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Culturally Responsive, Trauma-Informed Care for Newcomer Students: Engagement and Clinical Strategies from Providers in School-Based Health Centers

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ABSTRACT

Culturally responsive service delivery is an essential component of trauma-informed schools. While there is clinical guidance, how culturally responsive care is operationalized in practice is not as well understood. The current paper provides practice-based insights into the application of culturally responsive, trauma-informed care in the context of eight school-based health centers (SBHCs). Unique student groups served by the SBHCs include newcomers and non-English speaking students. Using a research-practice partnership process, including a focus group and key informant interviews with clinicians, supervisors, and SBHC leadership, the paper provides descriptive information and case examples of practice elements related to different components of integrated behavioral health care in schools. These include: 1) engagement strategies for newcomers, 2) culturally responsive mental health identification practices, 3) adaptations to evidence-based trauma treatments, and 4) facilitative organization processes for engaging in culturally responsive care (e.g., training, multi-disciplinary workgroups, leadership support, workflow processes).

Keywords: trauma-informed schools, school mental health, immigrant students, research-practice partnership, school-based health centers

Minoritized children and adolescents in the United States face alarming inequities in accessing high-quality behavioral healthcare (Hoffmann et al., 2022). Efforts to mitigate these disparities include ensuring that services are patient-centered, trauma-informed, and culturally responsive (Ranjbar et al., 2020). This is particularly true for recent immigrant families, who may experience additional barriers to mental health

support including, limited availability of language-concordant care and lack of familiarity with educational and service systems in the United States (Alegría et al., 2022; Mikhail et al., 2018). The current study provides practice-based insights on engagement and clinical strategies in the delivery of trauma-focused, school-based integrated behavioral health care to newcomer adolescents and their families.

In the educational context, the term "newcomer" is an umbrella term that is often used to refer to individuals born outside the U.S. who have arrived in the last three years. This group often includes English language learners and may include immigrants from a range of backgrounds and life experiences, including refugees, asylum seekers, and students who have faced family separation (U.S. Department of Education, 2023). Newcomer youth living in low-resource settings face myriad stressors as they navigate the challenges of resettlement, acclimation, and acculturation. They must learn a new language and navigate an unfamiliar society all while facing disproportionate risks for trauma exposure and limited access to behavioral health services which largely stem from racism, xenophobia, and the enduring impacts of historical and intergenerational trauma (Comas-Díaz et al., 2019; Kirkinis et al., 2021; Saleem et al., 2020). Notably, although immigrant and nonimmigrant minoritized youth report similar levels of trauma exposure, immigrant youth experience greater barriers to accessing health services (Bridges et al., 2010).

Among immigrant youth, those from Central America have particularly elevated levels of traumatic stress, with 60 % meeting clinical thresholds (Venta & Mercado, 2019). Elevated traumatic stress rates for Central American newcomer youth are linked to exposure to pervasive violence prior to migration, migration-related trauma, and ongoing stressors in the U.S., such as family separation, fear of deportation, and socioeconomic hardship (e.g., De Arellano et al., 2018; Gudino et al., 2011; Schapiro et al., 2024). Trauma-focused interventions such as the Cognitive Behavioral Intervention for Trauma in Schools (CBITS), a school-based group intervention, and trauma-focused cognitive behavioral therapy (TF-CBT), an individually-focused intervention, have shown promise in reducing post-traumatic stress symptoms among Latinx immigrant youth, including Central American newcomer youth, by building resiliency and coping skills (Kataoka et al., 2003; Mancini, 2020; Patel et al., 2024; Stein et al., 2003). At the same time, research has highlighted the need for tailored delivery of trauma-focused mental health care in culturally responsive ways. For example, in applying the trauma memory exposure component of the CBITS intervention, clinicians have reported that adolescents' concerns around safety and disclosure (for fear of family members' safety) are significant considerations (Schapiro et al., 2024). At the same time, Schapiro and colleagues (2024) found that in the context of schools, the ability to leverage the strengths of group-based support to foster connection was an important feature of the intervention for newcomer students.

Schools have long been recognized as one of the primary places where students receive health and social services, including mental health care (Duong et al., 2021). This is particularly true for youth who might otherwise face barriers to care, such as stigma, cost, transportation, and insurance (Kjolhede et al., 2021; Merikangas et al., 2011; Owens et al., 2002). There are a number of ways that schools offer and provide services to students, including school counselors and school psychologists, district-

employed clinicians, or co-located mental health clinicians through community partnerships. One unique model of school-based mental health care is through schools-based health centers (SBHCs).

SBHCs operate using integrated care models that offer a comprehensive range of supports, including immunizations, primary medical care, dental and vision services, health education, and behavioral health care (Knopf et al., 2016). Various community organizations (e.g., federally qualified health centers) operate school-based health clinics using state and federal fundings. There are currently approximately 3,900 school-based health clinics in the U.S. with 83 % including behavioral health services (Love et al., 2019; School-Based Health Alliance, 2023). School-based health services can help address barriers to learning, such as chronic illness and mental health challenges, which can hinder students' ability to fully engage in their education. School-based health services are particularly important in relation to educational outcomes. Past studies have found that access to and utilization of SBHC services, including mental health support, is associated with improvements in students' symptoms, overall well-being, attendance, and academic outcomes (e.g., Gall et al., 2000; Thomas et al., 2020; Walker et al., 2010).

To maximize the benefits of school-based health services, it is essential that these supports are grounded in culturally responsive, trauma-informed approaches. In education, cultural responsiveness refers to teaching and learning that is strengths-based and connected to students' lived experiences and background, with the idea that it will be more meaningful and relevant, and ultimately more effective (Gay, 2002, 2018). This is particularly vital for newcomer students and students from immigrant families, who as previously described, face uniquely challenging stressors including significant trauma exposure, dislocation, and cultural transition. Standard models of care may overlook the complex interplay of migration-related stress, cultural identity and systemic barriers these students face. By integrating culturally responsive, trauma-informed practices, schools can create environments that not only attend to students' health and emotional well-being but also promote a sense of safety, belonging, and readiness to learn (e.g., Day et al., 2015; Dorado et al., 2016; Ijadi-Maghsoodi et al., 2022; Perry & Daniels, 2016). To support this work, many schools and healthcare organizations utilize the U.S. Department of Health and Human Services' Trauma-Informed Care Framework. This framework centers on four assumptions (four Rs: realize, recognize, respond, and resist retraumatization) and six guiding principles to guide the implementation of trauma-informed, culturally response school practices. The six principles include (1) safety, (2) trustworthiness and transparency, (3) peer support, (4) collaboration and mutuality, (5) empowerment voice, and choice, and (6) cultural, historical, and gender issues (Substance Abuse and Mental Health Services Administration, 2014). Additionally, the U.S. Department of Health and Human Services put forth the Culturally and Linguistically Appropriate Services (CLAS) standards (U.S. Department of Health and Human Services, 2013). The core guiding principle in the CLAS standards highlights the importance of culturally responsive care, and emphasizes "effective, understandable, and respectful quality care and services that respond to cultural health beliefs and practices, languages, health literacy, and other communication needs" (U.S. Department of Health and Human Services, 2013). These fifteen CLAS standards

provide a framework for service delivery guided by a core standard of being responsive to language needs, cultural health beliefs and practices, preferred languages, health-literacy levels, and communication needs. The remaining standards emphasize workforce development and leadership, language assistance and community engagement, and continuous improvement (Koh et al., 2014).

Current Study

Culturally responsive, trauma-informed care is thought to be essential for increasing access to equitable mental healthcare for minoritized youth and is particularly critical for newcomers and young people from immigrant families. Despite the advent of national standards for both trauma-informed care and culturally and linguistically responsive care, we have few examples of how this is achieved in practice in educational settings. School-based health centers provide a unique and valuable context in which to understand such practices, given their combined focus on primary care, health and wellness, mental health, and education. On-the-ground implementation experiences of frontline providers can elucidate key practices and processes that can support trauma-informed care in schools and other settings. Translating principles of cultural responsiveness and trauma-informed care into high-quality, context-specific practice requires collaboration, adaptation, cultural and professional humility, and a focus on continuous learning and improvement.

As part of a research-practice partnership (RPP), the current study seeks to elucidate core components of a trauma-informed approach that specifically supports immigrant communities in an integrated care setting in schools. RPPs represent organic and collaborative exchange of empirical and practice-based knowledge between researchers and practitioners (Coburn et al., 2013; Cox et al., 2024), which improve our ability to gather and apply rich, context-specific data to best support and benefit students and families and improve the quality of care more broadly. In the current study, the RPP, through rapid qualitative analysis, sought to elucidate frontline providers' practice-based insights into the core practice and processes used to provide culturally responsive, trauma-informed care in school-based health centers.

METHODS

The project was conducted within a federally qualified health center located in an urban center that has historically been a key entry point for newcomers. Specifically, we focus on the work conducted across eight school-based health centers (SBHCs). Of the eight SBHCs, six were located on high school campuses, while two were school linked (i.e., next to the school building, and easily accessible during the school day). Each SBHC typically had one to two primary care providers (e.g., physician, nurse practitioner) and medical assistants, and at least one integrated behavioral health clinician. Newcomers are served at all clinics, with one clinic serving as the central access point. SBHC teams are provided with annual training on traumatic stress, how to conduct screenings in culturally responsive ways (administration, discussion of results, referrals and warm handoffs), and team collaboration. The team

is also trained in immigration-related topics, including updates on benefits and presentations from legal partners.

In 2023-2024, the eight SBHCs served 7,481 students (71 % Latinx, 12 % Black, 6 % Asian, 4 % White; 54 % female, 43 % male, 3 % other). Most patients are preadolescents or adolescents (15-19 years old, 51 %; 10-14 years old, 24 %), with 14 % under 9 years old and 10 % over 20 years old. Overall, patients speak over 10 different languages (56 % English-speaking, 35 % Spanish-speaking, 2.5 % Mam-speaking, and 6.5 % who speak other languages. According to electronic medical records, the SBHCs had approximately 28,713 service appointments. Of these, there were 14,408 medical and health education visits, 7,134 dental visits, 1,026 case management visits, and 6,145 behavioral health visits. Approximately 16 % of the medical and health education were behavioral health related. Of the students who had a behavioral health diagnosis, there was 27 % depression, 26 % adjustment disorder, 25 % PTSD, 12 % anxiety disorder; 4 % other, and 2 % ADHD. In addition, 24 % had an identified need related to Social Determinants of Health such as support for food or housing.

Participants and Procedures

As noted above, the current case study took place in the context of a longstanding RPP focused on the provision and evaluation of trauma-informed screening and service delivery efforts across the SBHCs. As part of this partnership, the behavioral health supervisory team and program planning team meet with the research/evaluation team regularly (about monthly with increased frequency as needed) to ensure that progress monitoring is going well, share feedback to improve research and practice, and report outcomes to key stakeholders. As part of those discussions, issues related to newcomers, trauma, and culturally responsive care are routinely discussed. It is within this context that the current project, which sought to document practice-based insights related to trauma-informed care for newcomer students, was launched. The core research/practice partnership team added several key informants and collaborators to these regular meetings to share information about the SBHCs approach to trauma-informed care for newcomers and to conceptualize the framework for the current paper. These additional members included a clinical supervisor who provides oversight for SBHC clinicians, a clinical director who oversees the integrated behavioral health program more broadly, a project director, and a program planner.

From these meetings, a decision was made to conduct a focus group and key informant interviews to gain deeper knowledge about the provision of trauma-informed behavioral health care to the newcomer students. One focus group was held with five school-based integrated behavioral health clinicians, a supervisor, and one case manager (all women, years of experience in the SBHC ranged from 6 months to 10 years, 6 were bilingual in English and Spanish). Two key informants were invited for additional interviews based on this initial conversation to deepen understanding of integrated care practices and specific adaptations made to school-based trauma interventions. In addition, RPP notes and team discussions were documented and reviewed by the authorship team.

Analysis

To conduct the analysis, we relied on rapid qualitative methods that have been developed in the context of implementation efforts, which integrates qualitative interviews and archival information such as meeting notes and other practice documents (Hamilton & Finley, 2019; Palinkas & Zatzick, 2019). Under this approach, qualitative analysis is guided by a theoretical framework, but with openness to content and themes that may not fit exactly into that framework. For the current study, the leadership team identified core processes for which they were interested in understanding trauma-informed practice for newcomers. These were guided by SBHC and integrated care practice models which highlight access points to services (i.e., immunization visit, health education visits, routine medical care),core integrated care practices (i.e., addressing behavioral health within medical, health education and community engagement practices) and targeted behavioral health interventions in schools (i.e., direct services).

In the current study, data analysis was led by the lead author and guided by the principles and processes in Consensual Qualitative Research (CQR; Hill et al., 1997, 2005). Key elements of CQR include reading and analyzing the data and building opportunities for reflection and consensus building when attempting to understand participant meaning. An additional key element of CQR includes continual reading of raw data to check for accuracy of conclusions. These reflective processes represent established qualitative credibility techniques (e.g., Brantlinger et al., 2005). For this analysis, data sources included meeting notes, co-created documents by the RPP team and clinic leaders, and transcripts from two key informant interviews and one focus group. In the first phase, the first author and a research assistant reviewed the notes and documents and transcripts and identified themes that were aligned with the project's intended goals, identifying relevant evidence in the forms of quotes and meeting notes. Preliminary themes were established a priori, reflecting the main interview domains. This approach is aligned with research showing that thematic saturation can be achieved on major domains with a small sample (i.e., 6 to 12 participants) when the study goals are narrow (Guest et al., 2006; Hennink & Kaiser, 2022). The first author then shared memos related to the core themes and subthemes during RPP meetings. During these meetings, the RPP members shared feedback, ensured interpretation was accurate, and refined themes and concepts to identify cross-cutting themes. The lead author and the second author then refined the themes and associated data through cross-analysis of notes, the focus group, and interviews (Hill et al., 2005). Having an iterative process that included consensus building and repeated comparisons and review helped enhance trustworthiness in our analysis (Lincoln & Guba, 1985). We also engaged in member-checking with the providers and with leadership.

The positionality of the RPP team is also important to acknowledge as it may influence the analysis and interpretation of findings. The co-authors of the study both identify as ethnic minority women (South Asian and Latinx), are affiliated with academic institutions, and have backgrounds in clinical psychology and implementation science. In addition, both authors have families from immigrant backgrounds and are bilingual (English/Spanish) or multilingual

(English/Spanish/Urdu). The remaining four members of the RPP team come from training backgrounds in social work and public health, have worked at the SBHCs ranging from 3 to 12 years, include three women and one man, all bilingual in English and Spanish.

FINDINGS

Findings from the analysis yielded several core domains of practices and key practice strategies used within and across domains related to the experiences and support for newcomer students. The findings below described key processes articulated by the clinic leadership and providers related to culturally responsive care for newcomers. The first three themes address elements of trauma-informed care practice related to the core services provided by the SBHCs, which include: 1) engagement in school-based integrated care, 2) identification of mental health needs and referral to mental health services, and 3) adaptation of evidence-based interventions. Theme and subthemes are summarized in Table 1 with definitions and sample quotes. The final theme was related to processes for organizational support. For this theme, the analysis yielded two case examples that were thought to exemplify organizational support processes and shared learning to support trauma-informed care for newcomers.

Engagement in School-based Integrated Care

Integrated Care Processes to Prioritize Pressing Needs Across Health and Education

A key element in integrated care is the connection between physical health and behavioral health. Focus group and key informant interviews with the behavioral health team revealed the unique focus that SBHCs have on academics as another layer of integrated support. As such, the clinical team noted that the school enrollment processes allowed for connection to care to occur in the context of families' most pressing and intersecting medical, behavioral, and educational needs. For example, the newcomer families often came to the agency when they were seeking to enroll their students in school, with the health centers providing necessary immunizations and supporting connections with the school district for enrollment paperwork. In addition, SBHC staff simultaneously shared resources around obtaining employment, food access, housing, schools, and other community resources that ease acclimation stress for newcomer families.

By addressing families' most pressing needs, staff were able to form connections with families and build institutional trust that in turn encouraged accessing additional health and mental health resources. One clinician reported that this institutional trust encouraged families across the community to engage with the agency.

Table 1. Overview of Themes and Subthemes

Theme	Subtheme	Illustrative Quote
1. Engagement in Integrated care	**1a.** Prioritizing pressing needs	**1a**. "I do a newcomer orientation, a community resource orientation. Where I basically try to explain the different resources like where to apply to medical, how to enroll the kids in school, housing, food.
	1b. Trust, safety, and relationship building	**1b.** "It's second nature, but something I can think of really like investing time using some of the terms that the patients use like the way like let's say they're describing a pastry. I try to pick up little things."; "I really love to like ask them.. describe where you are from, your home. Were you in the mountains, were you in the city, was there a river?
	1c. Cultural brokering	**1c.** "I asked [the interpreter] if she was adding additional details. She yes because they don't know a term like [program name]. She says I explained to them more in depth what it is with extra details. And then I always ask her for feedback. And so it's helpful."
2. Identification of Mental Health Needs	**2a.** Benefits of screeners	**2a**. [The screener] is descriptive rather than using a lot of clinical jargon. I think it's useful for some of my newcomer kids who are presenting that they are fine, okay and everything's great. I'm not sad, whatever. But then we'll have high ratings of not being interested in anything or worrying all the time. It's a different way to really identify symptoms and areas of need"

	2b. Challenges with screeners	**2b**. "I think that the number system on the screeners can be really challenging specifically for our indigenous population. They don't process information on a scale like that. Sometimes it takes a lot of time to explain what we're doing, why we're doing it, what it means. Something that is supposed to be a quick screener does not serve that function"
3. Adaptations to Evidence-Based Trauma Interventions	**3a.** Relevance and utility	**3a.** "I would say actually in our setting we're using so many different interventions, tons of CBT, tons of solution focused approaches"
	3b. Psychoeducation	**3b.** "She has you do like a sort of pictionary thing where they have to draw an animal and people have to guess what it is. And then you kind of explain how it relates to PTSD symptoms"
	3c. Cognitive restructuring	**3c.** "We have the choice of like what story we want to tell ourselves. So maybe the old story is: Because of what after what happened, I can't trust in anyone. And the new story is: I can trust some people."
	3d. Exposure	**3d**. "We do a lot of framing that it's not about everything they've ever been through. We have them pick a piece. A lot of people like the drawing and the visual stuff. And I think especially it is good with newcomers"
4. Organizational Processes for Continuous Learning	Overarching Processes and Shared Values	See case examples

Trust, Safety, and Relationship Building

Discussions with staff at all levels of the SBHC highlighted a concerted effort to build relationships, establish trust, and develop a sense of safety for newcomers. This was noted in the empathy that clinicians and leadership expressed for the challenges that recent migrants faced in their home countries and in the United States. SBHC providers also expressed strong appreciation for student and family strengths related to collective strength, mutual support, and individual and community resilience. Supervisors, clinicians, and the case managers described a concerted effort at connection-seeking and taking a learning stance in speaking to newcomer students. For example, a case manager described that connecting with patients and families on topics of daily life and getting to know them on a personal level was appreciated (e.g., connecting over different words used across Spanish speaking countries for daily items, connecting over interests in strengths). The group also described creating space during service delivery for students to share about their personal journeys ("camino") or potentially traumatic experiences. However, they also indicated that providers intentionally chose not to directly ask students to speak about traumatic events during initial visits for medical care and case management. Instead, they prioritized building trust and addressing the concerns that students identified as most pressing, while conveying openness and interest. This foundational trust was perceived as an important facilitator for students who eventually needed additional health or behavioral health support.

Cultural Brokering

SBHC staff described the important role of non-clinician staff as key connectors and sources of support for newcomer students and families. These staff primarily included interpreters and case managers. One particularly salient example was the use of a Mam, indigenous Mayan language interpreter at one of the clinics where a notable number of students primarily spoke Mam. Having an interpreter for these families was viewed as a critical resource, not only because of her ability to communicate directly and translate, but also for her knowledge of the culture and the needs of families that had migrated from Mam speaking communities. Clinicians noted that the Mam interpreter went beyond basic interpretation in her work but also provided case support in navigating educational and service systems and cultural brokering. The interpreter had knowledge of indigenous belief systems related to health and mental health, help-seeking behaviors, and traditional practices. This kind of knowledge allows her to bridge gaps for both providers and students, helping them navigate expectations within the U.S. health and education systems and facilitating more effective services. For example, while health educators and clinicians often relied on the language line (a call-in translation service), the full time Mam interpreter

was able to share that for conversations about nutrition, health, and relationships, girls would be more comfortable with a female translator rather than a male translator.

In addition, the SBHC team indicated that case managers played similar roles, particularly for Spanish-speaking students and families. Case managers were noted to typically provide guidance and instrumental support around access to services and community resources. Furthermore, providers emphasized that case managers went above and beyond their formal responsibilities by building personal connections with students and parents by taking the time to learn about their culture and identities. They also noted that case managers had skills that included the use of normalizing and destigmatizing language around mental health, and were able provide transparency and predictability for students with respect to key aspects of adjustment to the new health and educational systems in the United States.

Identifying Mental Health Needs

The SBHC team saw an important role that their staff played in helping normalize mental health needs and creating the conditions in which newcomers could facilitate access to mental health in a trauma-informed approach. In doing so, providers elucidated the benefits and challenges of brief screeners that are typically used in integrated care settings for newcomer students and highlighted alternative approaches to identifying mental health needs.

Benefits of Screeners

The SBHC team indicated that a typical workflow is for students to complete commonly used brief mental health screening tools such as the Patient Health Questionnaire-9 (PHQ-9) for depression (Kroenke et al., 2001), the CRAAFT for alcohol and substance use (Ramos et al., 2018), and the Primary Care-Post Traumatic Stress Disorder Screen (PC-PTSD; Prins et al., 2016) during annual physical health visits. These screeners are typically administered by a medical assistant. After a positive screen, a medical provider reviews the screener with the patient and, when possible, facilitates a warm handoff (i.e., an in-person introduction) to an integrated behavioral health clinician. If not, they encourage the student to work with a medical assistant to make an appointment. The team noted that they took care to support non-English speaking students in the administration of the screeners by reading to them, translating, and using visual tools to support completion. The clinical team noted the value of this process, noting that the use of the screeners helped students reflect on the impacts of life stressors and aspects of wellness that they might not otherwise think to report to the provider. The providers noted that for newcomers, this could be particularly helpful because they may not otherwise conceptualize potentially traumatic experiences related to migration and family separation as stressors for which they may need support. They noted that because they had supported many students with other services and resources prior to addressing mental health, they thought that the conversations about more personal topics felt more natural and comfortable.

Challenges with Screeners and Alternative Approaches

Despite the potential positive impact of screeners, the clinical team noted that there were several critical challenges. In addition to language and translation-related limitations of the screeners, there was a perception of cultural and conceptual misalignment between the tools, the screening process, and the experiences of some newcomer communities. For example, even with normalizing language and supportive staff at the SBHCs, for some patients the direct inquiry about mental health may not feel comfortable and they may have concerns about sharing information that their families or they themselves see as private. In addition, several clinicians felt that the screeners were not tapping into cultural expressions of distress, such as somatic complaints and the ways that distress, anxiety, and depression may be expressed and discussed as physical experiences such headaches and sleeplessness. In response to these observations, the SBHC team talked about how they have started to make connections between physical and mental distress in the students' own language (e.g., headaches, stomach issues, heart problems). The team also has adopted a screening tool called the "Maya Toolkit" which queries about different aspects of adjustment (i.e., physical and emotional) in a way that is tailored to the Mam-speaking and indigenous Mayan communities in Mexico, Guatemala, and Belize (Czerwinski, et al., 2011). This tool can be used in lieu of or to augment traditional screening tools.

Adaptations to Evidence-Based Trauma Interventions

For over a decade, the SBHC team has been trained in and implemented several evidence-based interventions for trauma, including the Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Jaycox, 2003), Seeking Safety (Najavits, 2003), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen et al., 2006). Across interventions, the clinical team saw the relevance and utility of the different interventions and described several ways they have tailored them to meet newcomer needs. Specifically, the team highlighted three core components of the trauma interventions that they typically adapt, specifically the psychoeducation, cognitive restructuring component, and the avoidance component of the intervention.

Relevance and Utility

There was a consensus amongst clinicians of the relevance of evidence-based interventions for trauma. They saw a need for the interventions and described high rates of trauma for students in their home countries and during migration, coupled with adjustment to the U.S. and the potential for additional trauma and loss. They also talked about components of the interventions that could be tailored for newcomers. For example, one clinician described augmenting core trauma treatment components with modules from Seeking Safety related to relationships, boundaries, and how to make safe and healthy choices for newcomers and many other adolescents. Another practice that clinicians found particularly useful for newcomers was a guiding imagery meditation focused on "safe spaces."

Psychoeducation

With respect to psychoeducation, the clinicians noted that emphasizing the physical and experiential aspects to symptoms was particularly useful. They also talked about using visuals, finding alternative metaphors and analogies, and making the learning experiential. For example, one clinician described using a "pictionary" style activity, where one student drew a specific animal, and the others had to guess what it was. The clinician then explained how the animal's behavior could illustrate PTSD symptoms. For example, a startled cat showing hyperarousal or hypervigilance by bristling its fur and appearing tense. When it feels safe, the fur flattens, it calms down and goes to a more relaxed posture. For intrusion, they used the image of a crocodile lurking underwater and suddenly jumping out to grab its prey--similar to how intrusive thoughts, memories, or nightmares can unexpectedly emerge, and feel overwhelming and frightening. For avoidance, they used the metaphor of the turtle retreating into its shell protectively to not think about or deal with the difficult emotions and traumatic memories.

Cognitive Restructuring

For the cognitive component, the clinicians felt that they could discuss the connection between thoughts, feelings, and behaviors, but some of the specific cognitive restructuring strategies were more difficult for some of the newcomer students to connect with. The clinicians reported that emphasizing self-compassion statements was particularly helpful for their newcomer students to achieve balanced thinking. Clinicians also shared that for addressing underlying schemas, they focused newcomer students on "old" stories that they have told themselves about themselves or the world, and the "new" story that they can tell themselves. Another strategy was "changing the channel" as a technique to help with negative thoughts or intrusive thoughts about memories that had been triggered (similar to thought stopping).

Exposure

For the exposure and avoidance component, the clinical team reported that many newcomer students did not see avoidance as an unhelpful coping strategy; instead, they viewed avoidance as important for personal safety. Even when differentiating between the things they are guided to avoid by adults (e.g., gangs, drugs) and the kind of avoidance that is linked to trauma, this remained a challenge. Clinicians also indicated that for some newcomers there was a strong cultural norm around not talking specifically about trauma and personal experiences. As such, they adapted some aspects of the intervention model related to exposure to the trauma memory and sharing. For instance, in the first session of CBITS, students are encouraged to share the reason they are in the group. However, because of the need to build trust and the cultural norms around not sharing, one clinician indicated that she provides examples and leads a discussion of common traumatic experiences commonly experienced by newcomers (e.g., gangs, community violence, domestic violence, migration trauma) in order to bring the trauma discussion into the room. The clinician also noted that for the individual trauma narrative and group sharing, emphasis on drawing and writing

rather than verbal re-telling was often a more comfortable approach for some of the newcomer students.

Other clinicians developed strategies tailored to newcomer experiences regarding sharing personal narratives, psychoeducation, and normalizing common reactions. They did this by facilitating discussion of additional common reactions to stress and trauma and family and societal influences on these experiences. One example is a "four quadrants" activity (See Figure 1). Quadrant 1 is an image drawn from their life before coming to U.S. Quadrant 2 is anything they would like to share from their immigration journey. Quadrant 3 is a current life image. Quadrant 4 represents their vision for their future (relationships, goals, etc.). Clinicians reported that this approach is aligned with storytelling traditions in many of the cultures served.

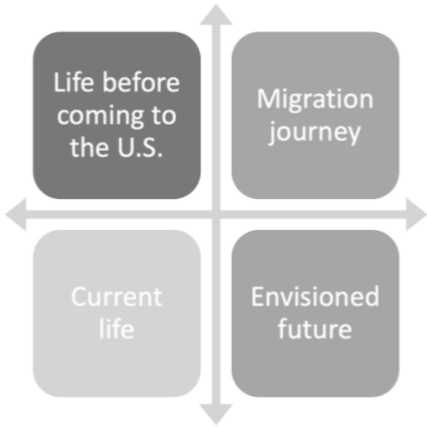

Figure 1. Four Quadrant Activity for Newcomers to Share Story of Their Journey

Processes and Organizational Support for Continuous Learning

Overarching Processes and Shared Values

Continuous learning focused on cultural humility, improvement of care, and access to care for newcomers were strong values articulated by SBHC frontline staff, supervisors, and leadership. A focus specifically on trauma-informed practice for newcomers was also evident across roles and levels of the organization. For example, the leadership team and focus group participants explained that there was a strong emphasis placed on acknowledging the impact of trauma and ensuring the newcomer students felt welcome. Sharing expertise and community, health, and educational resources within clinical teams at SBHC and across sites for cross-disciplinary and cross-site learning was perceived as highly useful and important. At a higher administrative leadership level, the data team has tracked their services to newcomers in their electronic health record systems to inform quality improvement efforts, procured training opportunities for the medical, clinical, and case management teams related to trauma and the specific needs and available supports for newcomers. Leadership and staff have also engaged in advocacy work to support newcomer communities. To illustrate how shared learning happens in the clinical teams, we

share two case examples of share learning initiatives and trauma-informed care improvement processes used by the SBHCs.

Case Examples

Example 1: Establishing an Integrated Care Workflow Tailored to Newcomers. One SBHC site has a high number of newcomer students and families, who often learn about this specific clinic and their newcomer-oriented supports from word of mouth in the community. This SBHC has developed an infrastructure, set of resources, and workflow for their own integrated medical/behavioral health/case management model for newcomer patient care which emphasizes the role of the case manager and integrated behavioral health clinician (See Table 2). The goal of the workflow is to establish a welcoming and safe environment, address immediate case management needs, and offer behavioral support once trust and safety has been established. Within this workflow, case managers' accumulated knowledge about the needs and supports for newcomer families guides practice. A team-based approach, characterized by regular knowledge-sharing, collaboration, and connection among team members, is considered essential.

Role of Case Management. As shown on Table 2, the case manager is essential to the workflow. In a typical scenario, a parent or guardian will bring a student in for immunizations for school registration. The case manager, serving as the point person, is very well versed in resources for the entire family related to jobs, food, and housing. They also have knowledge of the complexities of benefits. For example, before the SBHC established and routinized case management supports, newcomer children often lost the medical insurance they were legally entitled to in the U.S. The case manager was able to help families navigate be aware of the deadlines and the complex application process and avoid situations where the agency would not be reimbursed for services.

Table 2. Workflow for Newcomers at SBHC Site with High Newcomer Population

Referral:

- Self referral or school referrals
- Initial referral reasons include:
    - School enrollment support
    - Vaccinations for school
    - Health insurance assistance

Initial contact:

- Case manager accepts referral and contacts the family to schedule an in-person visit. Case manager will identify language preference.
    - *Note*: Most patients at this SBHC arrive from Central America and speak Mam and Q'anjob'al (Mayan languages).

Many speak Spanish as a second language. The medical assistant speaks Mam, Q'anjob'al, English, and Spanish

First case management visit:

- Case managers provide a basic clinic orientation to all newcomer patients that includes full review of health center services
    - Families are presented with a newcomer folder that includes resources the case manager will thoroughly review with them
    - Case Manager conducts an initial needs assessment
        - Immediate needs:
            - housing stability
            - food and clothing security
            - legal referrals
            - immediate needs for return to school
            - assist with insurance (*Note*: All newcomer patients arrive at the clinic Medical benefits expire after 1 month, unless they fill out an extensive application).
        - Informal discussion of medical and mental health needs:
            - Case manager builds rapport and asks about any physical health concerns that could related to mental health (e.g., "My head hurts," stomach aches, "I don't sleep well")_
            - The case manager will document any somatic complaints and current life stressors.
    - Case manager makes linkages for priority needs
        - Health care for parent
        - Other needs (bus pass, photo ID, phone)
        - Resources (English classes, library classes, employment, community supports)

Second case management visit:

- Address new priority issues
- After completing linkage to identified resources, allow patients to explore health, mental health, and other wellness concerns
- Conduct brief behavioral health assessment and provide information about behavioral health services, offering appointments or warm hand off

Integrated care referrals:

- If first visit is medical, a warm handoff is done for case management same day
- If first visit is for case management, a warm handoff for behavioral health or medical care is done during that visit or subsequent visits

Case managers are also able to attend to holistic needs for families. Even during visits that focus on instrumental supports and school enrollment processes, the team described that case managers may identify and document somatic complaints and life stressors that come up. Because the SBHC staff felt that most newcomer students are more likely to prioritize case management needs before addressing any physical or mental health needs, the case manager tended to ask about symptoms like headaches and chest pains in a way that integrates personal history (e.g., did you feel this way in your home country?) and follow up as appropriate once trust is established and initial priorities are addressed. The team reported that it is more acceptable in many cultures to discuss physical symptoms than emotional distress.

Connecting to Physical and Mental Health Care. To address these additional needs, the SBHC model emphasizes the use of warm hand-offs where the patient is connected in-person to the medical provider or clinician during the visit. According to SBHC supervisory team members, approximately 90 % of the newcomer students connected to behavioral health care using this workflow have continued with services. Although not all SBHCs have the same workflow and newcomer-focused community resources, from a shared learning perspective, the clinical providers reported that the newcomer workflow and use of culturally responsive language has informed staff across the other seven SBHCs about how they should work with newcomers when they arrive at their sites. They reported that having an established workflow that everyone can reference has been immensely helpful.

Example 2: Utilizing Workgroups for Shared Learning. Clinicians shared a concrete example of how they prioritize shared and collective learning as an organization. The SBHCs are currently developing care approaches to addressing newcomer adolescents' eating disorders, disordered eating, nutrition, and body image. The workgroup was initiated after some of the integrated behavioral health clinicians attended a training focused on how eating disorders and related issues can manifest differently and should be approached and discussed differently across non-American cultures. The SBHC team wanted to focus on how to support eating disorder identification, prevention, and care using a culturally responsive and trauma-informed lens.

The working group started by reviewing information from the training and to think about its application to their context—short-term behavioral health treatment in an integrated care context serving a high number of newcomer students and other students with caregivers from diverse immigrant backgrounds. The SBHC team indicated that because of their short-term model and lack of specialty eating disorder

expertise in their clinic, they were focused on their role as an interdisciplinary team with a goal of support students within the short-term model (i.e., psychoeducation and holistic health) and making referrals to specialty eating disorder programs if needed.

Cultural Responsiveness Strategies Developed through Shared Learning. SBHC staff indicated that even within an integrated care team, expertise can become siloed, and the eating and weight workgroup has allowed them to engage in interdisciplinary learning and integrate physical and mental health care. In this process, they identified a few core approaches that are beginning to guide their work with patients and families. The first is to be less BMI and weight-centric than is typical in the predominant medical model, conscious of fatphobia, and aware that many families have positive associations with "unhealthy" foods from their culture. The team expressed being conscious of the health implications of obesity while avoiding stigmatizing language. There was also discussion of patient self-advocacy and helping patients understand that they did not have to be weighed at every medical visit. A similar strategy was related to sensitivity about calling someone "underweight" and embracing a posture of learning and curiosity when speaking to someone about disordered eating behaviors like binging and purging.

The team felt that because of the existing mental health stigma, it was important to "slow down" and take time to learn from the patient. Motivational interviewing strategies were viewed as an avenue towards achieving mutually aligned goals of treatment and empowering students to be partners in decision making.

The third area related to health education approaches, by attending to language used, and cultural context. For example, the team talked about holistic health by using words like "intuitive eating", which focuses on natural hunger and fullness cues, rather than following rigid rules and guidelines. Health education also focuses on healthy relationships and body image. The team also talked about having a culturally grounded approach to talking about food and eating given the sociocultural role that food has for some families, specifically with food being a way to connect and show care for one another. They reported that many newcomer families may have experienced disruptions in family relationships, and food represents connections and attachment. There may also be specific past trauma that relates to hunger and food access. One clinician suggested that parents and caregivers could be included as partners under appropriate circumstances to support greater understanding of the patient's identity and continue to honor the patients' cultural practices and traditions in relation to food in the household.

Informing Specialty Care Providers about Newcomer Needs. The SBHC team indicated given that part of their role was to make referrals to specialty care, they have identified potential challenges in applying gold standard evidence-based treatment models for eating disorders to newcomer students. Because much of this work traditionally focused on the experiences and social norms of White adolescents and parents, the team hopes to develop recommendations about how family-based therapy for eating disorders could be adapted. Many newcomer students come to the

U.S. without parents or parents are not able to engage in traditional care due to high workloads, life stressors, and limited resources to apply some of the practices.

DISCUSSION

This paper offers practice-based insights into the application of culturally responsive, trauma-informed care in school-based health and mental health care, particularly for newcomer students. The paper draws on the expertise of school-based providers across eight school-based health centers (SBHCs) serving students from marginalized backgrounds. Major themes discussed by providers centered around 1) engagement in integrated care, 2) identification of mental health needs, 3) adaptation of evidence-based trauma interventions, and 4) processes and organizational support for continuous learning. The practice-based examples generated from this study offer concrete strategies for supporting newcomers. Across all themes, a consistent pattern emerged: trauma-informed practices with newcomer students were grounded in mission- and values-driven care, with collaboration and cultural humility serving as foundational elements.

Trauma-informed schools aim to create safe, supportive environments that recognize and respond to the impact of trauma on students' behavior and learning. Trauma-informed approaches in schools are often translated to school-wide policies and practice that promote relational safety, support emotional regulation, build resilience, and include evidence-based trauma interventions (Chafouleas et al., 2016). This model is especially critical in schools serving students from marginalized communities, who may face compounded adversity due to systemic inequities. School-based integrated care is a unique and informative setting to apply this model because of the connections across physical health, mental health, and education. Whether or not schools have SBHCs, schools are often frontline responders to health and mental health needs. Our findings highlight how school-based integrated care can facilitate a holistic, trauma responsive approach by addressing key social determinants of health and learning (U.S. Department of Health and Human Services, 2022).

Providers in our study noted the importance of focusing on practical issues like connections with school supports, food access, and housing resources. They also provided examples of specific principles of trauma-informed care related to relationships and trust-building, psychological safety, and cultural humility (Substance Abuse and Mental Health Services Administration, 2014). Cultural humility is an important component of culturally responsive care and refers to a lifelong process of self-reflection and self-critique whereby a provider learns about one's own beliefs, assumptions, and cultural identities. The individual also takes a posture of openness and learning about others' identities and experiences. This process of ongoing reflection and deeper learning is thought to improve the way vulnerable groups are treated (Yeager & Bauer-Wu, 2013). Although direct links between cultural humility approaches and educational outcomes are lacking, research outside education demonstrates the positive impact this has on youth and family engagement and other outcomes (Mosher et al., 2017; Slaton et al., 2023). Another subtheme that emerged was that of cultural brokering in case management and

interpretation (National Center for Cultural Competence, 2024). Cultural brokering has been documented as an essential component of culturally responsive care, but research is lacking about this practice in schools. In many schools, interpretation services are already mandated for communicating with families who speak languages other than English. This existing infrastructure presents an opportunity to integrate cultural brokering by training interpreters, bilingual staff, and mental health providers to also serve as cultural liaisons.

SBHCs were proactive in identifying newcomer students with mental health needs, noting both the advantages and the limitations of traditional mental health identification methods like screeners**.** Providers noted the importance of screeners (e.g., PHQ-9) for the identification of mental health needs, especially among newcomers. Screeners served as a type of mental health literacy tool, especially for understanding traumatic experiences as stressors. Challenges around screeners included the lack of cultural relevance (e.g., lack of somatic symptoms) and patient mental health stigma. Despite these challenges, a past study in a similar population found that Spanish-speaking students were more likely to be screened than English-speaking students (Nadeem et al., 2023), suggesting that concerted efforts by the SBHC team to focus on identification of trauma-related needs of newcomers may be yield a relatively strong rate of screener use and identification of needs.

Evidence-based trauma interventions were reported as highly relevant for meeting the needs of students. This finding is consistent with reports from other research in which practitioners perceived a strong fit for school-based trauma-focused interventions for their communities (Nadeem et al., 2018). The clinicians also expressed a commitment to using and learning evidence-based therapies; use of EBPs has been associated with reduction in racial and ethnic disparities in mental health outcomes in prior work (Lang et al., 2021). In addition, the clinicians identified ways in which they adapted or tailored specific intervention components to match newcomer students' approach to learning or their specific needs. One therapist noted using a well-received, Pictionary-like game where students took turns identifying animals that represented PTSD symptoms. In terms of cognitive strategies, therapists reported use of self-compassion statements to encourage more balance and helpful thoughts as opposed to other more traditional cognitive restructuring activities. This is consistent with prior work outlining specific adaptations to cognitive work with Latinx populations (e.g., Mercado et al., 2023) . With respect to conducting exposure work, clinicians demonstrated a thoughtful approach to the trauma narrative component of CBITS. They described structuring and scaffolding the activities (e.g., breaking the tasks into smaller parts), using different modalities (e.g., drawing), and building trust as a foundation for exposure work. Notably, although the clinicians expressed some concerns about readiness and psychological safety among newcomers, they viewed the opportunity to talk directly about traumatic experiences as important. This is notable given that prior research has shown that many practitioners perceive barriers to conducting trauma narratives (e.g., concerns about clinical worsening) and may not use them (Frank et al., 2021). In addition, clinicians reported that they incorporated storytelling traditions to support newcomer students' sharing personal journey narratives. This practice is consistent with recent

interventions for newcomers (Crooks et al., 2020; Martinez et al., 2020; Santiago et al., 2025).

Finally, analysis highlighted the specific and important role of being a learning organization committed to trauma-informed care**.** Providers emphasized that ongoing learning and knowledge-sharing was critical to improving care for all students, but especially for newcomers. They also shared that the leadership created space and time for shared learning, sought training for staff, and engaged in active quality improvement opportunities specifically related to trauma-informed practice. Specifically, our case examples highlighted the potential for workflows and working groups. The development of a structured, team-based integrated care workflow tailored for newcomer patients demonstrates how organizational leadership can facilitate innovation and high-quality care when frontline expertise is valued. This aligns with implementation science literature and frameworks highlighting the critical role of organizational readiness (support for new initiatives, shared vision, leadership engagement), leadership support, and a focus on facilitative procedures in successfully adopting and sustaining evidence-based practices (Aarons et al., 2011; Damschroder et al., 2009; Weiner et al., 2009). Interestingly, providers also emphasized the critical role of case management to optimize delivery of culturally responsive trauma-informed care. Case managers are not only crucial for connecting families to services but also for identifying physical and emotional needs in culturally acceptable ways. Consistent with studies on immigrant access to care (e.g., Hacker et al., 2015), addressing social determinants and administrative barriers is foundational to successful engagement in health and mental health services. The SBHC team's workgroup model to develop trauma-informed culturally responsive approaches to working with newcomers around eating, health, and mental health was another innovative approach that could be adopted in other educational settings as well. This approach leveraged multidisciplinary teams and cross-disciplinary learning in a way that is not unlike professional learning communities and reflective practice models used in educational settings (e.g., Machost & Stains, 2023; Vescio et al., 2008).

Limitations

This study was a qualitative study focused on developing practice-based evidence from school-based practitioners with expertise in supporting newcomer students from a trauma-informed lens. Although this focus provided an opportunity for learning and knowledge development in the field of trauma-informed schools, it also has limitations in that it may not be representative of other contexts and service models. Moreover, the study may have limited generalizability to communities that are not in large urban centers. That said there are elements of newcomer experiences and supports that are likely common across the United States and the implications for support strategies can be tailored to other contexts. We had a small sample size for our semi-structured interviews and focus groups. While this is a limitation, the project included providers with extensive experience working at each site. We also leveraged rich content and context through our partnership's existing meeting structures with leadership, allowing perspectives from a diversity of role and discipline. This approach is in line with recent research highlighting that it is possible to reach

thematic saturation in targeted studies using a small sample size (Hennink & Kaiser, 2022). Finally, and importantly, this study lacked the perspective of the young people and families that were served by the SBHCs and the schools. We also were unable to capture the nuanced experiences within and across different cultures and backgrounds, including different newcomer needs and experiences based on age of migration, reasons for coming to the U.S., language backgrounds, and family circumstances. Future research and practice-based reflections on trauma and culturally responsive practice would benefit from the inclusion of additional critical voices, and concerted efforts to ensure representation of different newcomer communities.

CONCLUSION

This study advances and deepens our understanding of how culturally responsive, trauma-informed care is implemented within school-based health centers serving newcomer students. By centering the experiences of frontline clinicians, supervisors, and organizational leaders, we identified practical strategies for engagement, identification of mental health, treatment adaptation, and team-based work grounded in cultural humility. Qualitative insights from the current study particularly highlight the importance of organizational culture and infrastructure, including a strong shared mission, interdisciplinary collaboration, and structured and adaptive workflows to guide practice and facilitate communication. Themes and examples offer strategies for schools and providers working to meet the needs of immigrant students using a trauma-informed approach. Future research should test how these culturally responsive, tailored approaches to trauma-informed care and practice improve mental health and educational outcomes.

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