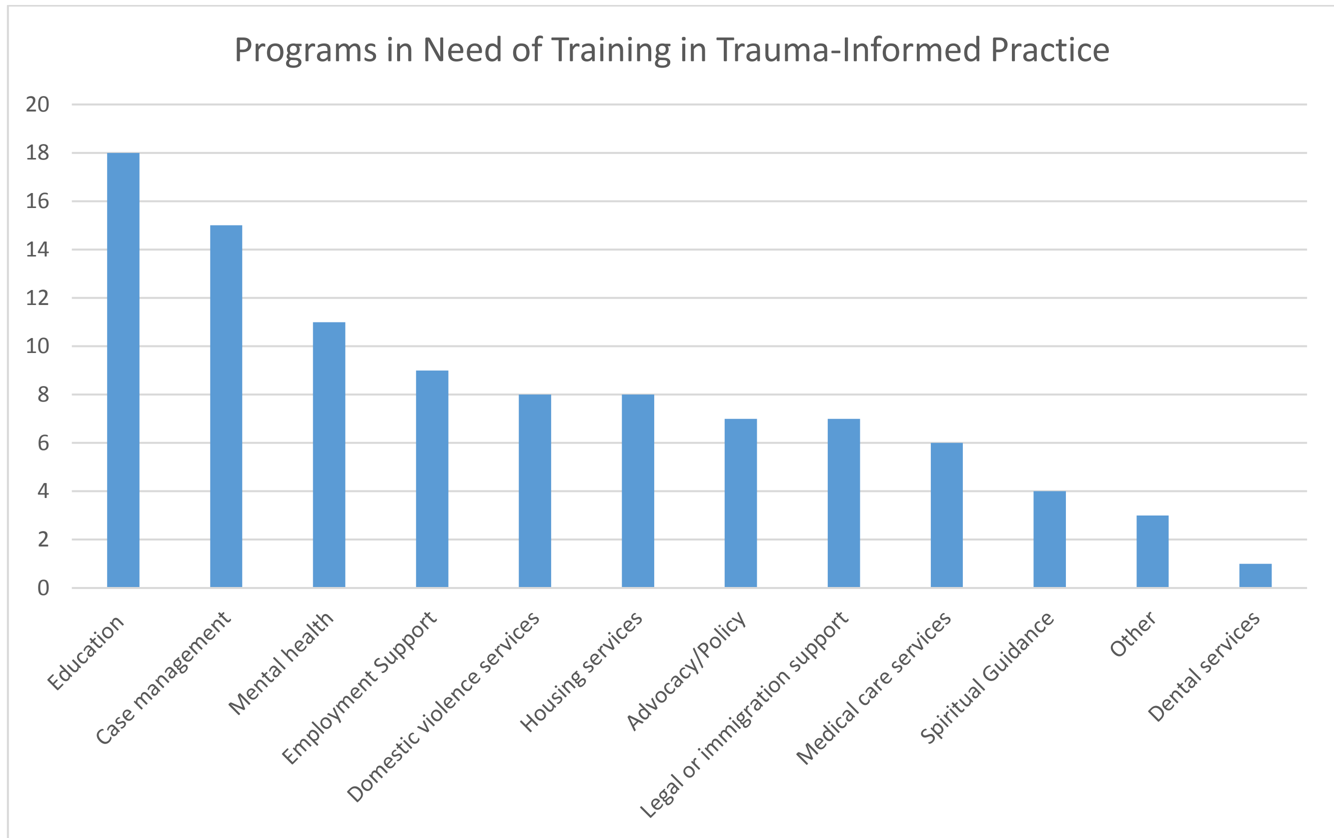
Program Type	Trauma Screening	Physical Environment	Crisis Response
Case Management (21)	3	4	4
Domestic Violence (4)	--	1	1
Education (20)	--	--	2
Employment (12)	--	--	--
Housing (6)	1	1	2
Legal (12)	--	--	1
Medical (8)	1	1	--
Mental Health (15)	6	7	9
Spiritual Guidance (2)	--	--	--
Total	**11**	**14**	**19**

Notes: total number of respondents in each category noted in parentheses

Training Needs per Program Type

Respondents noted the 3 audiences with the greatest training needs for providing trauma-informed care were educators, case managers, and mental health service providers.

Chart 5

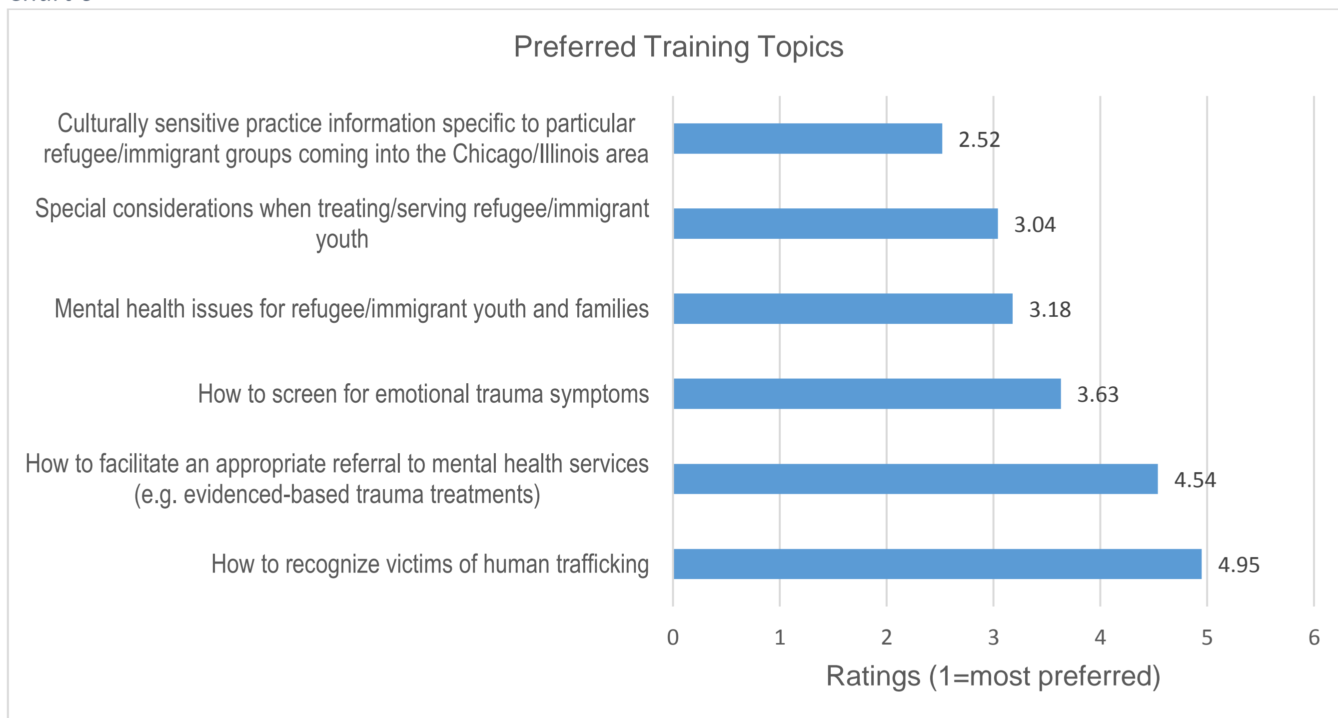


Note: "Other" training audiences suggested were staff from after school youth programs and child and family services programs.

Perceived Training Needs Across Programs

The top 3 areas of training perceived as most needed were culturally sensitive practice information specific to refugee/immigrant populations coming into Illinois, special considerations when treating/servicing refugee/immigrant youth, and mental health issues for refugee/immigrant youth and families.

Chart 6



Pilot Data Subsample of Training Interests Endorsed (unranked)

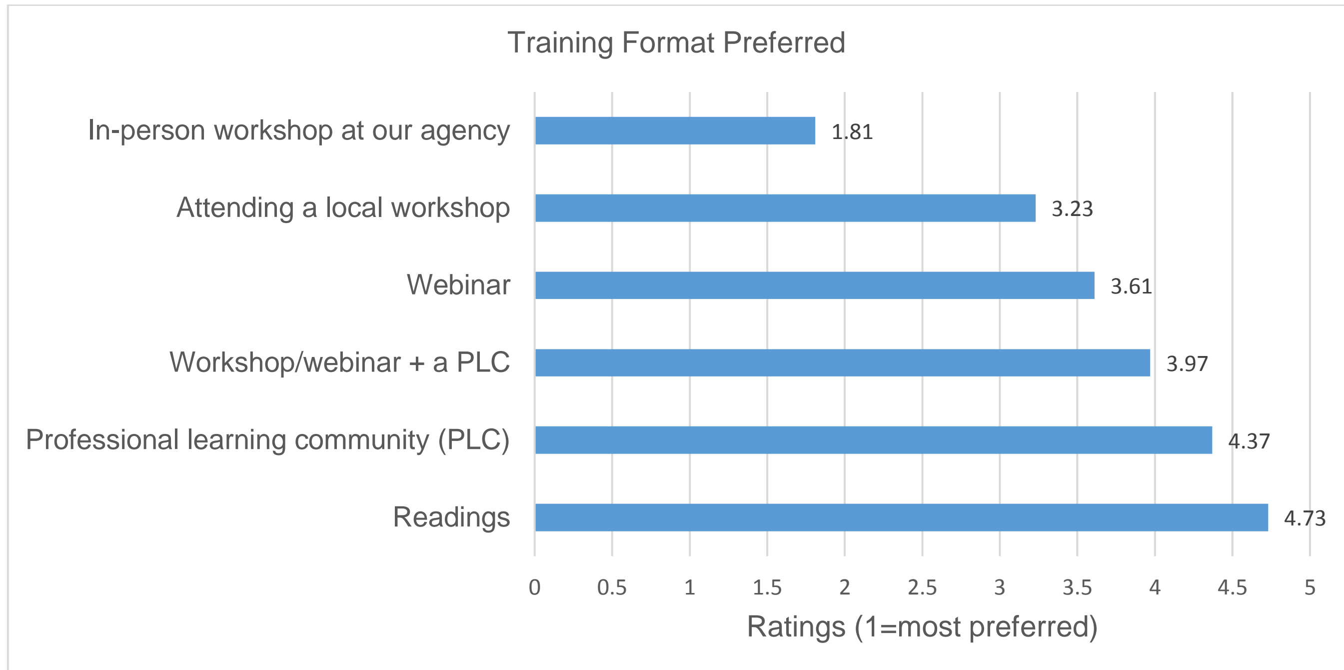
A subsample of participants (*n* = 8) did not rank order their preferences, but indicated the following training topic preferences (a slightly different list from the large sample). The top 3 most endorsed are consistent with the findings reported above.

Training Topic	*n*	%
Special considerations when treating/serving refugee/immigrant youth	7	88%
Mental health issues for refugee/immigrant youth and families	7	88%
Culturally sensitive practice information specific to particular refugee/immigrant groups coming into the Chicago/Illinois area	7	88%
How to screen for emotional trauma symptoms	5	63%
Special considerations on providing/adapting evidence-based treatment for use with this population	4	50%
How to recognize victims of human trafficking	4	50%
How to facilitate an appropriate referral to mental health services (e.g. evidenced-based trauma treatments)	4	50%
Treatment engagement with refugee families	3	38%
Providing mental health care with the assistance of interpreters	3	38%
Special considerations for child survivors of torture	3	38%

Training Modality Preference

In terms of preference for what type of training would be the most preferred, the top 3 choices were an on-site training at their agency, attending a local workshop, and doing a webinar. Readings was the least preferred method to receive training. This finding is noteworthy in the context of the above finding of readings being the most commonly received training modality.

Chart 7



Perceived Barriers

Respondents were asked to rank what they felt were the most significant barriers to their ability to improve, expand, or add services for refugee and immigrant children. Total number of responses (N=36) can be seen below in Table 6. Notably, 69% of organizations ranked funding as the top barrier. Other high ranked barriers included general office staffing (28%) and direct service staff bilingual in the primary language of clients served (28%). In terms of improving, expanding, and adding services, having resources and staff would logically precede the need for training.

Table 2: Ranked Barriers to Improve/expand/add services

	1	2	3	4	5	6	n/a
Funding	25	4	0	1	0	0	2
General Office Staffing	3	10	6	2	4	0	4
Bilingual Staff	2	6	10	4	4	2	4
Space	1	3	8	5	4	5	3
Inadequate Training	1	2	0	6	9	6	7
Fed/State/City Regs	1	4	5	4	1	7	7

Notes: Numbers indicate total number of responses; ranking 1= most important

Unmet Services and Needs

Respondents were asked to report on areas they felt were unmet gaps in services and resources currently impacting the clients they served. Respondents were asked to indicate if the gap was within their organization, within the population as a whole, or both. Table 2 illustrates the total number of responses for each service/resource (N=36). The three highest areas reported as unmet within organizations were mental health, dental and housing services. The highest areas reported for the community were mental health, dental, housing and education. Interestingly, organizations felt that there was a higher need in the broader community rather than within their individual organizations.

Table 3: Unmet Services and Needs, Total Responses

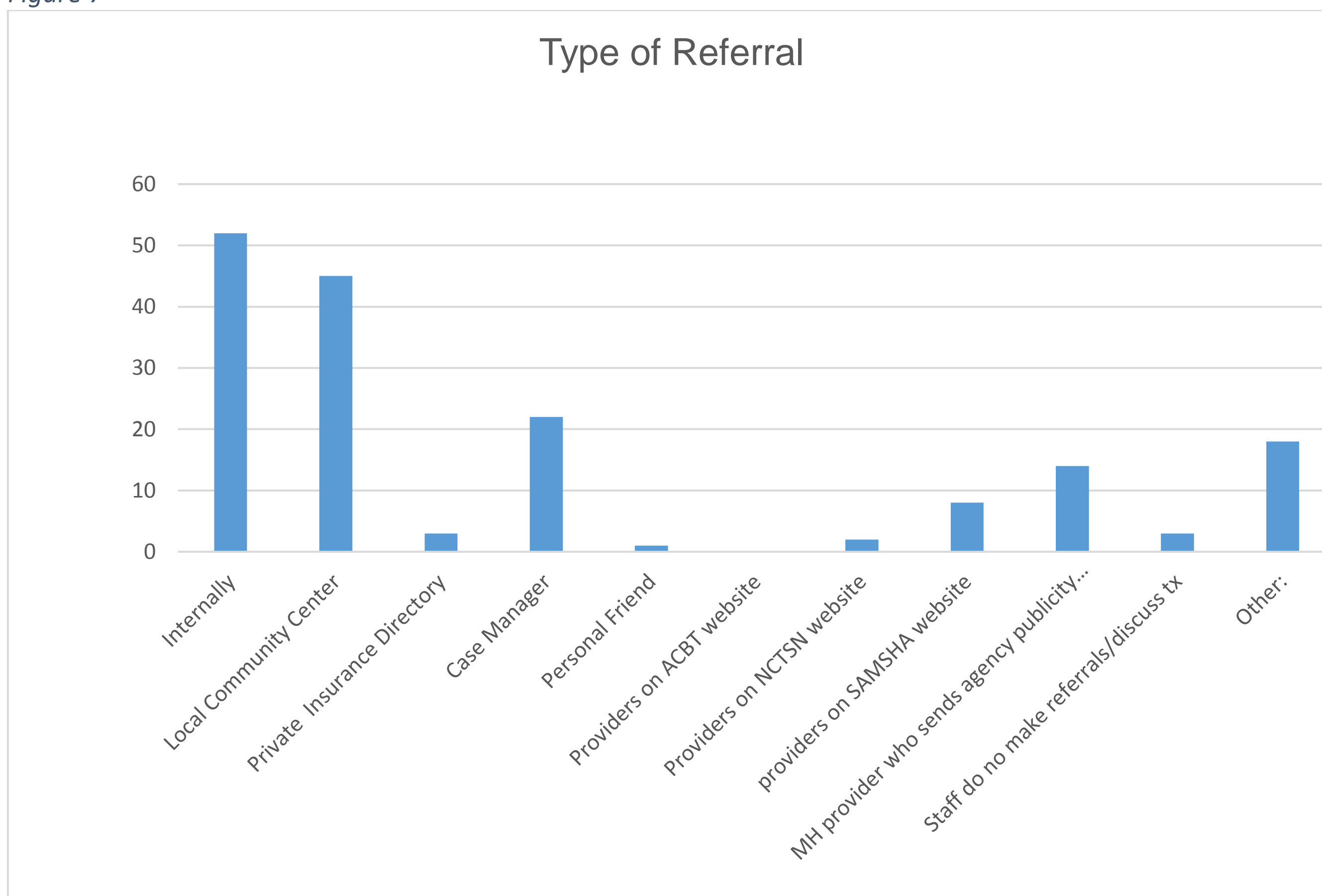
	Unmet for your Org	Unmet for Community
Mental Health	42%	67%
Housing Services	36%	58%
Education	25%	56%
Dental Services	36%	56%
Employment Support	31%	50%
Advocacy/Policy	25%	47%
Legal or Immigration Support	19%	42%
Medical Care Services	25%	42%
Domestic Violence Services	25%	39%
Spiritual Guidance	11%	36%
Case Management	28%	36%

**Percentages out of total number of respondents (N=36)*

Mental Health Referral by Type

Respondents were asked to report on the type of referral made and the process they follow when staff identify a behavioral health need in a child or youth with whom they are working. Below is a chart that illustrates the total responses for each referral type. Since respondents may have responded for more than one program, the total number of responses reflected in the chart is higher than the number of individual respondents (N=36). Table 3 illustrates the referral type, broken out by program type. The majority of respondents indicated they either refer internally, or refer to a local community mental health center. It is interesting to note that few to no organizations utilized the Substance Abuse and Mental Health Services Administration (SAMSHA), Association of Cognitive and Behavioral Therapy (ACBT) and National Child Traumatic Stress Network (NCTSN) websites for referrals. This may highlight an opportunity to educate organizations on these resources as referral options.

Figure 7



Notes: Results based on total number of responses. "Other" described as partnerships with other organizations, internally to volunteers, or unsure

Table 4: Referral Type, by Program

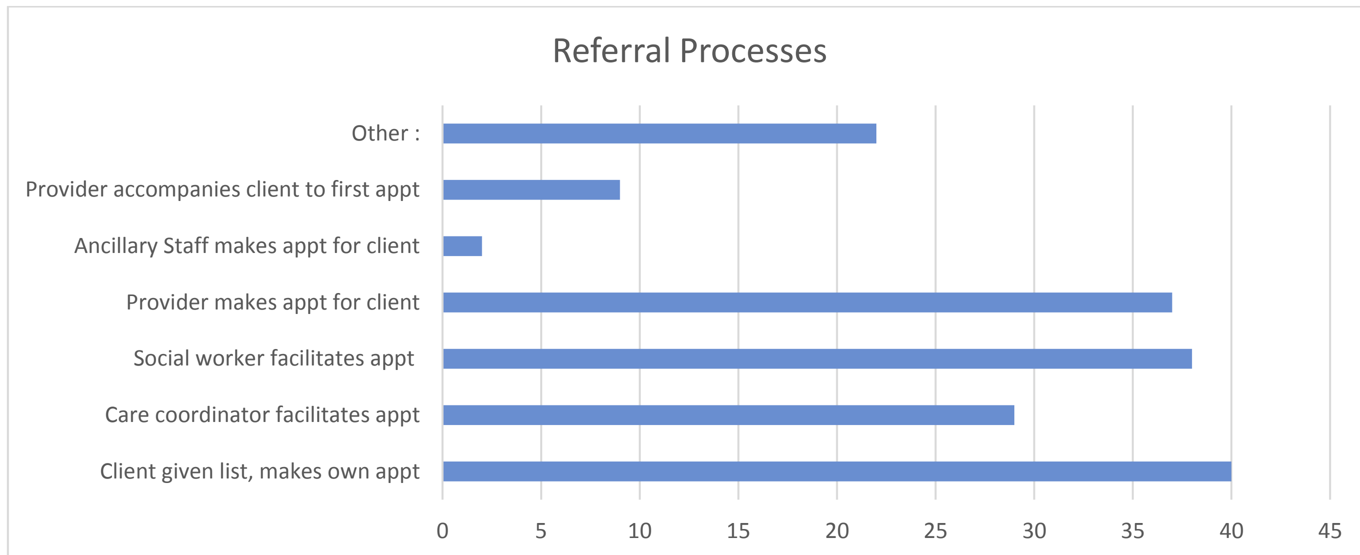
Refer to:	CM (26)	L (14)	EM (14)	MD (8)	DV (3)	H (8)	ED (23)	S (2)	O
Internally	16	6	7	6	1	4	11	1	0
Local Community Center	11	8	5	2	2	3	10	2	2
Private Insurance Directory	2	0	0	0	0	0	0	1	0
Case Manager	3	5	3	1	1	2	5	1	1
Personal Friend	0	0	0	0	0	0	0	1	0
Providers on ABCT website	0	0	0	0	0	0	0	0	0
Providers on NCTSN website	2	0	0	0	0	0	0	0	0
Providers on SAMSHA website	3	1	1	0	0	1	2	0	0
Mental health provider who sends agency publicity materials	5	3	2	0	1	1	2	0	0
Staff do not make referrals/discuss treatment	0	1	0	0	0	0	2	0	0
Other:	3	4	1	2	1	2	4	0	1

Note 1: Total number of respondents in each category noted in parentheses. "Other" in referral processes category can be described as partnerships with other organizations, internally to volunteers, or unsure. CM=Case management, L=Legal services, EM=Employment, MD=Medical, DV=Domestic Violence, H=Housing, ED=Education, S=Spiritual Guidance, O=Other (includes child advocacy, family reunification, language/interpreter services, and older adult services).

Mental Health Referral Processes

In addition to the type of resource used to refer for mental health services, respondents were asked to report the process used when referring a client. The chart below (Chart 8) illustrates the total responses provided, across programs. Since many respondents responded for more than one program, the total number of responses reflected in the chart is higher than the number of individual respondents (N=36). Table 4 illustrates the referral process, broken out by program type. The most common process when it comes to making a referral is to provide the client with a list of resources to make their own appointment, with the two next highest involving the provider/social worker assisting with the facilitation of the appointment.

Chart 8



Note: "Other" in referral processes category can be described as partnerships with other organizations, internally to volunteers, or unsure.

Table 5: Referral Process, by Program Type

	CM (26)	L (14)	EM (14)	MD (8)	DV (3)	H (8)	ED (23)	S (2)	O
Client given list, makes own apt	10	6	5	3	1	3	9	1	2
Care coordinator facilitates apt	8	5	5	2	1	2	5	0	1
Social worker facilitates appt	11	4	5	1	2	5	9	1	0
Provider makes appt for client	10	6	6	0	1	6	6	1	1
Ancillary staff makes appt for client	0	0	0	0	0	0	1	1	0
Provider accompanies client to first apt	3	1	1	0	1	2	1	0	0
Other :	5	1	2	3	1	1	7	1	1

Note: Total number of respondents in each category noted in parentheses. "Other" in program category includes child advocacy, family reunification, language/interpreter services, and older adult services. "Other" in referral processes category can be described as partnerships with other organizations, internally to volunteers, or unsure.

Limitations
There are several limitations of this survey that are worth mentioning. Due to the fact that respondents were able to report on multiple programs at once, we were not able to calculate the percentage of respondents per program type. Additionally, because we had different response rates for the different program types, we cannot compare means across programs. Although some definitions were provided in the survey, questions on trauma screening, trauma-informed physical environmental characteristics and crisis response protocols were not defined; therefore, responses to these questions relied on the respondents' own understanding of these terms. Regardless of these limitations, the information garnered from this survey suggests that programs need additional support around increasing their capacity to respond to the trauma-related needs of refugee and immigrant children and youth.

Conclusions

Mental health services was the most frequently identified unmet need impacting the clients served by respondents (both in their agency and in the community).

Training Specific to Work with Refugee/Immigrant Youth and Families
Notably, only slightly more than 50% of respondents from agencies whose mission it is to serve refugee/immigrant youth reported having received training specific to working with refugee/immigrant children.

Trauma-Informed Training Experiences

When considering all respondents, the majority reported having some level of trauma-informed training for some staff, however a smaller group endorsed received training for every staff member. Additionally, consistent implementation of trauma-informed practices varied across program types (with mental health and domestic violence programs showing the greatest compliance, but not universally), indicative of the need for more universal trauma-informed practice training for all staff.

FUTURE DIRECTIONS
Given the findings of this survey, the following points are recommended next steps:

1. **Increasing access to mental health services for refugee youth and families has been indicated as a priority need.**
   Action Item 1: Develop a comprehensive resource guide that is made publicly available to increase awareness of existing resources.
   Action Item 2: Train providers to make informed and effective referrals to increase the likelihood of refugee/immigrant families' receipt of needed mental health services.

2. **Workforce development opportunities are needed to help increase provider capacity to serve refugee/immigrant youth and families in a trauma-informed manner.** Notably, only slightly more than 50% of respondents from agencies whose mission it is to serve refugee/immigrant youth reported having received such training.
   Action Item 3: Develop and deliver in-person and webinar trainings to increase provider capacity.
   Action Item 4: Prioritize training areas of workforce development to target:
      i. Providers with expertise in culturally responsive service provision to refugee/immigrant populations (educators, case managers)

    ii. Providers with expertise in trauma-informed, evidence-based care (mental health service providers)

3. **Increased investment in promoting workforce development in trauma-informed care for refugee/immigrant children and families is needed.** Funding was identified as the biggest barrier to expanding/improving their programming for these families.
   Action Item 5: Identify and pursue funding streams for improvements in trauma-informed services for refugee/immigrant children and families.

Report2:

Needs Assessment of Trauma-Informed Services for Refugee & Immigrant Youth and Families November 2016

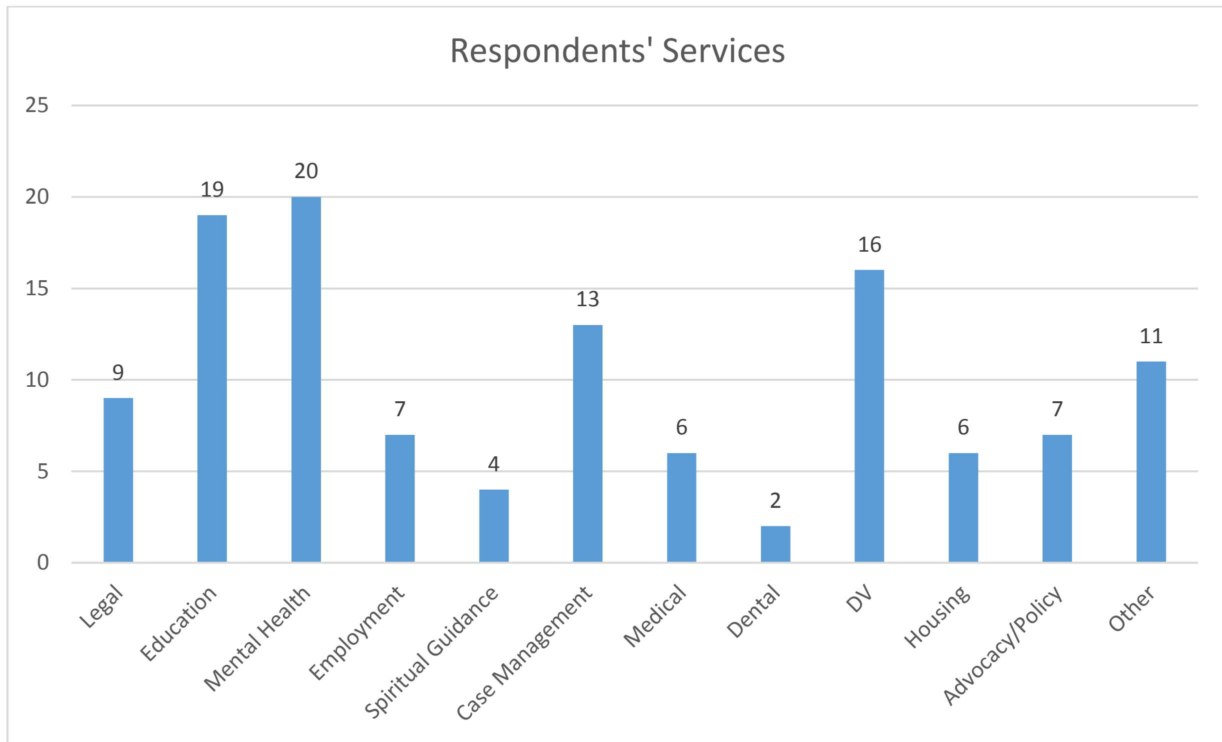
From July through October 2016, the Illinois Childhood Trauma Coalition's Ad-Hoc Committee on Refugee and Immigrant Children and Trauma sent out an electronic survey to personnel at a variety of coalitions whose member organizations were expected to have some contact with refugee/immigrant youth and families. **These organizations serve the general population** and do not have a specific mission to serve refugees and immigrants. The goals were to (1) learn more about existing refugee/immigrant children's services and needs, (2) facilitate connections among service providers, and (3) inform workforce development and system-wide capacity building activities that would enhance trauma-informed care for all those who come in contact with refugee/immigrant children.

Respondents

The 37 respondents reported on a variety of programs. Some reported on more than one program at their agency and sometimes multiple people from the same agency responded. For this reason, most data will be reported in terms of total respondents instead of percentages. The largest number of respondents reported on mental health (20), education, (19), and domestic violence (16) services.

Definitions
TRAUMA: When the term TRAUMA is used in this survey, we are referring to the experience of an event by a child that is emotionally painful or distressful which often results in lasting mental and physical effects. The *National Institute of Mental Health* notes that trauma includes an*:* • Event – One time or chronic • Experience – whether the event is experienced as scary or threatening • Effect - long-lasting and life altering TRAUMA-INFORMED: A trauma informed organization is defined by the 4 Rs: 1. REALIZE the widespread impact of trauma & understand potential paths for healing; 2. RECOGNIZE the signs & symptoms of trauma in people; and 3. RESPOND by fully integrating knowledge about trauma into practice, settings, procedures, policies & laws; and 4. Try not to RE-TRAUMATIZE children and families seeking services.

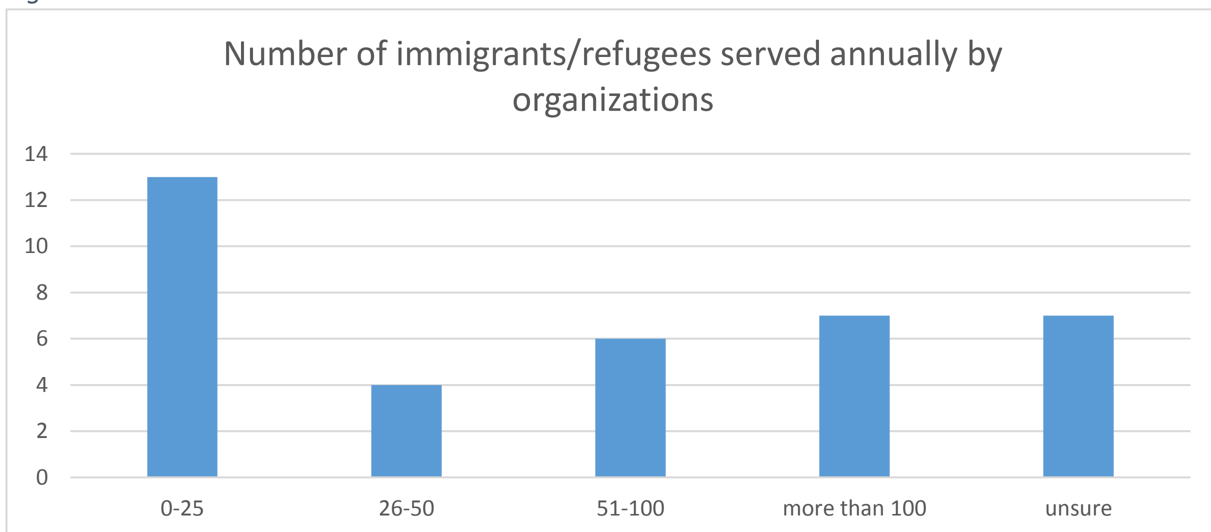
Figure 9



Number of Immigrants/Refugees Served by Respondent Organizations

A total of 30 out of 37 agencies reported that they provide child and/or family-based services. Respondents were asked about the number of immigrants/refugees they serve, which yielded variable responses. That is, some organizations served as few as 0-25 per year (n=13), while several reported serving more than 100 per year (n=7). There was also uncertainty about if and how many immigrants/refugees are served per year (n=7) (Figure 2).

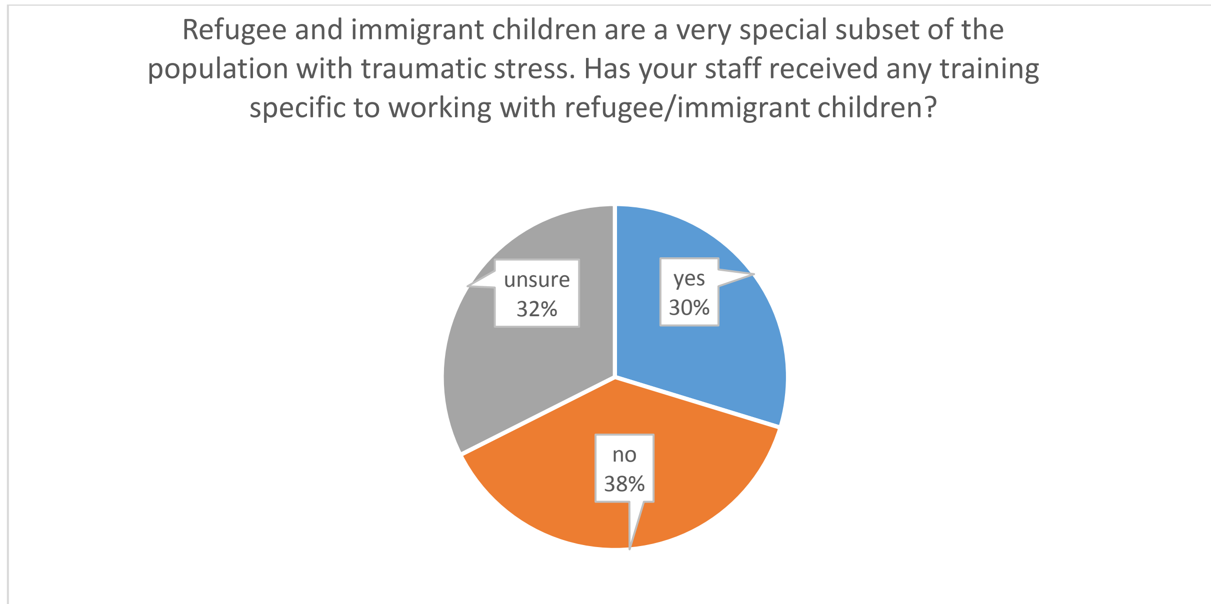
Figure 2



Training Specific to Work with Refugee/Immigrant Youth and Families

Respondents were asked whether their staff received training specific to working with refugee/immigrant children. Notably, only 11 respondents (about 30%) reported having received such training. This does not necessarily mean that they are not providing high quality services, but it does point to the need for professional development opportunities in this area.

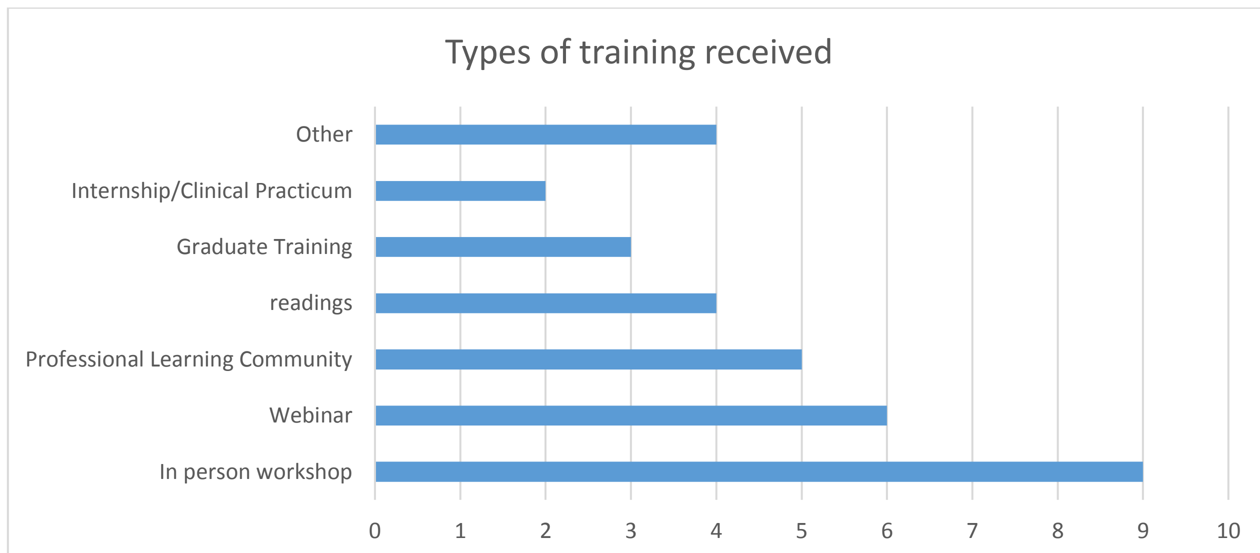
Figure 3



Type of Training Received

Of those who responded that their staff was trained, in-person workshops appeared to be the most common form of training received across different types of programming (see Figure 4).

Figure 4



Trauma-Informed Practice Integration

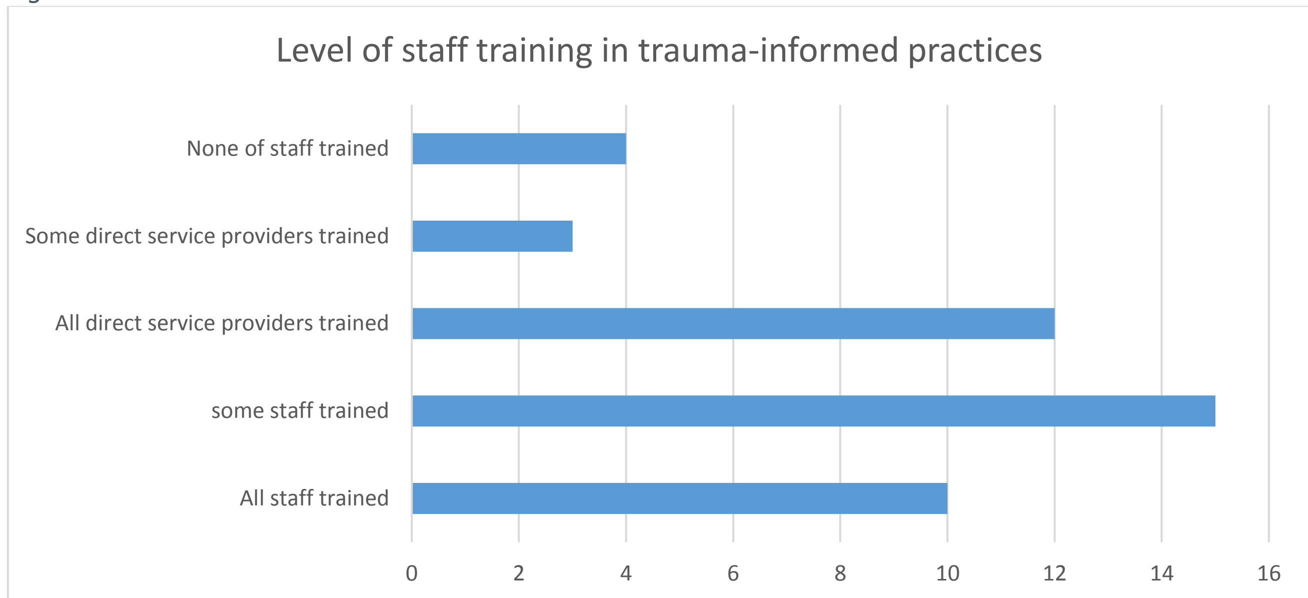
Respondents were asked to describe level of staff training in trauma-informed practices across their agency, ranging from none of staff trained to all staff (direct service and support staff). Respondents were able to mark more than one response. Ten respondents reported that *all* staff were trained in trauma informed care, but the majority reported that *some* program staff were trained. Of note, some reported (n=4) that none of their program staff had been trained in trauma-informed practice. See Figure 5 for more details.

Trauma Screenings: Few respondents (only 30%) noted that trauma screens are performed as part of routine practice.

Physical Environment Characteristics. Only 19% of respondents endorsed that physical environment characteristics are aligned with trauma-informed practices.

Crisis Response Protocol. Similarly, only approximately 30% of respondents indicated that their crisis response protocol integrates trauma-informed practice:

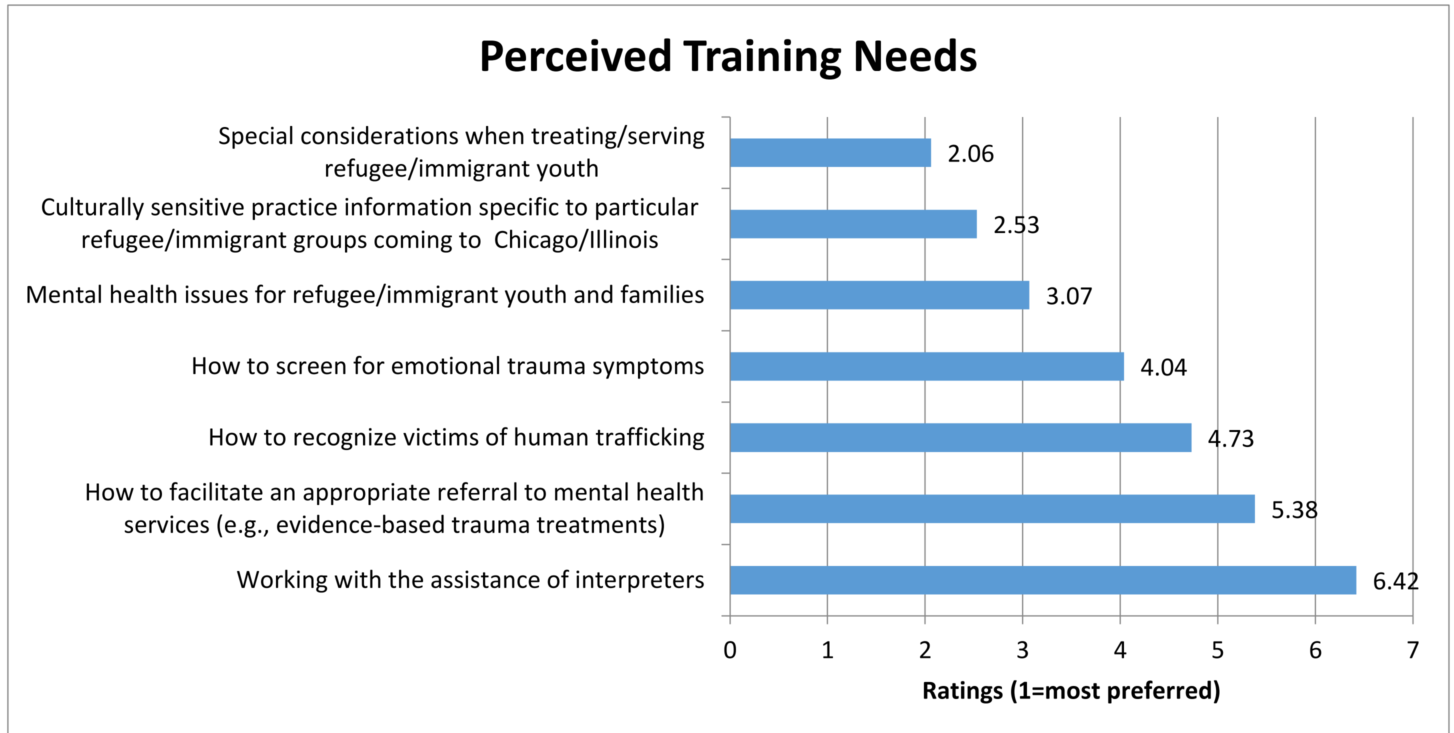
Figure 5



Perceived Training Needs

Respondents were asked to identify their needs for training related to various topics relevant to working with immigrant/refugee groups. The top 3 areas of training needs were 1) special considerations when treating/serving immigrant/refugee youth, 2) culturally sensitive practice information specific to immigrant/refugee groups coming to Chicago/Illinois, and 3) mental health issues for immigrant/refugee youth and families.

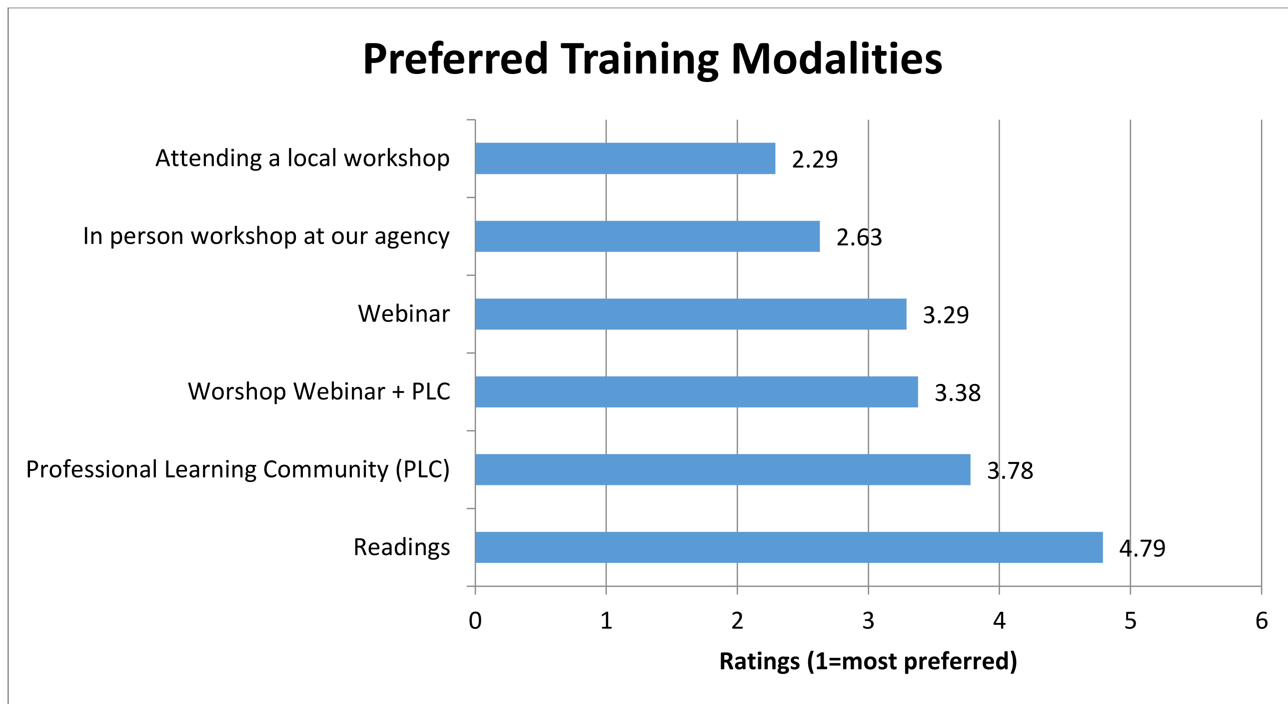
Figure 6



Training Modality Preference

In terms of preference for what type of training would be the most preferred, the top 2 choices were attending a local workshop and having an on-site training at their agency, respectively. Readings were the least preferred training modality.

Figure 7



Limitations

There are some limitations of this survey that are worth mentioning. Due to the fact that respondents were able to report on multiple programs at once, we were not able to calculate the percentage of respondents per program type. Additionally, respondents answered collectively about their agency's staff training experience and preference for future trainings. Although some definitions were provided in the survey, questions on trauma screening, trauma-informed physical environmental characteristics and crisis response protocols were not defined; therefore, responses to these questions relied on the respondents' own understanding of these terms. Regardless of these limitations, the information garnered from this survey suggests that programs need additional support around increasing their capacity to respond to the trauma-related needs of refugee and immigrant children and youth.

Conclusions

Social service agencies serving the general population would benefit from additional supports to prepare staff to improve access and quality of services to refugee/immigrant children and families.

Training Specific to Work with Refugee/Immigrant Youth and Families

Notably, more than 80% of respondents from organizations serving the general population reported serving refugee and immigrant youth or their caregivers, yet these organizations vary widely in the numbers of immigrants and refugees served per year and their general awareness of those served. However, only 30% of respondents reported having received training specific to working with refugee/immigrant children. Given the large proportion of immigrant and refugee youth and families being served by organizations that serve the general population, it is important to provide training and support for these organizations to better serve refugee and immigrant youth and families.

Trauma-Informed Training experiences

When considering all respondents, the majority reported having some level of trauma-informed training for some of their direct service staff, and less than 30% claimed to have received training for every staff member. Additionally, less than a third of respondents were consistently implementing trauma-informed practices, indicative of the need for more universal trauma-informed practice training for all staff.

FUTURE DIRECTIONS

Given the findings of this survey, the following points are recommended next steps:

1. **Education and consultation should be provided to community organizations in order to raise awareness about the immigrant and refugee youth and families they serve, and how they can begin to better track which programs/services are accessible to these families.**

   Action Item1. Prioritize organization leadership trainings to raise awareness about the needs of refugee and immigrant families and the ways in which community organizations can minimize barriers to services and provide welcoming environments.

   Action Item 2. Foster networking and coalition-building activities to facilitate resource-sharing and collaboration between organizations serving the general public and local partners serving the immigrant and refugee communities.

2. **Workforce development opportunities are needed to help increase provider capacity to serve refugee/immigrant youth and families in a trauma-informed manner.**

   Action Item 3: Develop and deliver trainings using various modalities to increase provider knowledge and awareness of the mental health context of immigrants and refugees.

   Action Item 4: Develop and deliver trainings using various modalities to increase knowledge of trauma-informed care and its relevance to working with vulnerable populations.

Appendix 1: Services Provided By Respondent Agencies - Report 1

	Case management	Legal Immigration Support	Mental Health	Employment	Med Care	DV	Housing	Education	Spiritual Guidance	Other
American Red Cross of Greater Chicago								✓		
Ann & Robert H. Lurie Children's Hospital of Chicago			✓		✓					
Arab American Family Services	✓		✓	✓	✓	✓				✓
Asian Human Services	✓	✓	✓	✓	✓			✓		✓
Barr-Harris Children's Grief Center Chicago Institute for Psychoanalysis			✓							
Casa Central	✓		✓			✓	✓	✓		✓
Centro Romero	✓	✓				✓		✓		
Chicago Commons	✓		✓	✓				✓		
Chicago Counseling and Training	✓		✓					✓		
Chicago Public Schools	✓							✓		✓
DePaul College of Law Asylum and Immigration Law Clinic		✓								
Ethiopian Community Association of Chicago	✓	✓		✓			✓	✓		
GirlForward								✓		
Global Garden Refugee Training Farm								✓		
Heartland Alliance	✓		✓				✓			
Heartland Health Outreach	✓		✓		✓		✓	✓		✓
Iraqi Mutual Aid Society	✓			✓				✓		
Kilmer-Sullivan School Health Center			✓		✓					
Living Water Community Church									✓	
Mano a Mano Family Resource Center	✓	✓		✓		✓		✓		
Marjorie Kovler Center	✓		✓	✓	✓					
National Immigrant Justice Center		✓								

	Case Management	Legal Immigration Support	Mental Health	Employment	Med Care	DV	Housing	Education	Spiritual Guidance	Other
Ounce of Prevention	✓		✓					✓		
RefugeeOne	✓	✓	✓	✓	✓		✓	✓		
SPARK Aurora Early Childhood Collaboration	✓							✓		✓
Syrian Community Network	✓	✓	✓	✓				✓	✓	
The Young Center for Immigrant Children's Rights	✓									✓
Vietnamese Association of Illinois		✓		✓			✓	✓		✓
World Relief DuPage	✓	✓	✓	✓	✓			✓		✓
World Relief/Aurora	✓	✓	✓	✓	✓			✓		

Notes: Other services include dental, advocacy/policy, child advocate services, home-based services and programming for older adults, language/interpreter services, and family reunification

Appendix 2: Services Provided By Respondent Agencies - Report 2

	Advocacy Policy	Case management	Dental Services	Domestic Violence	Employment	Education	Housing	Legal	Medical	Mental Health	Spiritual	Other
Barrington Youth & Family Services				✓	✓	✓		✓		✓	✓	✓
Casa Central-La Posada						✓						✓
Casa Central – Violence Prevention	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Catholic Charities of Chicago	✓	✓		✓		✓	✓	✓		✓		✓
Chicago Children's Advocacy Center	✓	✓		✓						✓		✓
Child & Family Connections #22						✓						✓
Children's Home Association		✓		✓	✓					✓		
Chicago Park District												✓
Civitas Child Law Clinic								✓				
Cook County Juvenile Probation		✓								✓		
DePaul Family and Community Services										✓		
Egyptian Public and Mental Health Department	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Evanston Township H.S.						✓						
Freedom House	✓	✓		✓	✓		✓					✓
HOPE of Ogle County		✓		✓	✓	✓	✓					
Ideas Magicas, LLC										✓		
Illinois Department of Public Health									✓			
Mid Central Community Action-Neville House				✓								
McLean County Unit District #5						✓						
Moline-Coal Valley CUSD 40					✓							
Mujeres Latinas en Accion				✓	✓							

Naperville CUSD #203/ Ann Reid EC Center						✓					✓	✓
North Palos School District #117						✓				✓		
Northwestern Bluhm Legal Clinic								✓				
Paletine CCSD 15					✓				✓	✓		
Safe Passage				✓	✓	✓				✓		
South Suburban Family Shelter	✓	✓		✓	✓	✓				✓		
Tinley Park CCSD 146					✓							
Turning Point, Inc.				✓						✓		
Violence Prevention Center of Southwestern IL	✓	✓		✓			✓	✓		✓		
West Chicago District 33		✓				✓						

Notes: Other services include dental, advocacy/policy, child advocate services, home-based services and programming for older adults, language/interpreter services, and family reunification