The Organizational Journey toward Cultural and Linguistic Competence: Part Four

The NCCTS extends a special thank you to Vivian H. Jackson, PhD, for her conceptualization of and major contributions to this series.

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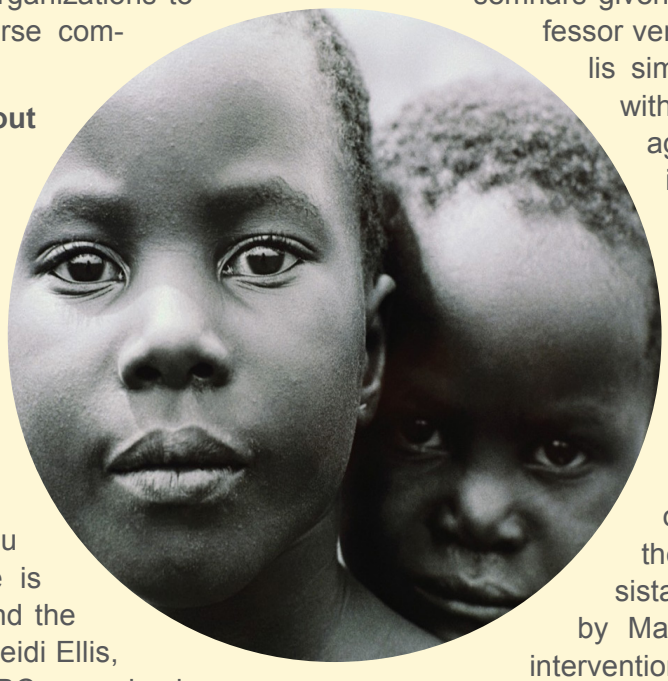
- B. Heidi Ellis, PhD, Director, Refugee Trauma and Resilience Center, Children's Hospital Boston

This is the last of a four-part series on culturally and linguistically competent organizational services. Network members from the Refugee Trauma and Resilience Center (RTRC) at Children's Hospital Boston, and the Center for Trauma Recovery and Juvenile Justice at the University of Connecticut School of Medicine in Farmington, offer examples of the ongoing and reciprocal dialogue required for organizations to engage effectively with diverse communities and collaborators.



A Shared Language about Trauma

"One of the great difficulties when we work cross-culturally is the expectation that everything will fall into place once we perceive the need of a community," said Saida Abdi, MSW, LICSW, Director of Community Relations at the RTRC. "You see there is a need, and you have the answer. But there is a lot in between the need and the answer." Ten years ago, B. Heidi Ellis, PhD, now Director at the RTRC, perceived that refugee children and their families from war-torn Somalia could benefit from trauma-informed mental health services. Some Somali children were being referred to the clinic because of their disruptive behavior, and were mandated to receive mental health evaluation and treatment before they could return to school. With funds from the National Institute of Mental Health, Ellis and colleagues conducted research that showed trauma and PTSD to be significant problems among these children. "Typically, mental health services were grossly under-accessed," Ellis said. "Based on this information and qualitative information that suggested schools were trusted institutions, we decided to develop and implement a schoolbased program."Before offering their school-based intervention program to the community, the developers attended a series of semnars given by a Wellesley College professor versed in the Somali culture. Ellis simultaneously began outreach with community members and agencies already working within the Somali community. The aim was to identify community leaders and to understand how the community saw its own concerns. "The appropriate way to begin trauma work with any community is to start by listening," Ellis emphasized. Early on, the RTRC partnered with the Refugee and Immigrant Assistance Center (RIAC), directed by Mariam Gas.The school-based intervention program, Trauma Systems Therapy for Refugees, begins with a community education process built upon an evolving relationship with families and community. In initial phases of offering services to parents, Ellis and her colleagues discovered an important obstacle: "In our culture," explained Abdi, who is Somali, "we do not have language for mental health. A person is either mad or sane. So we needed to do community groundwork to sensitize people to understand the complexity of what can happen in the mind." At RIAC, staff member Naima

Agalab helped with some of that groundwork. She invited community members to tea gatherings and began a dialogue with parents, soliciting their thoughts about the possibility that their children might need help with mental health issues.“ She kept raising this point,”said Ellis, “that in her services as an interpreter she was asked to tell mothers that their children needed a mental health evaluation. And even though the concept of mental health was unfamiliar to Somali parents, she suggested that parents should be involved in the discussions, since their children were getting involved in the system anyway.” That was five years ago. By partnering effectively with the cultural brokers of the community, such as RIAC, the RTRC clinicians began to develop a common language about trauma and its effects. “It’s been exciting to see how the community leaders have developed a deeper understanding of trauma and mental health,” Ellis observed. “We can now have a different conversation because we have a shared understanding of these terms.” Today, the RIAC has its own freestanding mental health clinic offering services to the community. The RTRC, a Category II site, is training Maine schools and mental health providers in their treatment model. RTRC staff are also working with the National Child Traumatic Stress Initiative, a Category III site at the University of Louisville, KY; and will begin working with Bhutanese and Iraqi refugee children through a partnership with agencies in West Springfield, MA.

Focus on Collaborators

Last March, as part of the NCTSN Category II Complex Trauma Treatment Network grant, Julian Ford, PhD, and Rocío Chang-Angulo, PsyD, from the University of Connecticut Health Center, arrived in Bayamón, Puerto Rico, to conduct an initial training for the Caribbean Basin & Hispanic ATTC (Addiction Technology Transfer Centers) Network. The topic was how to develop trauma-informed services in marginalized communities, and the host was the Universidad Central del Caribe.Chang-Angulo and Ford expected to train only the members of the ATTC department. In the training room, however, they encountered more than 50 participants. Traineescame from seven agencies, including a feminist grassroots agency Taller Salud (“Health Workshop”), located in a highrisk, violence-prone community; El Buen Pastor (“the Good Shepherd”), a Catholic-run rural agency; and the Juvenile Institutions, which oversees all juvenile justice facilities on the island. That’s when Chang-Angulo and Ford realized that organizer María del Mar García,MSW, MHS, Education Coordinator at the ATTC, “had a larger vision in mind,” Chang-Angulo said. García explained that she had firsthand knowledge of the need for addressing trauma in Puerto Rico. Many of the students trained in her department work in thecommunity organizations she had invited; none had received training in delivering trauma-informed services. The needs of each organization were diverse, but theirresponses to Ford and Chang-Angulo’s trauma training sessions were uniformly positive. Attendees were especially enthusiastic about the Spanish language traumatools available, some from the NCTSN and some from Carlos Albizu University in San Juan. They quickly organized into a learning community: Comunidad de Aprendizaje Sobre Trauma de Puerto Rico. The first sessions were so successful that the agencies asked for the trainers to return.

Chang-Angulo said that she and Ford were surprised by the variety of training needs. Eager to continue the momentum, they secured funding, again through the Justice Resource Institute in Needham, MA, to conduct a second session last September. This time, though, they needed to adapt their approach to deliver training that was culturally specific to each organization. For example, staff from Taller Salud had not spoken about vicarious trauma before the initial training and now wanted tools to incorporate that element into staff work in the future.

The trainers proposed a unique format for their sessions, dictated by the agencies’ requests. Instead of didactic presentations, they offered to work one-on-one in three-hour sessions with each of the agencies. It was an intense two days, Chang-Angulo recalled. “The second time, we were very aware, as clinicians, of creating a safe network and really listening to their concerns. It was a growth experience on both ends.”

These scenarios demonstrate that partnering with existing organizations is always a good first step when reaching out to culturally diverse communities in need. No matter how effective the established interventions might be, careful listening to community members enables agencies to assess and retool their approaches to make them culturally specific. Whether at the community or service systems level, said Abdi, “If you go into communities with the same level of commitment to learn as to teach, you will be so much more successful.”