Trauma Systems Therapy for Refugees (TST-R): AT-A-GLANCE

What is TST-R?

Developed at Boston Children's Hospital, Trauma Systems Therapy for Refugees (TST-R) is a multi-level, phase-based organizational and clinical model for youth who have experienced forced displacement. TST-R addresses barriers to accessing mental health services (e.g., stigma, language, distrust, primacy of basic needs). TST-R requires adequate infrastructure and partnerships to implement all tiers and phases. This includes community engagement (Tier 1), skills-based groups (Tier 2), and clinical intervention under the TST model (Tiers 3 & 4) comprised of individual and family sessions. TST-R promotes culturally responsive care by pairing clinicians with cultural brokers. Cultural brokers are members of the cultural community who (1) speak the language, (2) share similar lived experiences of the families being served, and (3) understand youth-facing service systems. Clinicians and cultural brokers are paired together dyadically to deliver services at each tier of intervention.

What are the goals of TST-R?

1. Reduce barriers to accessing mental health services for youth who have experienced forced displacement through community engagement by increasing trust and awareness of health and wellness and understanding needs. TST-R is often embedded in service systems families engage with (e.g., schools, ethnically based community organizations, etc.). Integrating cultural brokers as a core part of the treatment team promotes linguistic and culturally appropriate care.
2. Stabilize the social environment by addressing stressors forcibly displaced families often face including resettlement stress, acculturation stress, isolation stress, and traumatic stress.
3. Improve youth's emotion regulation skills, interpersonal skills, and other trauma related symptoms.

What does TST-R look like?

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Additional Information

TST-R is an organizational and clinical model; partnerships are often needed to implement various tiers of the model. For example, resettlement agencies, community mental health agencies, and schools partner together to implement all tiers of the model. Clinicians and cultural brokers work dyadically across all tiers. Tier 1 community engagement focuses on developing trust, providing education about mental health, and understanding community needs. Tier 2 skills-based groups for youth focus on decreasing acculturative stress and increasing social support. Tiers 3 and 4 are clinical interventions for youth who demonstrate significant mental health needs and include family work as needed.

What is the commitment?

Establishing trust and safety for communities who have experienced war and adversity requires significant time, sometimes years. TST-R looks at the individual child within their social environment. Clinical implementation, which includes safety-focused, regulation focused, and beyond trauma phases of treatment can range anywhere from several months to several years. All children and families go through assessment, treatment planning, and treatment engagement which can take up to one month. Caregivers and children may be asked to participate in assessment including interviews and an agency's own clinical measures. Time commitment can vary depending on severity and need.

1. Community engagement events or activities (Tier 1), are held, on average, two to eight times each year by TST-R sites;
2. Skills-Based groups (Tier 2) run weekly over the course of 8-14 weeks; and
3. Clinical interventions (Tiers 3 and 4) may range from several months to up to several years.

LOCATION:

In client's home, In a provider's office, Virtually/via telehealth, In a school, In a community setting

How do we know it works?

TST-R has Practice-based evidence, Research evidence, and Program Evaluation to support its benefits.

TST-R was adapted from TST (Trauma Systems Therapy) to address the specific needs of youth who have experienced forced displacement. TST was inspired in part by Bronfenbrenner's social-ecological model (Bronfenbrenner, 1979), which acknowledges the complexity of the social environment that surrounds an individual, and how disruptions in one area of the social ecology may create problems in another. Interventions in TST are designed to work in two directions: strategies that operate through and in the social environment to promote change, and strategies that enhance the individual's capacity to self-regulate. TST has been adapted for refugee/immigrant populations (i.e., TST-R). TST-R focuses on the experiences of trauma that forcibly displaced populations face, from pre-migration, during migration, during resettlement, and beyond. Community engagement, skills-based groups, and the inclusion of cultural brokers as core members of the treatment team are all key adaptations of the TST model for refugees and immigrants.

TST-R was developed in collaboration with community members and cultural brokers from various cultural groups, including Somali and Bhutanese populations. Target populations for TST-R include newly arriving, recently resettled, and established refugee and immigrant youth and communities. At the core of TST-R implementation is a multidisciplinary team that emphasizes the inclusion of community stakeholders (e.g. teachers, spiritual leaders, community advocates, case managers, etc.) in treatment implementation. Because of the strong emphasis on community engagement and participation, TST-R is applicable across diverse cultures and communities. Skills-Based group protocols (Tier 2) have been formally adapted and delivered for Central American, Bhutanese, Somali, and multi-ethnic cultural groups. With thoughtful cultural broker and community stakeholder involvement, TST-R can plausibly be tailored for any refugee/immigrant population. While most commonly delivered by a clinician and cultural broker, some programs have delivered Tier 2 groups with two cultural brokers or with classroom English Language Learner teachers, alongside clinician consultation.

TST-R: THE EVIDENCE

What types of evidence are available for TST-R?

- ❒ Best Practices
- ❒ Practice-Based Evidence
- ❒ Promising Practices
- ❒ Community-based Participatory Research
- ❒ Culturally and Socially Embedded Practice Based Evidence
- ❒ Program Evaluation

Where can I learn more about the evidence?

- Trauma and Community Resilience Center at Boston Childrens Hospital Interventions webpage
- Miller, A. B., Davis, S. H., Mulder, L. A., Winer, J. P., Issa, O. M., Cardeli, E., & Ellis, B. H. (2022). 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. https://psycnet.apa.org/doi/10.1037/tra0001392
- Abdi, S. M., Miller, A., Agalab, N., Ellis, B. H. (2022). Partnering with refugee communities to improve mental health access: Going from "Why are they not coming" to "What can I (we) do differently?". Cultural Diversity and Ethnic Minority Psychology, 28(3), 370–378. https://doi.org/10.1037/cdp0000476
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- 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.
- Saxe, G. N., Ellis, B. H., & Brown, A. D. (2016). Trauma systems therapy for children and teens (2nd ed.). Guilford Press.
- Ellis, B.H. et. Al (2019). Mental Health Practice with Refugee and Immigrant Youth; a Socioecological Framework

How is TST-R measured in real time?

TST-R provides recommended measures, however specific measurement tools are at the discretion of the site. Tier 1 focuses on trust and engagement. Tier 2 focuses on social belongingness and acculturative stress. Tiers 3 and 4 focus on assessment of mental health symptoms and stability in the social environment.

What changes for the better as a result of TST-R?

Refugee and immigrant families have greater trust and engagement with mental health services. Youth have a greater sense of social belonging and decreased acculturative stress. Youth gain skills for regulating their emotions. Caregivers and other important adults in the social environment are more trauma-informed so that youth and family are able to reach their goals.

> ***"I feel respected by the team and my family is doing better now. Having someone who understands the things we have been through and speaks our language has helped."***
>
> – Father of 16-year-old Congolese boy; Tiers 3 and 4.

What do the numbers tell us (i.e., quantitative data)?

(1) increased engagement with mental health services; (2) decreases in traumatic stress symptoms; (3) increases in effective psychosocial skill building; (4) increased capacity and sustainment for responsive systems.

What do the stories tell us (i.e., qualitative data)?

TST-R programs report high engagement with families. Families report feeling understood by TST-R treatment teams and that they see their child's behavior through a trauma-informed lens, rather than as "bad behavior".

TST-R: ADAPTABILITY AND ACCESSIBILITY

- **What is the history of TST-R?**

  TST was developed in 2003 by Drs. Glenn Saxe, Heidi Ellis, and Julie Kaplow at Boston Medical Center for youth who have experienced traumatic events. During Dr. Ellis' practice, she noticed that her refugee clients did not attend therapy sessions. This led her to conduct research on the barriers that refugee populations face in accessing mental health services. Results included stigma, distrust of authority, lack of providers who speak their language, and the need to prioritize basic needs over mental health needs. In partnership with Somali community members in Boston, TST was adapted for refugee and immigrant youth that directly addressed these barriers, becoming 'TST-R'. Two additional tiers of prevention (community engagement and skills-based groups) as well as cultural brokering across all tiers were added. Since that time, TST-R has continued to evolve across the United States and Canada, serving communities from around the world.

- **How did TST-R developers proactively reach out to, center, amplify, and learn from the voices of those most impacted by racism and trauma?**

  Developed through an academic and Somali community partnership, TST-R leveraged a community based participatory approach to a community-identified issue (youth struggling behaviorally in school). Initial model developers included Somalis with lived refugee experience and an advisory board of Somali mothers. TST-R was designed to center, amplify, and learn from communities it seeks to serve.

- **What is the role of TST-R providers in tailoring the model for individuals, families, and communities?**

  Site-specific and culture-specific tailoring occurs in the context of consultation to ensure effective, culturally responsive delivery, while maintaining fidelity to the model. More broadly, the TST-R National Advisory Board, comprised of TST-R programs across the nation, creates a space for providers to discuss challenges and solutions for TST-R Model implementation.

- **How are lessons learned from individuals, families, communities and providers used to keep improving TST-R?**

  The TST-R Implementation and Science and Practice Advisory Board and the National Community Advisory Board, comprised of TST-R clinicians, cultural brokers, and program leaders create a structured space for bidirectional feedback and model improvement with the model developers. Providers are also in regular contact with the TST-R consultants to discuss challenges, solutions, and lessons learned.

- **Resources and materials are available:**

  - Materials are available in more than one format: TST-R powerpoint slides, a TST-R workbook with case examples and completed forms, and TST-R training videos demonstrating the role of the clinician and cultural broker dyad as well as implementing specific TST-R clinical concepts. Information on the original model, TST, is available as a published book and on the NYU/TST website.
  - For more information, contact: tcrc@childrens.harvard.edu

TST-R: PROVIDING, SUPERVISING, TRAINING, AND SUSTAINING

TO PROVIDE TST-R

Provider prerequisites:
- Experience: Varies for clinicians/cultural brokers; See page 6
- Education: Varies for clinicians/cultural brokers; See page 6
- Licensure: Varies for clinicians/cultural brokers; See page 6

Trained providers can:
- Deliver TST-R
- Trained providers can deliver model within their own organization. TST-R is both an organizational and clinical model.

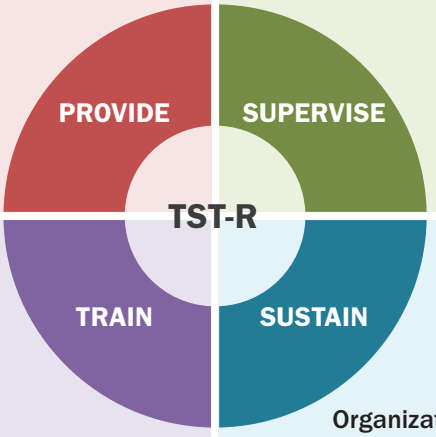
Access for Provider Training:
- Live in-person training
- Live virtual training
- Pre-recorded training
- Consultation
- A training manual

TO SUPERVISE TST-R

Supervisor prerequisites:
- Meet provider prerequisites
- TST-R trained, interest in forcibly displaced youth
- Willing to supervise the dyad using TST-R model

Trained supervisors can:
- Supervise others in TST-R

Access for Supervisor Training:
- Through consultation



TO TRAIN TST-R

Trainer prerequisites:
- Meet Provider and Supervisor prequisites
- At least one year providing or supervising TST-R
- Trained in TST-R, co-train/observe with TST-R consultants, complete the train-the-trainer process

Approved trainers can:
- Train within their own organization

Access for Trainer Training:
- Live in-person training
- Live virtual training
- Pre-recorded training
- Consultation
- A training manual

TO SUSTAIN TST-R

Organization prerequisites:
- Assessment of readiness and fit
- Protect time for providers to participate in TST-R training and implementation
- Maintain communication with TST-R consultants

Organizations can:
- Maintain diverse funding streams (e.g. billing mechanisms, grants, in-kind, etc.) to provide services across all four tiers
- Train new staff on the job by in-agency TST-R trainers
- Commit to cultural responsive and trauma-informed care

Access for Organizational Readiness Supports:
- Connection to other organizations using TST-R model

TST-R: MORE ON PROVIDING, SUPERVISING, TRAINING, AND SUSTAINING

PROVIDE TST-R

- **Training cost:** TST-R implementation is typically multi-year and includes training and consultation to teams, not individuals. Cost varies and is determined by organizational needs and program size.
- **Time Commitment:** TST-R requires teams to commit to multi-day training and regular consultation across implementation. **Additional Details:** Clinicians: Minimum master's-level, on an independent license track, experience working with youth. Cultural brokers: Minimum high school diploma or equivalent, members of the cultural community being served, with linguistic and cultural expertise and shared lived experiences.

SUPERVISE TST-R

- **Training cost:** TST-R full team training includes supervisors. Cost estimates include supervisor training and consultation.
- **Time Commitment:** Supervisors must attend regular supervisor consultation focused on supervision of both clinicians and cultural brokers.
- **Additional Details:** Both clinicians and cultural brokers require supervisors who are trained in TST-R.

TRAIN TST-R

- **Training cost:** TST-R Train the Trainer (TTT) process is for TST-R trained staff to become internal trainers within their organization. Program leaders receive TTT materials and consultation. The cost will vary depending on organizational need and readiness.
- **Time Commitment:** TTT includes reviewing TST-R training materials, completing knowledge assessments, shadowing trainers and/or delivering a practice training.
- **Additional Details:** Trained TST-R trainers can train internally within their organizations. A team of supervisors, clinicians, and cultural brokers are recommended to participate in the TTT process.

SUSTAIN TST-R

- **Training cost:** TST-R implementation is typically multi-year and includes training and consultation to teams, not individuals. Cost varies and is determined by organizational needs and program size. If there are questions, please contact the TCRC - Trauma and Community Resilience Center.
- **Time Commitment:** Training and consultation from TST-R consultants decreases over time across the implementation of TST-R.
- **Additional Details:** Upon completion of TTT, organizations have the tools to train, maintain supervision, sustain internal processes, and provide TST-R to fidelity.

To learn more about providing, supervising, training, or sustaining, please contact the Trauma and Community Resilience Center at Boston Children's Hospital: tcrc@childrens.harvard.edu

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