J T S E | Journal of Trauma Studies in Education

"Working at the Speed of Trust": The Roles of Trust and Power in Effective Implementation

Laura Soltani
University of Minnesota School of Social Work

Johara Suleiman
University of Minnesota School of Social Work

Jasmine Banegas
University of Minnesota Institute of Child Development

Hopewell R. Hodges
University of Minnesota Institute of Child Development

Saida Abdi
University of Minnesota School of Social Work

Mimi Choy-Brown
University of Minnesota School of Social Work

ABSTRACT

Availability of effective, culturally responsive interventions is urgently needed to support immigrant and refugee youth resilience and mental health. Critical to successful scale-up efforts is evidence of barriers and facilitators to the implementation of multi-tier interventions that integrate cultural brokers into existing infrastructure. Data sources for this process evaluation included 10 interviews, two focus groups, and team meeting notes from 2021-2024. Modified grounded theory methods, reflective memos, and data triangulation generated a conceptual model that highlights the central role of cultivating trust and attending to power within and across partnering agencies during implementation of a manualized, evidence-informed, and community-engaged mental health intervention. This was especially important for cultural brokers, who are critical to the delivery of culturally responsive services yet vulnerable to marginalization and burnout. This novel conceptual model can inform future efforts to implement and scale culturally responsive interventions, sustain cultural brokers, and avoid replicating marginalizing power structures.

Keywords: Trauma Systems Therapy for Refugees (TST-R), implementation, ethnographic process evaluation, grounded theory, cultural brokering, culturally responsive intervention

In a time of unprecedented levels of forced migration, there is an urgent need to support internationally displaced children's wellbeing and healing with culturally responsive and accessible care. Globally, 47 million children have been forced to flee their home countries due to conflict, violence, persecution, human right violations, and natural disasters, with children accounting for 40% of forcibly displaced people worldwide (UNICEF, 2024). Displaced children are at increased risk of exposure to traumatic experiences before, during, and after migration, as well as related adverse mental health outcomes, including higher rates of posttraumatic stress disorder (PTSD), depression, and externalizing behaviors compared to non-migrant youth (Betancourt et al., 2012; Pumariega et al., 2022; Rosenberg et al., 2020). Despite their histories with traumatic experiences and risk for poor mental health outcomes, immigrant and refugee children and youth can thrive when adequately supported (Abdi et al., 2023).

Effective, culturally responsive mental health interventions are not widely accessible to immigrant and refugee youth in the United States (Cheng & Lo, 2022). Schools are well-positioned to make significant strides to meet these needs given that they are highly accessible sites of mental health supports with the opportunity to promote linguistic support, peer relations, and belongingness (Abdi et al., 2023; Fazel & Betancourt, 2018). However, due to inadequate support for long-term implementation within complex cross-system settings such as school-linked mental health care, schools are failing to meet the rising demand, with difficulties especially marked in lower-resourced school districts, smaller schools, and private schools (Demissie & Brener, 2017; Martinez et al., 2024). A lack of accessible mental health care results in reduced attendance, achievement, and unresolved mental health issues (Ijadi-Maghsoodi et al., 2024). Yet, there is little understanding regarding which factors thwart and facilitate implementation efforts across systems (Potocky, 2024). Thus, the primary purpose of this qualitative paper is to evaluate the implementation of a multi-tier preventive intervention model for immigrant and refugee youth in a United States metropolitan city from the implementers' perspectives.

LITERATURE REVIEW

Increasingly, researchers and mental health professionals are calling for culturally responsive interventions that help reduce psychological distress and promote well-being during resettlement (Peltonen & Punamäki, 2010). Interventions used to promote immigrant and refugee youth mental wellbeing include psychological first aid, manualized cognitive and behavioral therapies, and art therapy. Multi-tier models, which intervene across community, group, and individual systems to promote wellbeing and supportive environments, have been identified as particularly suited for immigrant and refugee youth in schools (Martinez et al., 2024; Schimke et al., 2022). The vast majority of research on culturally responsive, school-based mental health services has been conducted in urban settings, with limited research completed in rural and suburban contexts (Martinez et al., 2024). While still an emergent area, culturally responsive approaches to supporting and promoting immigrant and refugee youth mental wellbeing have demonstrated early effectiveness (Herati & Meyer, 2023).

A Multi-tier, Culturally Responsive Intervention: TST-R

Trauma Systems Therapy for Refugees (TST-R) is a multi-tier, school-based intervention that addresses the impacts of trauma and ongoing stressors associated with forced displacement for immigrant and refugee youth (Ellis et al., 2013). To do this, TST-R utilizes culturally adapted skills groups, individual therapy, assistance with accessing basic needs resources, and community outreach, as illustrated in Figure 1. These supports are co-delivered by clinicians and cultural brokers who are "trusted and respected member[s] of the refugee/immigrant community who speak the language and [are] of the same cultural background as the community being served, providing both interpretation and cultural perspectives" (Miller et al., 2024, p. 4).
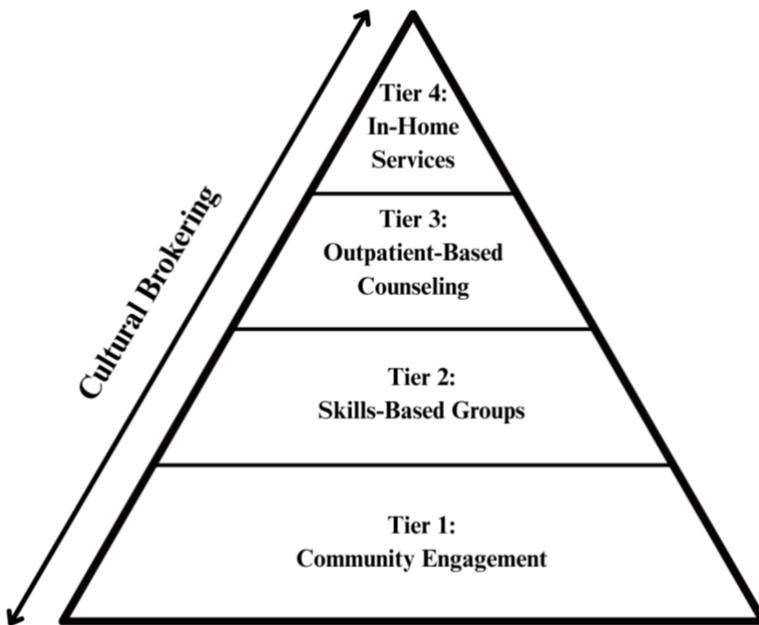
Figure 1. Trauma Systems Therapy for Refugees (TST-R) Multi-Tier Model

Note. Adapted from "Multi-tier mental health program for refugee youth," by Ellis et al., 2013, *Journal of Consulting and Clinical Psychology.* Adapted with permission.

Integration of cultural brokers across tiers is the primary strategy to ensure that TST-R is culturally responsive. The model positions cultural brokers and clinicians as collaborative partners; each bringing equally important expertise and both participating in the same training and consultation groups. They jointly provide 1) holistic services to youth and families and 2) outreach and training to schools and the

community. Cultural brokers and clinicians participate in professional development trainings and group supervision from clinical and research staff, as well as group consultation focused on implementation and peer-support. Ideally, the TST-R training and services scaffold the development of effective cultural broker-clinician collaborations, disruption of racism and xenophobia in the school environment, and community responsiveness to immigrant and refugee families' cultural, contextual, and trauma-related needs (Miller et al., 2024). However, such institutional culture change requires considerable time and effort, which in practice means that nonwhite cultural brokers and clinicians may step into spaces where they face similar harms as the students and families they serve.

Given the dynamic systems within and around immigrant and refugee youths' environments (Ijadi-Maghsoodi et al., 2024), effective school-based mental health intervention benefits from a multi-tier structure like TST-R (Ellis et al., 2013). TST-R is also consistent with the existing evidence of interventions supporting the unique needs of refugee children and families, including 1) contextually and culturally adapted and co-delivered by cultural insiders (i.e. cultural brokers), 2) informed by the post-migration experience, 3) implemented in the community, and 4) engaged in cross-system collaborations between caregivers, community organizations, and schools to enhance relationship building and implementation strategies (Reynolds & Bacon, 2018).

Emerging empirical evidence for the usefulness of TST-R has led experts to label TST-R a "promising" model (Kaplin et al., 2019). Individual TST-R therapy has been associated with increased sense of school belonging, reduced depression symptoms, and reduced acculturative and resettlement hardships for youth (Kaplin et al., 2019). Access to cultural brokering services for youth has augmented the effectiveness of therapy (Cardeli et al., 2020) and the community member ratings of acceptability of the school-based skills groups (Benson et al., 2018). TST-R has been implemented with diverse immigrant and refugee populations in municipalities of varying sizes across North America, with efforts underway to expand access to TST-R in rural settings (Abdi et al., 2023; Cardeli et al., 2020; Winer et al., 2025).

The Current Study: A Qualitative Process Evaluation with Implementers

Multi-tier interventions such as TST-R face considerable barriers to sustainability because widescale implementation requires policy, community, organizational, and individual change (Maiorano et al., 2024). Understanding the nature of barriers and facilitators will inform and streamline future implementation and scale-up efforts. This qualitative inquiry seeks to understand program implementers' experiences and perspectives on the barriers and facilitators to the adoption and implementation of TST-R in schools.

METHODS

This process evaluation integrated ethnographic and grounded theory methodologies and implementation frameworks using a social justice lens. Ethnographic methods are particularly well-suited for implementation research, generating a richer

understanding of contextual factors impacting implementation from multiple perspectives over time, ultimately strengthening credibility and transferability of qualitative findings (Bunce et al., 2014). Constructivist grounded theory, fitting for social justice research on power and inequality, guided the iterative process of uncovering implementation processes and pursuing emergent questions throughout data collection as well as the development of a conceptual framework from findings (Charmaz, 2017).

Study Context

This TST-R implementation effort occurred from 2021-2025 in a midwestern U.S. city (see Figure 2). Some implementers had had exposure to the intervention, but previous implementation had stalled. This was the largest ever TST-R implementation in schools, with over 100 youths participating in group or individual services.
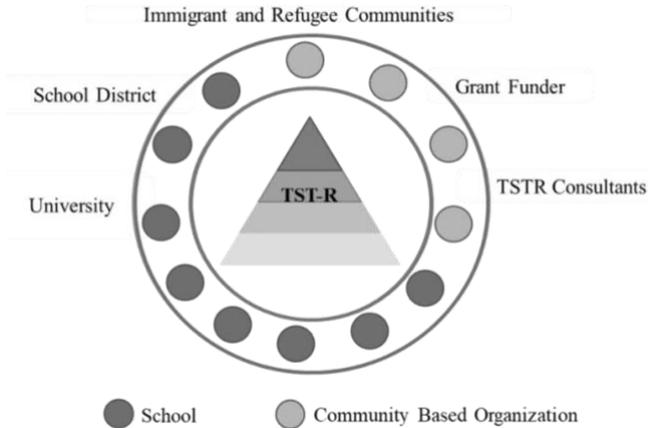
Figure 2. TST-R Implementation Multisystem Collaborative Map

Participant Recruitment and Description

Purposive samples were recruited of participants (*n*=16) with extensive knowledge of this implementation effort, including those participants who delivered, coordinated, and oversaw TST-R services and were working in community mental health or human service organizations funded for TST-R delivery. Potential participants were invited by email to participate in a 45-minute focus group or interview across two waves of data collection; in Wave 1 (2022–2023 school year), schools were in the planning or early implementation stage, having completed 0-9 months of active TST-R implementation, while in in Wave 2 (2023-2024 school year), schools were 18-24 months into TST-R implementation. Informed consent procedures were completed with all participants. Nine participants were in Wave 1

and ten participants were in Wave 2. Of the 16 participants, 15 identified as women and one identified as a man. Participants held roles as cultural brokers (8), clinicians (6), and leaders (2), and they had an average tenure in their roles of 2.2 years (SD=2.4). Participants' highest level of education was an associate's degree (12.5%), bachelor's degree (31.3%), and master's degree (56.3%). Participants identified as Afro-Latina/Latina (43.8%), European American (31.3%), Asian, (6.3%), and Haitian/Black (6.3%).

Data Collection

Two waves of qualitative data collection elicited participant perspectives on barriers and facilitators of the implementation. This process evaluation was reviewed by the authors' University Institutional Review Board and determined not to be human subjects research. The Consolidated Framework for Implementation Research (CFIR) informed the development of the interview and focus group guides in both waves (Damschroder et al., 2022). CFIR is the most widely used implementation framework and includes five domains of factors with evidence of impact on implementation efforts. Given the multi-tier nature of this intervention and the research question focused on multilevel barriers and facilitators to implementation, interview guide items were mapped onto the five domains of CFIR: the outer setting, inner setting, characteristics of the innovation itself (TST-R), the implementation process, and characteristics of individuals (Damschroder et al., 2022).

In Wave 1 (2022–2023 school year), participants were invited by email to participate in 45-minute interviews via Zoom with the first, second, and fourth authors. Interview guides elicited perspectives on anticipated and observed barriers and facilitators to TST-R adoption and implementation. In Wave 2 (2023-2024 school year), interview guides invited reflection on barriers and facilitators to implementation across CFIR domains (e.g., inner setting characteristics). This wave consisted of two focus groups and one key informant leadership interview conducted by the last author. Participants were separated by role within each focus group including either only cultural brokers or only clinicians. In both waves, ethnographic field notes were completed by interviewers following individual interviews noting salient observations, dynamics, researcher reactions, and emergent themes. Interviews and focus groups were audio-recorded, transcribed, and de-identified.

This evaluation also drew from structured meeting notes (*n*=173 pages) from across the evaluation period. Notes were recorded during implementation and program meetings and consisted of agenda items, action items, and barriers and facilitators related to implementation.

All data including videos and transcripts were stored on the University's HIPAA-compliant Box.com platform. Data were managed in NVivo.

Data Analysis

A modified grounded theory (Charmaz, 2017) approach to data analysis was used in this ethnographic process evaluation and began with codebook development. The first and third authors independently co-coded two Wave 1 interview transcripts,

identified emergent codes, and came to consensus on final codes. The Consolidated Framework for Implementation Research (CFIR) was a sensitizing framework, and the five domains (listed above) were included in the codebook. Coders did not search for data to "fit" in the codes. Rather, each CFIR code had to "earn its way" into findings (Padgett, 2016) consistent with an inductive-deductive approach (Fereday & Muir-Cochrane, 2006). The first four authors then used the codebook to code the remaining Wave 1 transcripts, with two authors independently coding each transcript and meeting to decide on final codes through consensus. Using axial coding across all transcripts, authors reviewed data by domain and by code, to understand the conditions, connections, and characteristics of the codes.

Further conceptual mapping clarified and identified emergent, interconnected themes and documented their presence across CFIR domains. Consistent with ethnography, particular attention was paid to themes related to positionality, culture, and power, as well as to implementation facilitators and barriers. In addition, the first author reviewed all meeting notes from the implementation period and generated a document memo of barriers and facilitators to implementation, as well as notes on consistency or contradictions with emerging themes from focus groups and interviews. The first four authors and the last author explored the relationships between emerging concepts in data sessions and created a conceptual framework based on the data. False starts, repetitions, and filler words (e.g., like, um) were removed from quotes to improve readability.

Strategies for rigor in qualitative research to guard against potential bias were employed throughout the study. Weekly peer debriefing, triangulation of data sources, and an audit trail were employed to address potential researcher bias. Additionally, prolonged engagement with the participants and ongoing triangulation of multiple perspectives and data sources significantly lessened the potential for participant reactivity to the evaluators in the data collection process and respondent bias in our findings (Padgett, 2016).

Limitations

The findings should be considered within the context of study limitations. Authors held dual roles as project evaluators and implementation supporters performing a variety of as-needed duties (e.g., recruitment and enrollment, data collection, training and technical assistance, supervision, and group facilitation) to fill gaps in capacity. Having all been engaged in the project for three or more years, the authors had built relationships with some of the implementers interviewed, which, depending on the nature of the relationship, may have helped participants feel more comfortable to speak openly, or contributed to participants "holding back" or giving what they perceived to be socially desirable responses. The authors' roles as members of the research team also hold power through their ability to influence the implementers' workloads (e.g., evaluation paperwork), implementation supervision (e.g., availability for troubleshooting implementation challenges), and access to information related to the intervention (e.g., trainings). This power dynamic may have affected implementers' willingness to share critical feedback. Similarly, since Wave 2 of data collection did not include individual interviews with implementers, instead

consisting of separate focus groups with clinicians and cultural brokers, some participants may have filtered what they shared in front of their colleagues.

Positionality Statement

The authors of this study include five social workers by training; as such, this study is grounded in the social work profession's values, ethics, and social justice lens. As discussed above, authors provided multiple types of and varying degrees of intervention support throughout the planning, implementation, and evaluation processes. The first five authors also, to varying degrees, shared insider knowledge of the cultures and/or languages among cultural brokers and youth. The lead evaluator (last author) and second author had some distance from intervention implementation beyond data collection facilitation and weekly meetings. These diverse vantage points provided a nuanced and close-up view of the implementation, as documented in our meeting notes and correspondence.

FINDINGS

Findings revealed that equitable structures for collaborative work are necessary conditions for developing and maintaining trust, attending to power differentials, and ultimately significantly contribute to effectively implementing culturally responsive interventions (see Figure 3).
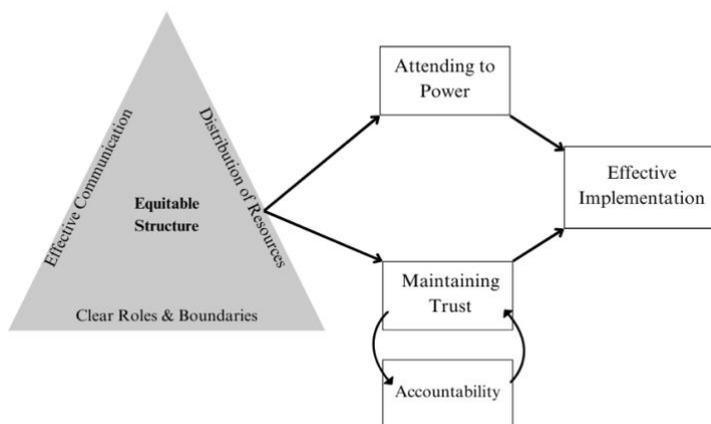
Figure 3. Conceptual Model for Key Determinants of Effective Implementation

Maintaining Trust

Implementers described successful implementation as hinging on trust, where trust was needed between implementers and 1) recipients of TST-R (e.g. schools, students and families); 2) members of the cross-agency project implementation team;

and 3) the intervention itself. As a cultural broker, discussing how to engage families, voiced:

> [W]orking at the speed of trust with families is something that is gonna come up a lot when implementing this TST-R model. Like, you can't push them to tell you something. You have to, you know, *love* them into telling you something.

Implementers also referenced schools' prior experiences with programs that broke promises, which necessitated additional groundwork to build trust. A cultural broker reported a school staff member saying,

> [W]e've been burned before and so we wanna make sure that you will be here and that this program will stick and that you will stick here with us... We want to feel like we can trust you because we're trusting you with our kids.

While building trust with families and school personnel was essential to implementation, of particular importance to the intervention implementation was the trust implementers had in their fellow members of the cross-agency project team. One clinician reflected on how fostering trust within the project team should be the first step in implementation, before working on relationships outside the team: "I would ... do a lot of intentional relationship building, team building within our team first, and *then* at school, and *then* with families and clients."

Clinicians and cultural brokers often expressed high levels of trust in the effectiveness of the model, which served as motivation in their roles introducing and implementing TST-R. A clinician described the way TST-R was addressing a gap in services for immigrant and refugee families:

> Typically, historically, I feel like they just don't get those services. Like the kids just get the one-on-one and the family misses out on what's not possible. 'Cause we do what we can. But the cultural brokers have made a huge difference in them having more equitable services.

Still, some implementers had doubts about the model, and a cultural broker posited that if mental health providers were from the communities they serve, there would be no need for cultural brokers, saying, "I'm kind of advocating for the elimination of my role, but it's like, hire these people [clinicians] to do this work because they're the ones that are fully capable of doing it."

Role of Accountability in Maintaining Trust

Accountability served as the primary mechanism for both building and repairing trust within the project and with partnering schools. One cultural broker described how demonstrating the effectiveness and appropriateness of services served to deepen trust and buy-in:

> [O]nce they see the value it has for families, the buy-in is this, well, it's not costing them anything except providing a space. And schools are more willing

to do that [implement TST-R] once they see and are able to recognize within the population that they serve. This is what cultural brokers can do.

Meeting or exceeding schools' expectations of services helped to repair the trust broken from other previous programs that had not fulfilled their promises.

However, implementers shared that when breaches of trust were not mended through accountability, trust eroded further. An example was described in the context of a racist interaction at a school. This incident harmed cultural brokers and the harm was magnified by a lack of accountability to address and prevent further harm. A cultural broker described the reasons that TST-R implementation would not continue at the school, saying,

> ...the problem itself involved racism. And this needs to be addressed, not only to mend a relationship, but also to advocate for our own cultural brokers and really truly understand what was happening and set those boundaries to avoid these types of situations.

In this instance, cultural brokers had expected powerholders within the project team to speak with school leaders about the harm caused and communicate expectations about respectful partnership with cultural brokers going forward. Trust, then, is not static, but rather once established, must be maintained through accountability for successful implementation to be possible.

Attending to Power

Implementers discussed the relationship between immigrant and refugee families and school-based staff as well as their own struggles with limited power within their roles. When they used the term "power," they were describing a person's ability to act in alignment with their beliefs of what their role should be, as well as recognizing constraints on power based on their own racial and cultural identities within a white supremacist society.

One cultural broker discussed how families experienced clinicians in the project, noting how immigrant and refugee parents were wary of clinicians due to their perceived positions of power. This cultural broker then contrasted this dynamic with observations that their children connected more readily with clinicians in order to navigate the school. In this way, cultural brokers' engagement with families flattened the power differential for parents, largely due to belonging to the same communities.

The importance of cultural brokering in empowering families within the school system was a consistent theme. Cultural brokers illustrated their efforts to shift more power to families when engaging with the school systems through advocacy and informing families of their rights. For example, a cultural broker spoke about facilitating conversations around the correct implementation of 504 plans in order to support parent agency, resulting in parents realizing, "as a parent, I can, I have the right to say like, I don't think you're doing your job right and I need—or my child needs more help."

In other cases, advocacy work included interactions with ill-prepared staff. Another cultural broker shared their perspective on how lived experience helped to

inform their work advocating with families regarding a particular school staff member:

> [T]here was this white savior mentality, which was terrible to work with just because trying to help the families, I know exactly how the families and kids feel because one, I'm a first-generation immigrant to the US and I've been in the system, I've worked with people like her [school staff member] a lot that I know when someone wants to help and doesn't do anything versus someone that is very culturally unaware and tries to do everything and [still] doesn't do anything... it's something that obviously happens and ... I have to learn how to navigate that but also empower the families to speak up and not let themselves feel like there isn't an out to this thing or to this type of people.

Cultural brokers were both actively working against the power imbalance between families and school staff by informing families of their options, while also at times experiencing a similar oppressive power dynamic working alongside staff members. This excerpt also calls attention to the additional emotional labor involved in cultural brokerage as a person with shared lived experience, a kind of labor the staff person this cultural broker is partnering with does not have to take on.

Implementers shared experiences of limited autonomy constraining their ability to perform the duties of the role. A school-based clinician discussed being left out of implementation planning and engagement with the school staff despite their role as a communicator, noting: "I feel like I need to be involved, not to micromanage it, but because I'm the link. [I need to be] involved in what that plan is." A cultural broker discussed co-facilitating TST-R skills groups with a clinician, explaining, "My role, just sometimes I feel like I should have given an answer about something when the clinicians actually did. It's like, well, I was the one doing that job."

While all implementers faced limitations in their role due to lack of power, accommodations were awarded differentially. When implementers expressed discontent with TST-R implementation, clinicians' wishes were accommodated more often than those of cultural brokers. In meeting notes documenting changes and discussions related to implementation, structural decisions were often made to reduce clinicians' workloads, including changes to data management, evaluation measures, timing of the evaluation rollout, as well as the creation of a collaborative workgroup for the project team to engage with and troubleshoot with clinicians, and, to a lesser extent, cultural brokers, about the evaluation process. Efforts to reduce the workload of cultural brokers were more piecemeal and included other project team members periodically taking on ad hoc tasks like facilitating groups and obtaining parental consent for youth to participate in services and the evaluation.

In contrast to these experiences of power imbalance, others shared only positive experiences when active efforts were made to share power. One cultural broker stated, "I've kind of always felt like we're equal [with clinicians] just because of the way that they can be candid with us and also show that they don't know something and to share that." Transparent communication and acknowledging gaps in knowledge with humility were communication strategies attributed to higher comfort with power sharing.

Further description highlights that not all intentional efforts are the same. In particular, efforts that only recognized the contributions of implementers without actively balancing power strained implementation. As a cultural broker described, "everyone's like, thank you for the work. You guys are so amazing. But at the end of the day, cultural brokers are the ones expected to do the majority of the work, and that's what happens." This imbalance was confirmed in team meeting notes as well; in November 2023, a meeting note read that the most work was falling on those with the least agency within the project and captured potential strategies: "idea of doing a power map—consider role clarity, find tensions."

Interconnections of Trust & Power

Through exploring the interconnections of trust and power among project implementers, a typology emerged to describe roles implementers took on depending on where they fell on the spectrums of trust in and power within the project, as shown in Figure 4. Based on their levels of trust (in the intervention and in the project team) and power (within the project), implementers may assume roles of *championing, gatekeeping, persisting,* and *burning out* (Figure 4). This typology can serve to describe benefits of maintaining trust and attending to power within project implementation, as well as the risks of failing to do so.
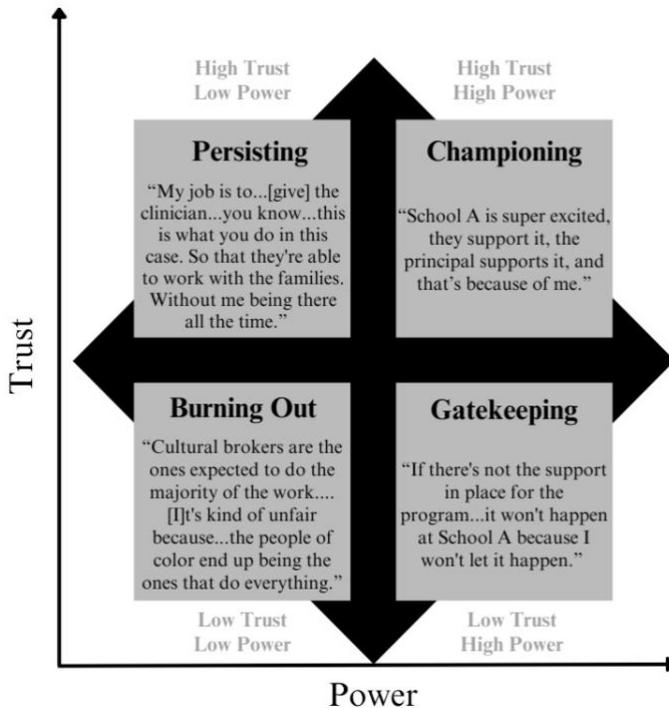

Figure 4. Typology for Approach to Implementation: Interconnected Spectrums of Trust and Power

High Trust & High Power: Championing

When implementers have both trust in the project and power in their role, they can be especially effective at furthering implementation of the project. This was particularly evident with clinicians, given their long-standing relationships with the schools. Strong existing relationships with schools gave clinicians the ability to influence schools' reception to the project. If clinicians, as trusted members of the school community, expressed optimism and faith in the project, schools were more likely to get on board. As one clinician explained:

> [School name] is super excited, they support it, the principal supports it, and that's because of me.... [T]hat's just me being honest, is that I presented it in a way of like, 'Wow! We got this grant money, it looks great.' I was able to do that and because I already had relationships with principal and with support team. So I think a lot of the kinks last [year] I was able to smooth that over honestly, where I was able to say, 'this is new and we're still figuring it out'.

The clinician not only helped "sell" the intervention to schools initially but also could help maintain and rebuild trust when problems arose over the adoption and implementation process.

Low Trust & High Power: Gatekeeping

If implementers lost trust in the project and occupied a position of power, they could become gatekeepers to further implementation. As a clinician stated, "what's gonna happen is we're gonna get really busy with our work. And if there's not the support in place for the program... it won't happen at [school name], because I won't let it happen." That is, if the proper groundwork is not laid where the implementer trusts in the project's preparation, the implementer can block progress. This can be viewed as a protective role, as the implementer was seeking to prevent a chaotic rollout.

High Trust & Low Power: Persisting

There were also examples where implementers were in positions with little power but felt buy-in and trust in the project. As one cultural broker described their role in supporting families and clinicians:

> [M]y job is to build trust with the families and to kind of hold their hand and to walk them over that bridge so that they can receive the services that the clinicians are giving, and to the clinician—background info of, you know, 'okay, this is what you do in this case,' so that they're able to work with the families. Without me being there all the time.

Another cultural broker lamented needing to go through clinicians to get access to working with students, naming the importance of integrating cultural brokers into

the school because "we're still part of their team. And so truly incorporating us so that we're not relying so heavily on the clinicians." High faith in the value of cultural brokering services motivated work to improve access and a greater level of power.

Low Trust & Low Power: Burning Out

When implementers experienced both a lack of power and distrust in the project and its team, they burned out. An implementer described the twin lack of decision-making power and loss of trust in cultural brokering roles,

> [A]nd it gets thrown on and it's like, 'I know you're so busy, but this, that and third needs to get stuff.' And I feel like that in itself is, I don't know, it's kind of unfair because, again, the people of color end up being the ones that do everything.

Cultural brokers experienced an added burden of emotional labor that is required to work within their own communities. At times, the emotional labor was described as contributing to burnout:

> I have a lot of experiences that I can relate to when I speak to families and stuff that it has affected my mental health. And so then on top of that, when cultural brokers are expected to do absolutely almost everything, then yeah, it's going to lead to burnout.

Though this work took an emotional toll on cultural brokers, it also at times facilitated their own healing:

> [I]t was just so healing for me and it was like, I've never been to, well, yeah, no, I've never been to therapy or talked about my own grief or the separation that I had with my own family and just reading through the manual, just thinking about my past and working with kids and working on their past to really help me heal on my own experience.

While aspects of the model felt healing, the low levels of trust and power experienced in the cultural brokering position resulted in role precarity.

Maintaining Trust & Power Through Equitable Structures

Implementers revealed that TST-R needs to be structured equitably in order to develop and maintain trust, attend to power, and ultimately effectively implement the program. These data revealed three key and interconnected components of an equitably structured program: the distribution of resources, effective communication, and clear roles and boundaries. These components must be intentionally and actively addressed to promote trust and manage power within the program and among implementers.

Distribution of Resources

Implementers identified the equitable distribution of resources — in particular, time and training — as necessary for increasing trust and attending to power in the implementation of TST-R.

Time was described as an important resource in two ways: as a burden power-holders should be mindful of and as a resource that needs to be protected for debriefing. Implementers said it was important for power-holders assigning tasks to have a dual awareness of the amount of time required to complete assigned tasks *and* the amount of time an implementer had available. A clinician elaborated on this point, "The people who are doing this are just doing a whole bunch extra than all the other staff who aren't doing this, and how does that feel equitable?" This clinician expressed concern about the number of added unpaid hours for clinicians who were participating in the intervention. Given the substantial amount of time required to implement this program, capitalizing on moments to ease that burden was supportive. Another school-based clinician reflected that it was important to be "intentional" about how TST-R groups could be folded into existing "cultural time" in schools: "[Cultural broker] can come in and have those conversations [about intentional scheduling], invite them in, you know...?"

Additionally, partner organization implementers (i.e., clinicians) and school staff with limited time available to them required an awareness of the time burden placed on implementers with little power within the program's hierarchy (i.e., cultural brokers). A clinician explained, "I'll tell you, as therapists we say we don't have time to do that [TST-R implementation activities] either. ... So if a cultural broker could be doing that, I bet that would be helpful to the [school] social workers as well." As such, when tasks previously assigned to clinicians and school social workers were shifted to the cultural broker position, it had a dual impact of improving acceptability of TST-R for school staff and expanding the cultural broker role beyond the original scope.

Implementers described time as a resource that needed to be protected for peer support and debriefing. A cultural broker elaborated:

> [T]here can be a lot of heaviness within the work and a lot of responsibility within the work. So being able to have those check-ins I think is really important. [A]nd really important to us to just to kind of be mindful of the availability of time that we all have, within this program and within implementing the time at schools.

This implementer notes, first, that cultural brokering is heavy and time-consuming work, and a mindfulness of this from leadership is necessary. Second, because of the heaviness of the work, it felt important and valuable to have time protected for supportive peer-to-peer check-ins.

Access to training was also identified as an important resource. Training was described as necessary for empowering cultural brokers to in turn manage expectations and roles of others (e.g., school staff, service recipients, and other implementers). While describing the importance of clinical training for cultural brokers, one said, "[A]ctually having language to be able to talk about the different forms of therapy itself is really a great tool to have." This access to information was

described as "self-care" and a tool that would allow cultural brokers to better collaborate with others in the intervention.

Trainings were also described as important for allowing implementers to manage expectations at their implementation sites, orient them to the intervention, and their collaborative roles. One implementer stated: "I would've liked more information on the grant itself and the flexibility that we have, and what we can and cannot do as far as supporting the students and the schools. That would've been really wonderful." Another also described benefiting from trainings that oriented them to the structure of TST-R. Both implementers, however, segued this feedback into a focus on the importance of trainings that clarify the collaborative roles of cultural brokers and clinicians, with one implementer stating: "I do wish we would've been, kind of instructed more as to how there is a mesh between working with a therapist and as a cultural broker and how those really, really link together."

Effective Communication

Effective communication was defined by implementers as concise and involving the appropriate people. Communication, whether via email, phone, or in-person, needed to be simplified in its content and frequency to avoid flooding or overwhelming partners. One implementer described an example of poor communication between leadership and an implementation site that would, "... muddy things up sometimes with a lot of language and a lot of emails and not a lot of clarity." In this example, over-communicating challenged the partnership with a potential implementation site and acted as a barrier to relationship building and mutual understanding.

Clinicians revealed that *who* was involved in a communication was as important as the communication's content and frequency; being included in the conversation as a trusted link was as important as the conversation approach. A clinician corroborated this point and applied the idea to the collaborative relationship between clinicians and cultural brokers, "[P]art of it [effective implementation] was just taking out all the middle people and just me communicating directly with cultural brokers." They cautioned that when communication lapsed through verbosity, opacity, or a failure to include the relevant people, trust was ruptured. To illustrate this point, this clinician narrated an experience related to purchasing food for a school event. They recounted receiving direction from program leadership to bring food for the event, but being unable to get clarity around the budget or any other details related to this task:

> We need to communicate, we need to have everything together because when we don't have that, that's why I think schools are struggling to implement is because like...if we don't really know something as simple as 'what is my budget for food'....

The inability of program leadership to maintain clear and consistent communication strained this implementer's relationship with this project *and* threatened the relationship with the implementation site.

Clear Roles and Boundaries

Finally, clearly defined roles and maintained boundaries make up the third component of an equitable structure. Implementers described this as reliant on clear communication and an awareness of the equitable distribution of resources. A clinician expressed concern about the unsustainable workload and scope of work of a cultural broker:

> [Cultural broker name] needs a bunch of stuff taken off her plate 'cause she will NOT have time and she's gonna burn herself out... We need to think about logistics, and we need to think about if we want our cultural brokers to stay, just like if we want our clinicians to stay, right, all of that, we need to have intentional conversations about what does that balance look like. And it's not about self-care cuz that's complete BS. It *is* about what are your job duties? And can that fit into a reasonable work week?

Cultural brokers and clinicians need to have clearly defined, balanced roles, which is made possible through *intentional conversations* and an understanding of the *time* required and available to fulfill those responsibilities.

A common concern around role clarity came up specifically for cultural brokers. Cultural brokers described interacting with school staff and clinicians who did not understand or respect their role as cultural brokers, and instead used them as interpreters or relegated them into marginal roles. For example, a cultural broker described challenges around role clarity while working with a clinician in group facilitation, "[T]here would be times where we'd run into each other or something, or I don't even have control in my job cuz I don't get to say anything the whole time." This cultural broker clearly communicates the felt consequence of the lack of role clarity—a loss of power.

Another cultural broker described being asked to perform tasks that they deemed outside the scope of their roles or that they felt were inappropriate for their relationships with families, like interpreting for meetings unrelated to their roles or being asked to "scold" children or parents they did not know. This cultural broker described their reaction to a "terrible encounter" in which school staff requested the cultural broker reprimand students they were just meeting: "I was stunned. I was like, I am not going to interpret this information. I have no business doing this...So I didn't do it." Both the clinician example and this school staff example involve a perceived misuse of the cultural broker role through the misassignment of labor; one through the removal of work within their role and the other through the assignment of work outside of their role. Both examples suggested a struggle with power and the kind of disrespect that can be experienced when roles are unclear and, subsequently, boundaries are not respected. This failure to clearly define and then respect the role of cultural brokers has important implications for the power relationships modeled for students involved in the program. In the words of another cultural broker:

> [E]specially with these white clinicians, you're kind of setting a certain precedent for the kids that it's like when you work with these Americans, you're going to

be in a subordinate role. And it's like we have to be really intentional about modeling equality, which is difficult when you're new because we don't know what we're doing. And then when we're not giving very clear instructions, they're not really setting us up for success. And so then the clinicians have to take lead because they do know more about the groups. But then again, we're modeling this subordinate, this imbalanced relationship.

This cultural broker warns that the lack of clear, respected, and balanced roles replicated power imbalances that fall along racial and national lines. This implementer goes on to describe clinicians taking on leadership roles based on their knowledge of group work, subordinating the role and knowledge of the cultural brokers. Finally, the cultural broker describes the kids seeing whiteness and Americanness as dominating and cultural brokers with whom they identify on a cultural and perhaps ethnic level as subordinated.

DISCUSSION

Findings highlighted that the successful implementation of TST-R requires an attention to equity. This intervention, intended to supplant ineffective services for forcibly displaced youth and their families with culturally responsive, trauma-informed programming, must calibrate to power imbalances both in its own structure and in the organizations through which it is implemented.

The impact of 1) the distribution of available resources, 2) timely and intentionally inclusive communication, and 3) respected boundaries and roles were weighted differently by cultural brokers and clinicians. Study findings suggest that the amount of discursive power (ability for one's perspective to become reality) and epistemic power (ability to have one's knowledge or perspective considered valuable) allotted to the clinician and cultural broker roles were not equal. Cultural brokers' expressions of discontent or mistreatment were not treated as equally valuable as clinicians'. This difference in implementer experience is consistent with Stanton et al.'s (2022) three-part typology of power in implementation that details how discursive, epistemic, and material power (ability to control the ownership and disbursal of resources) are dispersed throughout implementation based on decision making, and this dispersal impacts outcomes. This typology provides a frame for the lessons conveyed by implementers in this project around how an equitable structure develops trust, balances power, and thus allows for the effective implementation of an intervention.

This differential power dynamic within the project team highlighted the precarity of the cultural broker role. The role was 1) grant-funded through the intervention rather than a permanent role within a partner organization, 2) unlicensed and did not require a graduate degree, and 3) low-paying and at times part-time or internship-based. The role had significant relational distance from powerful administrators (e.g., principals, executive directors), which reduced the opportunity for building relational capital within the project team. When a cultural broker expressed disrupted trust in the intervention and its leadership due to an overload of work and ineffective communication, they had less leverage than a clinician expressing the same concerns.

Cultural brokers, then, more often expressed and experienced burnout. In contrast, clinicians were still able to wield their discursive, epistemic, and material power when their trust in the intervention was disrupted and gatekeep implementation of the intervention within partnering organizations.

Cultural brokers importantly noted that these power differentials fell across raced and national lines. They noted that, in an intervention setting wherein most clinicians were white and almost all cultural brokers shared racial identities with the various ethnic groups served, cultural brokering at times felt like an agency-less bandage; they filled the cultural literacy gaps of clinicians while being pushed to the margins in decision-making moments. Culturally responsive mental health services are valuable for improving ethnically matched and non-matched client-clinician relationships and help-seeking behaviors among racially marginalized youth (Chu et al., 2023; Olaniyan & Hayes, 2022). Cultural understanding has been shown to increase students' engagement with mental health resources to a much greater degree than ethnic or race matching (Chu et al., 2023). The cultural understanding that cultural brokers bring to the team, then, is a highly valuable resource; arguably as valuable as the technical training possessed by clinicians.

Ray's (2019) theory of racialized organizations helps to connect these findings to the ways in which superiority/inferiority social ordering within concepts of race act as a template for organizational decision-making and action. This creates racial hierarchies inside organizations and within staff members' interactions with external collaborators. As such, organizations can become "meso-level social structures that limit the personal agency and collective efficacy of subordinate racial groups while magnifying the agency of the dominant racial group" (Ray, 2019, p. 36). TST-R is an intervention implemented through existing organizations, and it was thus susceptible to the existing power differentials within those organizations and systems of care. The successful implementation of TST-R required a consideration of, and targeted implementation strategies intervening upon, the existing racial and cultural homogeneity within partner organizations, as well as the distribution of power within existing professional roles, as early as the planning phase of the project.

Implications for Practice

While this study highlights barriers to implementation of a promising and culturally responsive mental health intervention, it also illuminates key implementation strategies to cultivate trust with project implementers that can be adapted in other implementation settings. As our conceptual framework suggests, laying the groundwork of an equitable structure helps establish trust; accountability serves to maintain and repair trust; and attending to power works against structural power imbalances within and beyond implementing partner agencies.

In our own work, we have operationalized and integrated this conceptual framework in six ways in an effort to improve equity. First, we directly discuss power imbalances in trainings on TST-R to prepare schools and implementing teams to plan for equitable implementation. Second, with cultural broker leadership in (re)defining roles, we have shifted our framing of the cultural broker-clinician collaboration from equal partners to identifying cultural insiders (whether in cultural broker or clinician

roles) as the leaders with cultural outsiders holding a supportive role. Third, we have advocated for cultural brokers having direct partnership with and independent access to schools and families without clinicians serving as the only communication link. Fourth, the emotional toll and power dynamics navigated in the cultural broker role are explicitly addressed in supervision and peer debriefing. Fifth, multiple, accessible pathways for feedback and recommendations have been provided to encourage open communication and improvement of implementation and working conditions. Sixth, we have begun working with partner organizations to adopt anti-racist and anti-oppressive frameworks with the intention of reducing environmental harm for staff. Within these six strategies, cultural brokers' power and leadership has been expanded across implementation and evaluation.

Our findings are both novel in their integration of power and trust as predictors of implementation effectiveness *and* supported by existing conceptual work in trust. Through establishing that trust alone cannot ensure effective implementation, our work uniquely contributes that the integration of maintaining trust and attending to power are key for building project champions and effecting successful and equitable rollouts of culturally responsive, community-based interventions. Concepts within our model are reinforced by Reina and Reina's (1999) model on trust and betrayal in the workplace where successfully building three forms of trust can lead to "transformational trust". The elements we identified as crucial to creating equitable structures resonate with the three forms trust in the Reina and Reina (1999) model: our "clear roles and boundaries" overlaps with their "contractual trust," described as establishing clear boundaries and fulfilling stated expectations; our "effective communication" connects with their "communication trust," which consists of sharing information effectively and respectfully; and our "distribution of resources" aligns with their "competence trust," which consists of respecting knowledge and skills of others and helping them build skills for their role. This conceptual consistency with existing research provides evidence for the theoretical soundness of our model.

The findings in this study also raise questions related to the necessity of a cultural broker role at all. As a cultural broker argued, if clinicians were hired from communities served, there would be no need for cultural brokers to bridge between communities and clinicians. However, this may expand the scope of work typical of clinicians if the role is expected to attend to the emergent basic needs issues that cultural brokers typically address with families. While the clinician role may offer some protections in terms of job security and credentials, racialized power imbalances and burnout experienced by cultural brokers may also impact nonwhite clinicians. Efforts to recruit and retain nonwhite and cultural insider clinicians should be supported and evaluated. The lack of diversity in the mental health field also hampers these efforts (Kim, 2022).

When the cultural broker role is maintained, structural protections in terms of resource distribution and workload boundaries must be carefully established to support sustainable work in this role. This could look like parity with clinicians in terms of job security, benefits, and pay. Given the multi-agency and multi-tier nature of cultural brokering, project partners should receive ongoing guidance on cultural brokers' scope of work. To this end, a cross-agency organizational chart can clarify

roles and relationships between staff across the project. Investing in cultural brokers through thorough and extensive training with ongoing, supportive individual and group supervision, as well as through creating mechanisms for providing and addressing feedback, demonstrates that cultural brokers are not expendable or easily replaceable. Cultural brokering could also be envisioned as a step toward a mental health career pathway that could lead to pursuing a clinical degree, as four cultural brokers with this project either went on to do or simultaneously pursued while in their positions. Allocating resources in a way that equally values the support and connections cultural brokers build with families would be a step toward acknowledging the multiple pathways that can lead to effective mental health promotion, wellbeing, and thriving among immigrant and refugee youth and families.

Implications for Future Research

The depth of practical lessons and conceptual understandings gleaned from this evaluation highlights the importance of engaging in implementation research in intervention rollouts. In particular, these findings signal the need to develop and evaluate implementation strategies that specifically intervene to improve the equity of the implementation process as well as on the power and trust among implementers. Without intentional focus, efforts to bring interventions like TST-R to scale across communities in need will be hampered by existing inequitable power structures. This may include exploring the effectiveness of equity assessments of partner organizations prior to implementation to identify areas in need of attention to power and to assess readiness for implementation.

Future research can evaluate modifications to the cultural broker and clinician roles for better parity and power-sharing from implementer and youth perspectives and through comparing youth mental health and school success outcomes between traditional and adapted TST-R models. Further study to understand the experiences of cultural brokers and the features of cultural brokering that promote healing for cultural brokers themselves may offer strategies for improving sustainability and appeal of the profession. In this study, differences in power dynamics related to racism emerged inductively from the data. Therefore, research is needed to further explore experiences of nonwhite clinicians and cultural brokers in order to improve retention of, and equity for, nonwhite implementers.

Importantly, critical feedback from implementers may be a key sign of trust and commitment within implementation teams. Surfacing the implementation barriers, particularly around power dynamics, takes notable effort. Implementers' willingness to share their observations, however painful, has been intentionally framed as an important gift for persevering through this complex collaborative effort.

CONCLUSION

This is the first implementation evaluation of TST-R, a promising yet understudied community-based approach to supporting immigrant and refugee student wellbeing. Findings from this process evaluation indicate that even when an intervention intends to promote belonging and resilience among immigrant and refugee youth in schools

and work against structural oppression, it will not ameliorate existing inequity without targeted implementation strategies. If implementation teams attend to power and use intentional and effective strategies to maintain trust, services can be delivered more sustainably, equitably, and ethically. This study serves to both highlight the dangers of power imbalances and ruptures in trust in implementation, as well as to illuminate pathways to equitably planning and implementing culturally responsive, school-based mental health interventions. Future implementation research can develop and test effective strategies that target inequity within organizations and systems, promote power sharing, and sustain cultural literacy in mental health care.

REFERENCES

Abdi, S., Akinsulure-Smith, A. M., Sarkadi, A., Fazel, M., Ellis, B. H., Gillespie, S., Juang, L. P., & Betancourt, T. S. (2023). Promoting positive development among refugee adolescents. *Journal of Research on Adolescence*, 33(4), 1064-1084. https://doi-org.ezp1.lib.umn.edu/10.1111/jora.12890

Benson, M. A., Abdi, S. M., Miller, A. B., Heidi Ellis, B., Nickerson, A., & Morina, N. 2018). Trauma Systems Therapy for Refugee Children and Families. In *Mental Health of Refugee and Conflict-Affected Populations* (pp. 243–259). Springer. https://doi.org/10.1007/978-3-319-97046-2_12

Betancourt, T. S., Newnham, E. A., Layne, C. M., Kim, S., Steinberg, A. M., Ellis, H., & Birman, D. (2012). Trauma history and psychopathology in war-affected refugee children referred for trauma-related mental health services in the United States. *Journal of Traumatic Stress,* 25(6), 682–690. https://doi.org/10.1002/jts.21749

Bunce, A. E., Gold, R., Davis, J. V., McMullen, C. K., Jaworski, V., Mercer, M., & Nelson, C. (2014). Ethnographic process evaluation in primary care: Explaining the complexity of implementation. *BMC Health Services Research*, 14(1), 607. https://doi.org/10.1186/s12913-014-0607-0

Cardeli, E., Davis, S., Issa, O., & Ellis, B. H. (2020). Trauma Systems Therapy for Refugees (TST-R) in a multi-ethnic refugee population in Maine, USA: Early findings from a programme evaluation project with children and adolescents. *The Lancet Global Health*, 8, S9–S9. https://doi.org/10.1016/S2214-109X(20)30150-9

Charmaz, K. (2017). The power of constructivist grounded theory for critical inquiry. *Qualitative Inquiry*, 23(1), 34–45. https://doi.org/10.1177/1077800416657105

Cheng, T. C., & Lo, C. C. (2022). Factors related to use of mental health services by immigrant children. *Journal of Child and Family Studies*, 31(1), 228-236. https://doi.org/10.1007/s10826-021-02209-6

Chu, W., Chorpita, B. F., & Becker, K. D. (2023). Race, racial matching, and cultural understanding as predictors of treatment engagement in youth mental health services. *Psychotherapy Research*, 33(5), 669-682. https://doi.org/10.1080/10503307.2022.2150582

Damschroder, L. J., Reardon, C. M., Widerquist, M. A. O., & Lowery, J. (2022). The updated Consolidated Framework for Implementation Research based on user

feedback. *Implementation Science: IS*, *17*(1), 75–16. https://doi.org/10.1186/s13012-022-01245-0

Demissie, Z., & Brener, N. (2017). Mental health and social services in schools: Variations by school characteristics-United States, 2014. *Mental Health & Prevention*, *5*, 5–11. https://doi.org/10.1016/J.MHP.2016.11.002

Ellis, B. H., Miller, A. B., Abdi, S., Barrett, C., Blood, E. A., & Betancourt, T. S. (2013). Multi-tier mental health program for refugee youth. *Journal of Consulting and Clinical Psychology*, 81(1), 129-140. doi: 10.1037/a0029844.

Fazel, M., & Betancourt, T. S. (2018). Preventive mental health interventions for refugee children and adolescents in high-income settings. *The Lancet. Child & Adolescent Health*, *2*(2), 121–132. https://doi.org/10.1016/S2352-4642(17)30147-5

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, *5*(1), 80-92. https://doi.org/10.1177/160940690600500107

Herati, H., & Meyer, S. B. (2023). Mental health interventions for immigrant-refugee children and youth living in Canada: A scoping review and way forward. *Journal of Mental Health*, *32*(1), 276–289. https://doi.org/10.1080/09638237.2020.1818710

Ijadi-Maghsoodi, R., Meza, J. I., Bravo, L., Lee, K., & Kataoka, S. (2024). Reimagining social and emotional supports in schools for immigrant students: A contextual and structural approach. *Academic Pediatrics*, *24*(5), 32–41. https://doi.org/10.1016/j.acap.2023.11.007

Kaplin, D., Parente, K., & Santacroce, F. A. (2019). A review of the use of Trauma Systems Therapy to treat refugee children, adolescents, and families. *Journal of Infant, Child, and Adolescent Psychotherapy*, *18*(4), 417–431. https://doi.org/10.1080/15289168.2019.1687220

Kim, R. (2022, March 7). *Addressing the lack of diversity in the mental health field.* National Alliance on Mental Illness. https://www.nami.org/mental-health-professionals/addressing-the-lack-of-diversity-in-the-mental-health-field/

Maiorano, N., McQuillan, K., Swords, L., Vallières, F., & Nixon, E. (2024). Barriers and facilitators to co-creating interventions with refugee and migrant youth: A process evaluation with implementors. *Global Implementation Research and Applications*, *4*(3), 257–271. https://doi.org/10.1007/s43477-024-00123-9

Martinez, W., Jimenez-Salazar, M. C., & Suárez-Orozco, C. (2024). School-based behavioral health programming for newcomer youth: A scoping review. *Academic Pediatrics*, *24*(5), 83–92. https://doi.org/10.1016/j.acap.2024.01.022

Miller, A. B., Davis, S. H., Mulder, L. A., Winer, J. P., Issa, O. M., Cardeli, E., & Ellis, B. H. (2024). Leveraging community-based mental health services to reduce inequities for children and families living in United States who have experienced migration-related trauma. *Psychological Trauma: Theory, Research, Practice, and Policy, 16*(Suppl 2), S426–S434. https://doi-org.ezp3.lib.umn.edu/10.1037/tra0001392

Olaniyan, F. V., & Hayes, G. (2022). Just ethnic matching? Racial and ethnic minority students and culturally appropriate mental health provision at British

universities. *International Journal of Qualitative Studies on Health and Well-being*, *17*(1), 2117444. https://doi.org/10.1080/17482631.2022.2117444

Padgett, D. K. (2016). *Qualitative Methods in Social Work Research* (3ʳᵈ edition.). Sage.

Peltonen, K., & Punamäki, R. L. (2010). Preventive interventions among children exposed to trauma of armed conflict: a literature review. *Aggressive behavior*, *36*(2), 95–116. https://doi.org/10.1002/ab.20334

Potocky, M. (2024). Implementation research in refugee resettlement: A rapid scoping review. *Global Implementation Research and Applications*, *4*(2), 232-246.

Pumariega, A. J., Jo, Y., Beck, B., & Rahmani, M. (2022). Trauma and US minority children and youth. *Current Psychiatry Reports*, *24*(4), 285–295.

Ray, V. (2019). A theory of racialized organizations. *American sociological review*, *84*(1), 26-53. https://doi.org/10.1177/0003122418822335

Reina, D. S., & Reina, M. L. (1999). *Trust & Betrayal in the Workplace: Building Effective Relationships in Your Organization*. Berrett-Koehler.

Reynolds, A. D., & Bacon, R. (2018). Interventions supporting the social integration of refugee children and youth in school communities: A review of the literature. *Advances in Social Work*, *18*(3), 745-766. https://doi.org/10.18060/21664

Rosenberg, J., Rosenthal, M. S., Cramer, L. D., Lebowitz, E. R., Sharifi, M., & Yun, K. (2020).

Disparities in mental and behavioral health treatment for children and youth in immigrant families. *Academic Pediatrics*, *20*(8), 1148–1156. https://doi.org/10.1016/j.acap.2020.06.013

Schimke, D., Krishnamoorthy, G., Ayre, K., Berger, E., & Rees, B. (2022). Multi-tiered culturally responsive behavior support: A qualitative study of trauma-informed education in an Australian primary school. *Frontiers in Education*, *7*, 866266. https://doi.org/10.3389/feduc.2022.866266

Stanton, M. C., Ali, S. B., & the SUSTAIN Center Team. (2022). A typology of power in implementation: building on the exploration, preparation, implementation, sustainment (EPIS) framework to advance mental health and HIV health equity. *Implementation Research and Practice*, *3*, 26334. https://doi.org/10.1177/26334895211064250

UNICEF. (2024). Child displacement and refugees - UNICEF data. https://data.unicef.org/topic/child-migration-and-displacement/displacement/

Winer, J. P., Davis, S., Forgeard, M., Pejic, V., Park, H. S., Lemus, D., Yohannes, S., & Senesathith, V. (2025). Self-efficacy and trauma symptom benefits following a psychosocial skills-based group intervention for forcibly displaced Central American youth: A Trauma Systems Therapy for Refugees (TST-R) Approach. *School Mental Health , 17*(3), 1069–1082. https://doi.org/10.1007/s12310-025-09774-x

LAURA SOLTANI, MSW, LICSW, is a PhD candidate at the at the University of Minnesota School of Social Work. Her major research interests lie in the areas of

humanitarian immigration policy, labor rights, guaranteed income, and immigrant family wellbeing. Email: garlo017@umn.edu

JOHARA SULEIMAN, MSW, LICSW, is a PhD candidate in the School of Social Work at the University of Minnesota. Her major research interests lie in the area of child welfare policy, race and racialization, and immigrant family wellbeing. Email: sulei024@umn.edu

JASMINE BANEGAS, MA, MSW, LICSW is a PhD candidate at the University of Minnesota's Institute of Child Development. Her major research interests lie in the area of risk and resilience, prevention and intervention, cultural stress, and immigrant youth and family wellbeing. Email: baneg029@umn.edu

HOPEWELL HODGES, MA is a PhD candidate in developmental and clinical psychology in the Institute of Child Development at the University of Minnesota. In addition to providing therapy, she conducts community-engaged research on positive development in children and families exposed to multisystem stressors. Email: hhodges@umn.eduUpload File

SAIDA ABDI, PhD, MSW, LICSW is an Assistant Professor at the University of Minnesota Twin Cities School of Social Work. Her research focuses on factors that contribute to resilience and reduce risk among refugee youth and families, and the development and evaluation of community-based and community-led interventions. Email: sabdi@umn.edu

MIMI CHOY-BROWN, PhD, MSW is an Associate Professor at the University of Minnesota - Twin Cities. Her primary research interests are in mental health services, implementation science, clinical supervision, and mixed methods. Email: mchoybro@umn.edu