

Trauma-Informed Care and Services for Immigrant Families: A Three-Part Symposium



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Health Disparities

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EXECUTIVE SUMMARY

According to the Migration Policy Institute, in 2018 one in seven U.S. residents was an immigrant, constituting approximately 14% of the national population (44.7 million people). The number of immigrants in the U.S. continues to increase and makes immigration policy one of the most controversial political topics of debate. During the Trump administration, changes in immigration policy heightened the importance of the need to look at trauma-informed care and services for immigrants, refugees and asylum seekers. The administration used executive orders and administrative policies to create and perpetuate an environment in which racism and xenophobia are maintained and even intentionally exacerbated. The “zero tolerance” and family separation policies created a human rights crisis at the U.S.-Mexico border. The chilling effects and fears created by the public charge rule, the rescission of the Deferred Action for Childhood Arrivals (DACA) and Temporary Protected Status (TPS), increased deportations, and other anti-immigrant policies brought to light the effects of adverse childhood experiences (ACEs) and trauma in the immigration experience and their impact on health care needs. Immigrants and refugees of all ages arrive with complex and nuanced mental health histories of war, torture and strenuous migration journeys, which need to be addressed by all providers, including health care providers.

The Center for Reducing Health Disparities at the University of California, Davis, and the California Health Care Foundation partnered to put together a three-part symposium to better understand the impacts and effects of anti-immigrant policies on immigrants and their families, and to focus on trauma-informed care and services for immigrants. Keynote speakers and expert panelists highlighted current practices, approaches, challenges and recommendations in addressing the health care needs of immigrants and refugees suffering from toxic stress and a wide range of traumas.

Part I: Trauma in Immigrant Families—Public Charge, DACA and COVID-19

In Part One of our symposium, our keynote speaker Dr. Demetrios Papademetriou, who is an international migration expert, highlighted a Migration Policy Institute report that details hundreds of executive actions on immigration policy that were taken during the Trump

administration. These policies and their implementation and enforcement have created a toxic environment for immigrants, their families and our communities. Dr. Papademetriou noted how comprehensive and detailed these changes have been, and how difficult it will be to undo their damaging effects on immigrant communities.

Our first panelist, Dr. Luis Zayas from the University of Texas at Austin, highlighted how the family separation policies created adverse childhood experiences and trauma in their most severe form. Dr. Zayas explained how that kind of separation impacts not only the children, but their parents and the entire community in terms of traumatic experiences. Dr. Zayas then described some of the responses that health care clinicians have been providing, such as mental health services, but also other kinds of social supports for the families that had experienced these horrible separations.

Our second panelist, Samantha Artiga from the Kaiser Family Foundation, presented an overview of other policies beyond family separation, including the public charge policy, that also have impacted immigrant families. She shared some of the qualitative research that the Kaiser Family Foundation has done, documenting the fear and uncertainty that these families are facing and how they are decreasing their use of health programs and other services because of those fears.

Our third panelist, Mayra Alvarez from The Children’s Partnership, shared data from California about how anti-immigrant policies affected immigrant families in California. She reported findings from focus groups The Children’s Partnership convened that found evidence of this kind of trauma here in California. Ms. Alvarez provided recommendations on how children who have these experiences of trauma can be supported.

Part II: How Health Systems and Providers Can Deliver Trauma-Informed Care to Immigrant Families

In Part Two of our symposium, we were honored to have the participation of Dr. Nadine Burke Harris, our first ever California surgeon general. Dr. Burke Harris has devoted her life and career to documenting the impact of adverse childhood experiences (ACEs) on the health of children, their families and communities. Dr. Burke Harris noted that similar to trauma from incarceration, trauma from deportation and immigration detention are

equally consequential types of trauma that we should be considering. Dr. Burke Harris also recommended several helpful training, education and research resources to support trauma-informed interventions.

Our Part Two panelists focused on how health care providers could be responding to this trauma. Dr. Andres Sciolla from the University of California, Davis, described some of the clinical approaches for dispensing trauma-informed care. He talked about the response as resilience, not just individual resilience, but the resilience of families, communities and society as a whole. Dr. Sciolla emphasized there are steps that individual providers can take, both as practitioners and within their organization and their institutions, to address this trauma.

Dr. Thu Quach from Asian Health Services of Oakland talked about the additional trauma that the Asian American community has undergone because of COVID-19. Those include the anti-Asian attacks blaming COVID-19 on Asian Americans or Chinese, and the disparate economic impact early on for Chinese restaurants in Oakland's Chinatown. As a community health center, Asian Health Services quickly adapted to telehealth, as other health care providers did, in order to continue serving their patients. However, Dr. Quach also realized that clinics needed to engage directly with offering testing for the community and making sure that the community had information about COVID-19 itself. Asian Health Services launched its community testing site shortly before our symposium panel and has conducted those multilingual, multicultural services for its communities.

Our third panelist, Dr. Altaf Saadi from Massachusetts General Hospital, described the broader global framework of how trauma begins in home countries before immigrants even migrate or refugees have to flee. She noted that trauma also is compounded during transit to the United States, in addition to the types of trauma that we have seen documented in detention and in the deportation process. Dr. Saadi has worked with health care systems and providers to show how they can reduce the risk of trauma and build what she calls “immigration-informed services” that are not just trauma-informed, but also take into account the complexities of immigration and immigration law.

Part III: Financial Impacts and Policy Solutions for Trauma in Immigrant Families

Our Part Three panelists discussed the financial impacts and policy solutions for the trauma being experienced by immigrants, their families and communities. Dr.

Jeffrey Hoch from the University of California, Davis, described how to understand the economic impact of trauma, citing research indicating that the costs are in the billions of dollars from avoidable health care expenses and lost economic productivity. Dr. Hoch noted that these are lifetime costs and that we may not see the immediate financial impacts when trauma is experienced by immigrant children or young persons.

Tanya Broder from the National Immigration Law Center framed the hundreds of anti-immigrant policies of the past four years as an “invisible wall” that has been intended to keep as many immigrants as possible from entering the U.S., and then creating fear for those millions of immigrants who are residing in the country. Ms. Broder noted the many ways that immigrant communities, their lawyers, advocates and allies have fought back against these policies, and how everyone—including health care providers—has a role in opposing these anti-immigrant policies.

Finally, Cynthia Buiza from the California Immigrant Policy Center noted the significant legal and policy changes that immigrants have secured here in California to protect and defend immigrant families. These state policies have included expansion of eligibility for Medicaid to California residents under the age of 26, regardless of immigration status, expansion of eligibility for the California Earned Income Tax Credit, and most recently, a first-in-the-nation public-private partnership that will provide up to \$125 million in disaster cash assistance to California residents in the midst of the COVID-19 pandemic and economic recession. Ms. Buiza also noted the importance of California laws and policies limiting cooperation with federal immigration enforcement, as well as state funding for immigration legal services, including deportation defense.

This symposium proceedings report includes the presentations from the keynote speakers and panelists, as well as summaries of the moderated discussions with the expert panelists from each part. Welcoming remarks and closing reflections from each part are also included.

We were pleased that the symposium was attended by over 600 participants, and that it yielded discussions that have highlighted the need for trauma-informed and immigration-informed care and services for immigrants, refugees and asylum seekers. We hope that this proceedings report will be a useful reference for health care providers, social service providers, educators, researchers, funders, immigrant advocates, government officials and policymakers.

INTRODUCTION

Understanding the importance of trauma-informed care and providing these services to underserved populations, specifically immigrant families, was the topic of a three-part virtual symposium held July–September 2020. Sponsored by the California Health Care Foundation, and the University of California, Davis (UC Davis) Center for Reducing Health Disparities, the symposium explored trauma-informed care and yielded key recommendations and best practices for providing services to vulnerable populations in California.

The California Health Care Foundation (CHCF) is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. CHCF strives to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF knows that health care is a basic necessity, and it works hard to improve California’s health care system so that it serves all Californians. Because Californians with low incomes experience the biggest health burden and face the greatest barriers to care, CHCF’s priority is to make sure they can get the care they need. It is especially focused on strengthening Medi-Cal — the cornerstone of California’s safety net.

The Center for Reducing Health Disparities (CRHD) takes a multidisciplinary, collaborative approach to the inequities in health care access and quality of care. This includes a comprehensive program for research, education and teaching, and community outreach and information dissemination. The center builds upon UC Davis’ long history of reaching out to the most vulnerable, underserved populations in the region. A comprehensive medical interpretive services program helps overcome limitations in access for those who don’t speak English. Its regional telehealth network provides a high-tech link between UC Davis physicians and smaller clinics around the state that cannot afford to maintain medical specialists on staff. The center’s wide-ranging focus on health disparities includes an emphasis on improving access, detection and treatment of mental health problems within the primary care setting. CRHD also focuses its efforts on achieving better understanding into the comorbidity of chronic illnesses, such as diabetes, hypertension, pain conditions and cancer with depression.

This report documents the proceedings of a virtual three-day symposium held by CRHD and open to the public. It includes a transcript from each presentation and a moderated discussion.

SYMPOSIUM OVERVIEW

The virtual symposium was organized as a three-part event, each part focusing on a unique theme with different panel experts who provided the context for the effects of trauma on immigrant families and:

- Reported on the experiences of immigrant families regarding the chilling effects and fears created by the “public charge” rule, the rescission of the Deferred Action for Childhood Arrivals (DACA) and Temporary Protected Status (TPS), increased deportations, and other anti-immigrant policies as trauma and adverse childhood experiences (ACEs).
- Identified potential trauma-informed approaches by health care, mental health and social service providers caring for immigrant families.
- Identified the financial impact of trauma on immigrant families, and potential policy and systems changes to support trauma-informed care and services for immigrant families.

The following is a list of themes for each event and summary descriptions of the event’s focus:

Part 1: Trauma in Immigrant Families—Public Charge, DACA and COVID-19

The first symposium highlighted leaders’ perspectives on this topic, including a panel of experts who discussed the implications and influence of policy decisions. See Appendix 1 for event flyer and program.

Part II: How Health Systems and Providers Can Deliver Trauma-Informed Care to Immigrant Families

The second symposium highlighted leaders’ perspectives on this topic, including a panel of experts who

discussed the delivery of trauma-informed care, and the implications for practice and policy. See Appendix 2 for event flyer and program.

Part III: Financial Impacts and Policy Solutions for Trauma in Immigrant Families

The third and final symposium highlighted leaders’ perspectives on this topic, including a panel of experts who discussed the fiscal impact and policy solutions for providing trauma-informed care to immigrant families. See Appendix 3 for event flyer and program.

Each event included a moderated panel discussion of questions that audience members submitted using the virtual platform chat option, or questions that participants submitted during registration for the event.

Please visit <https://health.ucdavis.edu/crhd/immigrant-trauma-informed-care-and-services.html> to review the events recordings and PowerPoint presentations for each panelist.

Profile of the Participants:

The symposium attracted approximately 680 participants among its three themed events. More than 80% of participants were California residents, and almost 20% of the participants were from 20 other states. Those in attendance included community members, health care providers, social services providers, teachers and educators, staff members from community-based organizations, and government officials. The event included one or more members of 171 organizations and sub-organizations. For a closer look at further participant affiliations, please see Appendix 4 with summary charts.

PART 1: TRAUMA IN IMMIGRANT FAMILIES—PUBLIC CHARGE, DACA AND COVID-19



Photo: John Moore / Getty Images News via Getty Images

July 28, 2020

Speakers

Keynote:

Demetrios G. Papademetriou, PhD
Migration Policy Institute

Panelists:

Luis H. Zayas, PhD
University of Texas, Austin

Mayra E. Alvarez, MHA
The Children's Partnership

Samantha Artiga, MHSA
Kaiser Family Foundation

Presentation Slides: <https://health.ucdavis.edu/crhd/pdfs/events/part-1-symposium-public-charge-daca-covid-19-slide-decks.pdf>

Recording: <https://www.youtube.com/watch?v=8jrwF4ITVWo&feature=youtu.be>



Welcome everybody! It's an incredible honor to offer a few remarks in advance of what I think you'll find to be an amazing symposium. It's important, I think, to step back for a moment and recognize that immigrants who come to this country are here for many different reasons, but many of them come due to rampant gang activity, gang violence, sexual violence, impunity of all kinds of abuses. They face violence in transit, in perilous journeys to get here. And then, once they get here, they are subject to the policies of our government and our administration.

As we think about COVID-19 and what it is, showing in our failures of public health and showing how vulnerable immigrants are to all kinds of public health contagions, but also to the trauma associated with policies, such as public charge, ICE raids in workplaces, schools and community centers. The story that Edgar shared of the resilience of our DACA residents is a story of resilience.

I think the purpose of our symposium series that the UC Davis Center for Reducing Health Disparities is trying to do is to talk about how important it is to understand this toxic stress and the combined traumas that our immigrant families in California and throughout the U.S. are facing today. So, it is an incredible honor that we have at the California Health Care Foundation to help support this work.

I want to acknowledge Dr. Sergio Aguilar-Gaxiola for his leadership, and his entire team. Before COVID-19, he was very early on convening conversations about the impact of these various policies on immigrant families and communities throughout the country.

It is my distinct honor to introduce our keynote speaker Dr. Demetrios Papademetriou from the Migration Policy Institute. He is one of the foremost leaders on public policy related to migrants, immigrants and refugees in the U.S. and globally.

He has been an advisor to numerous presidential administrations in the U.S., to governments in the European Union, and to international organizations, such as the World Economic Forum and Organization of Economic and Community Development. One of his most recent publications calls for a new social contract for countries in this age of global migration to counter the fear-based nativism that we're experiencing here in the U.S. and throughout Europe. The new social contract would focus more on economic, social, and political integration and inclusion rather than on just who, how many and where we're going to allow people to stay.



Thank you very much, Dr. Hernández, for this introduction and kind remarks. And I'd like to thank Dr. Aguilar-Gaxiola, of course, and his team for all the effort they have put into making all this possible—three virtual events in a relatively short period of time. It's certainly not an easy matter and a congratulations on that. I also want to say hello to my fellow panelists and to greet all of you in the audience. I will try to do three things. We'll see how far time will take me. The first one is that I will discuss the context in which the public charge rule and its implementation must be understood.

Second, I will discuss the rule and at least one of its deeply associated policies, the affidavits of support. I will say a few things about what the rule says, what it is, its origins, what its goals are and how it compares to the last rule on this issue. Because there is nothing new under the sun when it comes to U.S. immigration policy, as you will find out. Also, that criteria of the U.S. government officials, meaning the people who issue visas abroad, as well as the adjudicators in the United States from the USCIS, the criteria they use in making judgements as to whether someone is likely to have to rely on government benefits, if they come to the United States or if they change their status to a permanent status and make a decision accordingly.

I will also say a few things about the public charge rules, likely impacts, both actual and at least one step removed the chilling effects of all this. And then, assuming that I have time, I'd like to gaze a bit into the future, what may happen next January and beyond. And apologies to all before I start, or as I'm getting ready to start. I have no good news for anyone.

This is a difficult issue, and I am afraid that we're going to have to deal with the consequences while, at the same time, trying to understand what the government is doing

and how we may protect ourselves and those who need to protect themselves. This way, they don't fall into a place they don't want to go to. I think the first statement I would like to start with is that this administration has engaged in nothing less than fundamental remaking of the U.S. immigration system.

It is important to understand up front that the U.S. immigration system is indeed a system that has an awful lot of interrelated pieces. And this administration seems to have found the key that allows you to go into the black box. Every system has a black box, and it works from there in order to move forward with its policy objectives. The changes the administration has made are both broad and sweeping, as my colleagues at the Migration Policy Institute, particularly Sarah Pearson and Jessica Bolter, have identified and made obvious for everyone to see.

When that report comes out, you should look at it in order to get a sense of how massive the effect the Trump administration has had on immigration. So, what the president is trying to do is deliver on all the promises he made. He made a lot of promises, and many of these promises focused on immigration, and he's doing that. He's doing that methodically, primarily via executive orders and actions.

Because this administration, unlike most previous administrations, understands the interlocking parts of the immigration system at the White House, rather than just the agency level, it has been particularly effective. You might ask, what about Congress? Well, Congress has, in a sense, resigned to simply look from the outside, take shots at what it is that the administration is doing and doing nothing about trying to move forward with the kind of necessary policy and legislative reforms that the United States immigration system has needed for almost 30 years (since either 1990 or 1996), with 1996 being the last year we had a fairly deep, though narrow immigration reform.

So, what has the administration done? It has—and this is in no particular order—pressured the immigration courts to streamline their decisions and increase the pace of making these decisions. Just to give you a sense of the numbers, between 2018 and 2019 there was a 40% increase in deciding cases, and a nearly 50% increase in deportations.

The second thing the administration has done is to systematically narrow access to humanitarian relief, and

we see this every day, particularly here in California. I know Davis is not at the border, but we see all this happening every day at the southern border. The third thing the Trump administration has done is to practically eviscerate refugee admissions.

Admissions stand both last year and this year roughly at about between 20% and 25% where they were in 2016. And enforcement has been dramatically increased across the board. Finally, we see that legal immigration, both permanent and temporary, has been reduced on average by about 17% since 2016. I use 2016 because that was the last year of the Obama administration. And the administration has used the pandemic as an opportunity to complete big chunks of its agenda by using public health emergency powers to stop and push back people at the U.S. borders that the president has had since 1944.

As I said earlier, there is nothing surprising in many of these actions and particularly using the economic crisis as an opportunity to try to reduce all forms of immigration, specifically with regard to the border. Asylum at the southern border has effectively ended, reducing visas including temporary work visas, but also visas for permanent residency.

And what is the administration's deep rationale? We know that just about everything the administration has

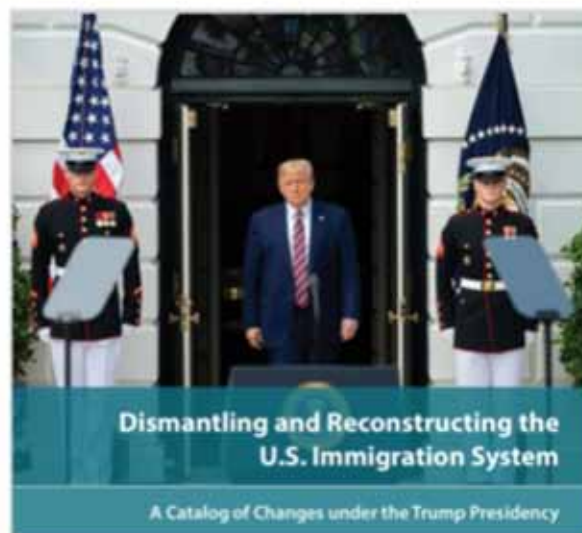
done has been challenged in court. But these pushbacks often tend to be only temporary, or drag on but hardly ever are completely resolved.

Most of what the administration started to do, even if it has had to amend what it actually was trying to accomplish, it has been able to accomplish. Moreover—and here is where the speculation gets a little deeper—the administration seems to not mind being challenged in court, but to even “welcome” some of these challenges.

And I say welcome in that the best way for people to understand the “base” of Mr. Trump’s supporters is for them to understand how hard this president is trying to deliver on his promises, not necessarily how successful he is. Is this, perhaps, perverse?

Well, I don’t know about that, but it’s certainly politically savvy, and it is the only thing that the administration cares for, particularly at this time in the election cycle. So, the political point is always front and center, including the importance of appointing judges at all levels that will support the president’s agenda. Legal challenges take time to resolve. But, in the meantime, some of the initiatives can be implemented. The administration has been willing to amend things most frequently at the margin. There is a chilling effect that goes beyond what the language of each proclamation or order actually says, and this is probably also, to a certain degree, intended.

Migration Policy Institute



And to bring this back to the theme of these three symposia, the trauma that is at the center of this meeting will only deepen. That's, I think, the context in which the public charge and its associated policies must be understood. So, what is the public charge?

It is an inadmissibility test that goes back to 1882. Since 1882, we have been trying time and again, to keep people out of the country if they are paupers. In other words, they are analphabets and others who might become a burden to the U.S. taxpayers, so keep them out of the country. There is a long history to all of these policies.

Since the 1930s, there has been something called an affidavit of support, whereby the sponsor of a family immigrant takes responsibility to support those who come, and they are financially responsible for them so they do not become a burden to U.S. taxpayers.

In case we think this is the only thing the administration is trying to do to toughen things up for immigrants, we only need to go back about 25 years to 1994 and 1996 under President Clinton, who reemphasized the importance of those affidavits of support in 1996.

That is known as the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA). So, this administration is trying to make sure people will not use benefits that are controlled by the Department of Agriculture, that they will not be able to use benefits that are controlled by the Department of Housing and Urban Development, subsidized housing, specifically, that they will not be able to use disability benefits. The administration is also pushing state agencies to actually seek reimbursement for expenses that immigrants incur in their states.

What the regulation basically says is that government officials are responsible for ascertaining a person's ability to be self-supporting. Officials in the United States or at embassies and consulates abroad will have to make decisions about the admissibility or inadmissibility of an individual applicant. If you're already in the United States, the USCIS, the immigration benefits agency, will have to make a decision as to whether someone can actually switch status and become a green card holder.

And there are two standards here. Back in 1999, there was a rule that immigrants are inadmissible to the United States if they're primarily dependent on government benefits, particularly two government benefits. One has to do with long-term care that the government has to pay for and the other one with monetary cash benefits.

The new standard focuses on the future completely. It has become whether someone is more likely than not to use certain benefits more than 12 months in any 36-month period. And the disqualifying benefits are most forms of Medicaid. There are some exceptions here, particularly things that have to do with emergencies and pregnancies, subsidized housing, and the Supplemental Nutrition Assistance Program (SNAP). This is a systematic attempt to make sure that people who come to the United States will not be a burden to American taxpayers.

There are exceptions to this, but the exceptions, which make a lot of sense, are essentially quite small. For example, refugees are exempt from this, asylees are exempt from this and members and families of the armed forces are exempt from this. There are very, very few other exemptions. In making the determination about admissibility, officials have to use five criteria. And I know this is too much detail, but I'm going to tell you what they are and then stop.

They have to look at age. The younger the person, the more likely they are to come to the United States and work. So younger is better than older. They look at health. If someone is likely to be using health benefits, that is a strike against the applicant. They look at family status. How large is your household? Is this a household of one, or two, or three or five? They look at education and skills because the assumption is that better educated and skilled individuals will also be able to be employed and do well in the United States. And they look at assets, resources and finances.

And this is where it gets quite complicated. I won't walk you through that. But although the minimum standard is having assets and resources that are 125% of the federal poverty guidelines, people are on much safer ground if they meet 250% of the federal poverty guidelines.

The logic here is to try to make sure the people who come to the United States and gain permanent status—although some temporary statuses are also included—should be, as far as the administration is concerned, not just be able to take care of themselves, but to be of that higher caliber that the White House has been trying to require, unsuccessfully in terms of legislation, since the time Mr. Trump became president.

So, what is the likely impact of all this? So far, the government has been applying something similar to that rule, even before the rule became the rule and before the

Supreme Court actually agreed that the administration could do that, which was in February of this year. In fact, the Department of State has been using similar standards since 2018. The Department of State issued 462,000 visas and denied 300,000 visas since then. But only 21,000 of those were due to concerns about the individual, the applicant becoming a public charge. So, this is what the public charge rule is all about, though a lot of people are concerned that the rule is already having chilling effects.

Although the pandemic has suspended most VISA operations abroad, the fact is the law will likely discourage immigrants already in the U.S. from accessing health, nutrition, housing and other services. And this is despite the government having said that it will not count COVID-19 tests and treatments against an applicant's petition for a change of status to a green card.

Although U.S. citizen children can have fully protected access to all of those things, a lot of parents are basically pulling their citizen children out of these support systems because they fear there might be immigration consequences that they can't imagine down the road. So that is a chilling effect. In fact, the Urban Institute

published in December 2019 the results of one of its surveys that shows high proportions of respondents were avoiding accessing non-cash benefits out of concern.

So, what about the future? There are two possible futures. By January, we'll either have a return of the Trump administration, or we're going to have a Democratic administration. We know what is likely to happen if there's a continuation of the Trump administration. So, I am not going to say anything about it. But the question is, can a Biden administration reverse all these things? Theoretically, it's certainly possible. But in reality, the same way we got to where we are, piece by piece, with intense knowledge not only about legislation, but also about rule making, and about detailed instructions to different departments' immigration policy involving the Department of Labor, Department of Agriculture, Department of State, SSA and HHS, this idea that, somehow, we are going to be able to fix all that is not realistic. It will take expertise. It will take political will. It will take resources. It will take a great deal of time and effort to fight things in court. And, of course, it will take the willingness to invest political capital for extended periods of time. And the pandemic and its economic aftermath is likely to occupy most of the attention of this next administration.

Impact of Enforcement Policies and Practices on Immigrant and Refugee Children



Our Panelist

Luis H. Zayas, PhD
Dean and the Robert Lee Sutherland
Chair in Mental Health and Social Policy
at the Steve Hicks School of Social Work,
and Professor of Psychiatry at the Dell
Medical School

The University of Texas at Austin

I'm pleased to be here with you to speak about how trauma is seen in immigrant and refugee children. My work has included studying U.S. citizen children whose parents have been deported, whether the children remained in the United States after their parents' deportation or whether they joined their parents in Mexico.

But today I want to focus, primarily, on the children who have come seeking asylum with their parents and the experience they've had along the way, as well as the impact of immigration detention and other immigration enforcement actions on them and their parents.

When we talk about trauma and children who have come here seeking asylum with their parents, we must speak about three levels of trauma. First, we have to address

what happened to them during the time they were in their country of origin and then leaving.

The next set of traumas we have to look at and assess are the experiences they had along the way, as they trek through Mexico. And then, of course, there's what happens after they come here, particularly at the hands of the U.S. government.

It is those three layers that I think are important to look at when we're thinking about the cumulative trauma of an asylum-seeking child. This is the drawing that was made for me by a seven-year-old boy I saw back in 2014 at a detention center in South Texas, called Karnes City Detention Center. They called it a family residential center, but none of us would really want our family inside of here. So, in this drawing Danny is showing me what happened in his little town in Honduras that led his family to leave.

At the bottom left, you'll see the bad guys, the gangs, who are shooting at birds and at people. Just above them is a dead man, whose face has been shot away, and that's Danny's uncle. Over to the far right, at the bottom, you see his mother who is really dismayed at the shooting of her brother. You also see his father, who is a single-leg amputee and cannot do very much. At the top, you also see his grandparents, who also are in agony at what has happened to Danny's uncle.



Detention and Separation

- Deprivation and threat
 - Determinants of detention trauma
- *Adverse Childhood Experiences*
 - Shape neural trajectories, brain development
 - Dysregulate children's stress response system
 - Impair psychological, social, emotional, academic, other functioning
- Detention
 - Adds parental distress, anxiety, depression
 - Disrupts family structures and interaction
 - Impedes sense of belonging
- Separation: Damages parent-child relationship



And, of course, look at the horrified sun that a seven-year-old drew for me on that occasion back in 2014. And he tells me he was six years old at the time this happened and that he saw his uncle's face disfigured and saw the teeth protruding from the back of his head. They immediately tried to leave, but they couldn't because his father couldn't manage the terrain on crutches. And they set out but, after two attempts, he decided to stay back and he told his wife, "Save our boys. Save our boys."

When I met Danny in the detention center, he had not heard from his father in about six months because he had been on the journey and then held in detention. So that is an idea of what happens prior to a child's departure from their country. And then we talk about what happens during the migration through Mexico. One of the constant dangers and stresses is, who do we trust?

The migrant can't really trust anybody because, say, the ice cream vendor over there might actually be in cahoots with a gang or even with the police, who are not necessarily ethical, trustworthy people in the journey. They have to deal with criminal organized gangs. Children see violence and death. They will see the remains of people who have died or who have been killed along the way, and they suffer all sorts of indignities and imprisonment, deprivation, intimidation, physical abuse, sexual abuse and all forms of depravity. The third level of trauma is what happens to them when they arrive in the United States. In these pictures, you see the places that are called hieleras.

These are places the immigrants are held in for the first 72 hours when they arrive after they've been apprehended by customs and border protection, or the immigration and customs enforcement. They're kept in these places for 72 hours. The air conditioning is kept at about 50 to 55 degrees. Lights are on for 24 hours. As I mentioned, they just arrived after a long trek, their clothes are dirty, their bodies are sweaty. They want to shower, but they don't get anything for 72 hours, not even a chance to shower.

And there's meager food, bologna between two slabs of bread and one toilet for all 30 or so people packed in there. The half walls in the rear of the room are exposed bathrooms where they will have to do their business in the presence of 30 other people. From there they go on to detention.

As Dr. Papademetriou has said, there have been many policies implemented over the years, but in the time

I've been working in evaluating children in detention, we've seen many more policy changes and executive orders. We've seen the creation of a detention center. In the summer 2018, the Zero Tolerance and Family Separation Policy was established. And then in the fall of 2018 there was the threat of indefinite family detention, which is actually becoming a reality. Families are being held much longer than they should. Between January 2017 and June 2020, there have been 50 major executive orders, policies and court decisions.

In the time since COVID-19, there have been 48 policy changes. Some of them are temporary and necessary because we want to prevent the spread of COVID-19, but we don't know how long they're going to be imposed. But many others are used as a pretext for dramatic immigration restrictions. I think this is the kind of problem our young people are experiencing. As those working with this population, we have had a level of secondary trauma. I recommend a report by Physicians for Human Rights, because it talks about the long-term effects of family separation and detention.

When we talk about detention, we're talking about two threats. One of them has to do with deprivation during detention. It is the absence for children of developmentally appropriate and expectable environments with input and experience. For example, riding a bike, going to school, joining your family at church, going to the store and shopping. When you're in detention, all of that is gone. There's also the persistent threat by guards and other staff on the child, an experience that threatens the child's sense of psychological security as well as physical integrity.

The children may be in detention and they may not be harmed, but they don't know what will happen to them. The idea is that many of these prison guards are threatening children and scaring them off. Most of you will have heard about adverse childhood experiences (ACEs), and we know that they shape the development of the brain—the trajectory, the wiring and the architecture of the brain.

And when children are piled up one on top of the other, over time they develop a chronicity and have greater damage to their psychological, social, emotional and other functioning systems.

I want to talk, specifically, about what happens with the children's attachment after being in detention and during family separation. We know that attachment is

a fundamental human bond between child and parent. And we also know when there's a secure attachment, the child shows confidence, joyful reunion and interaction with their parents. Those of you who've been parents, babysitters, uncles, or grandparents know that when your child is securely attached they run to you, into your arms, and it feels good. That results from good emotional, behavioral, cognitive and social outcome. But when there aren't secure attachments, we might see some problematic reaction.

One of them is what we call avoidance, when the child expects the rejection from the parent upon reunion and they avoid the parent rather than seeking proximity. They stay away because they want to reduce the chance of conflict or the possibility of rejection, yet again, by their parents. Or they may demonstrate more ambivalent behavior, in which children are uncertain of the parents' response to them, and they begin to display passive or angry resistant behavior when the parent responds to them. The child is, again, ambivalent and not comforted by the parent.

This video shows an example of a child who is demonstrating an insecure attachment reaction. He's reuniting with his mother for the first time after three months of being separated at the border. He and his father went in one direction, and his mother and baby sister went in another direction.

I want you to watch this video carefully. Look at what Sammy does. You'll hear the mother but look at what Sammy's behavior is saying. He's expecting her rejection, and he really does avoid her.

The video shows that Sammy didn't want to talk to his mom. She was trying to hold him, and he's drawing away after three months of separation. A securely attached child would be wanting to hold on to mom for safety and comfort. He then walks towards his father and, for a second there, when I first saw this, I thought, "Well, maybe he's reaching for the security of his father." But no. He goes between the legs and then continues on.

This is a tragic result of a family separation policy that was inflicted on people in 2018 by the Trump administration. You can hear the outcry that follows afterwards. They said it was discontinued, although there's still evidence that children are being separated. Notice how dad holds on to the baby girl he hasn't seen in three months. He is just overwhelmed and needs to hold on to her. In the next case, we see an ambivalent reaction to the separation. This a boy who'd been in the shelter with his mother, they had been in detention. They were then separated, and they were now reunited. He's not really sure about her affection. Does she love him? Does she not? Will she protect him? Will she not? And then he also berates her, because his attachment has now been disturbed. He's angry. He's resisting. So,

The University of Texas at Austin
Steve Hicks School of Social Work

WHAT STARTS HERE CHANGES THE WORLD

Case 1: Insecure-Avoidant

Boy reuniting with mother, separated for 3 months

- Expects rejection
- Avoids caregiver



UC DAVIS HEALTH

Urgently need services

- Medical care
- Psychosocial assessment and diagnosis
 - Reactive Attachment Disorder (313.89)?
- Psychoeducational services for parents
- Parent-child interaction therapy
- Educational assessment and intervention
- Social integration in community

ladies and gentlemen, this is how social policy burrows down to the core unit of our society—the parent/child interaction.

I'll just end on what we need to do, besides changing policy, which will take a long time to disassemble. As Dr. Papademetriou mentioned, our young people and their families need medical care. I think we really need to attend to their psychosocial assessment and look at what will happen to them after this detention and possible separation.

We could think about the possibility of a reactive attachment disorder, which happens when a child is suddenly separated, neglected, perhaps sudden and repeated changes in the care of their providers. They can manifest ambivalent, emotionally withdrawn behavior towards a parent—something like we've seen in both of these videos—and very limited positive affect with the parents, and then episodes of irritability and sadness or fearfulness.

That's what happened in the second video. The boy in the earlier video didn't, but the longer video shows him playing with his mother. At the moment there's a problem, some conflict between him and his mother, it triggers the ambivalent attachment reaction. As

clinicians, we need to think about how we bring parents and children together.

We have to educate parents. We need to explain what happened to their child and the reason for his or her behavior to take the guilt off the parent. We need to explain that their child is reacting to the damage that was done by current immigration practices. And then we have to engage in how we can repair that parent/child relationship. In the case of Sammy, the first boy, how do we work with that mother so she doesn't chase after Sammy, but be there as a comfort source that he can return to and gradually come together or, in the other boy, who can learn to trust his mother fully again? Again, we have to consider the trauma that has been formed is detention separation, the migration process will affect their learning and, therefore, good educational assessments and interventions are necessary.

I think we've got to do what we can to integrate them into our social settings, into our community, schools, churches, after-school activities, taking them out, riding bikes, being alone with friends and doing what normal kids should be doing.

Thank you very much, and I'm happy to answer questions.

Health and Social Needs of Immigrant Families Amid the Shifting Policy Environment



Thank you to Dr. Aguilar-Gaxiola and the entire team at UC Davis for the opportunity to join you all today. For those of you who don't know the Children's Partnership, I hope you get to know us. I have the honor of serving as president of the Children's Partnership. We're a statewide policy and advocacy organization, specifically focused on child well-being, and our job is to, first and foremost, advocate for children and to ensure that their well-being is considered in the policymaking process. Much of our work in the 25 years that we've been in existence has focused on technology and health care access.

Over the past few years, immigration has really emerged as an issue that is intricately connected to health and well-being for California's children. What I have the good fortune of doing is following my esteemed panelists and really bringing it home to California, focusing on who our kids are.

I'm going to begin by grounding us in that. Across the country one in four children are part of an immigrant family. Yet, in California, half of our nine million children have at least one immigrant parent.

In thinking how we can best support the health and well-being of California's children, we as advocates knew that we needed to consider how immigration was impacting every aspect of children's lives. I want to pause for a moment, because it's important to consider who our immigrant families are and where they come from. We know that children and immigrant families are a key driver of U.S. child population growth, but they're also a key driver of the increasing racial and ethnic diversity of our communities. Latin America, as most of the media demonstrates, continues to be the region

of origin for the parents of the majority of children of immigrants in California, as well as nationwide. About a quarter of parents of children in immigrant families are from Asia, and roughly 7% to 8% are from Africa. And what's interesting to note is that the number of African immigrants has almost doubled in the last 10 years.

As we work to collectively change the narrative on immigrants in this country and what we can do to better support immigrants in our communities is to make clear the diversity of our immigrant community so that we can better address the intersectional nature of the challenges children and immigrant families face. I want to remind us, again, the federal climate of anti-immigrant efforts that this administration has really advanced.

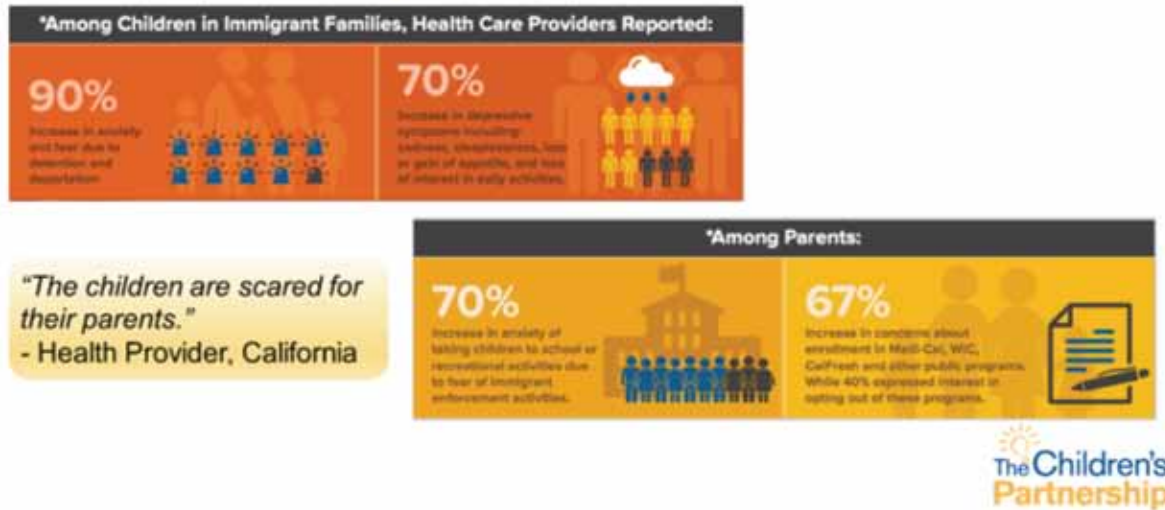
The Children's Partnership wondered what was happening in the state of California that may have pushed back against these federal actions given our state leadership. We know that over the last few years, and particularly last couple of decades, there's been a marked shift in California and its sentiment towards immigrant communities. California has demonstrated a very different approach than the federal government, one focused on inclusion and community for immigrant families.

That's been advanced by multiple state leaders. The attorney general has lawsuits in the double digits pushing back on anti-immigrant policies. We have a state legislature that has put forward multiple efforts to try and advance immigrant inclusion, thanks to the leadership of many of our immigrant-serving organizations and community partners.

The governor has put forward efforts to increase funding for mental health services for immigrant communities. Recently, in response to COVID-19 and this period of physical distancing, the governor's disaster relief assistance for immigrants program has been implemented in partnership with community organizations to support undocumented immigrants. Our budget has reflected continued investment in coverage programs for immigrant communities, including many undocumented immigrants.

While we definitely have more to do, there is a clear understanding in California that immigrants are part of our community. They are part of our families. They are

California Data: Provider Perspective



part of what makes California run. And because of that, we want to make sure we prioritize their well-being. We at the Children's Partnership wondered if that made a difference. Did it provide a buffer to what federal actions are doing? Were there protections in California that enabled immigrant communities to not be traumatized, to be able to lead healthier lives?

We had the opportunity to partner with our leading immigrant rights organization in California, the California Immigrant Policy Center, to create a multipronged research effort to explore whether in its state-level policies and inclusive agenda California was making a difference.

We've heard from our health center partners, our community partners, after-school partner colleagues and education leaders that kids are continuing to be worried. Families are paralyzed and communities are in need of support, and we wanted to ensure that there was data that demonstrated that here in California. So, in our partnership with CIPC, we started a project called Healthy Mind, Healthy Future to explore these impacts, specifically on children and immigrant families and, even more specifically, children in the interior.

I want to give credit to the many partners that enabled this project to come to life: kidsdata.org, California Primary Care Association, a number of our immigrant-serving organizations across the state whose collaboration really truly made this project come to life.

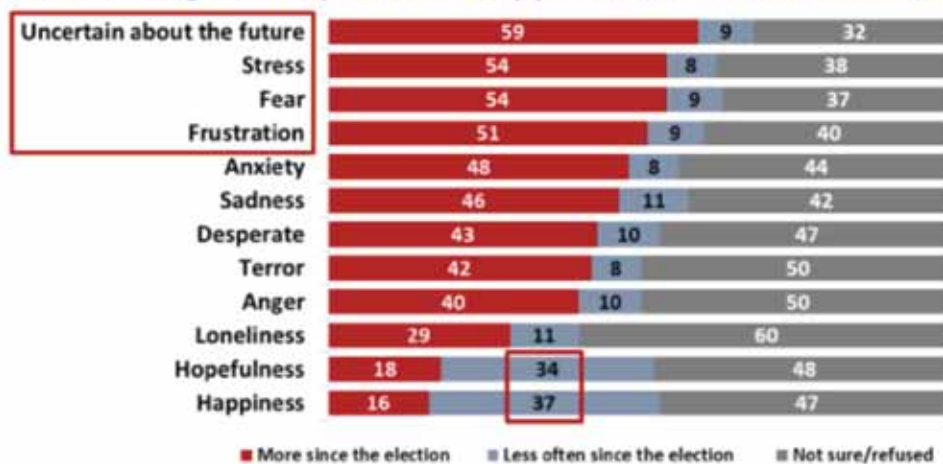
We conducted a survey of over 150 providers in California in partnership with our California Primary Care Association, which represents community health centers across the state. We found that many children and families were experiencing increased health and mental health needs while, at the same time, experiencing higher barriers to accessing care due to fears of detention, deportation and family separation. Ninety percent of providers reported seeing an increase in anxiety and fear among children.

Among parents, 70% of the providers reported observing increased anxiety in doing everyday activities, like taking their kids to school or to the park for fear of immigration enforcement. About two-thirds of the respondents observed an increase in families' concerns about enrolling in public programs, like Medi-Cal, CalFresh and WIC.

To better understand how families were faring, we did a survey in partnership with Lake Research Partners that we distributed to immigrant parents across California. About 500 immigrant parents responded to the survey that asked about their goals and challenges, recent behaviors and recent changes in behaviors and emotions, and community safety. It was conducted in 2017 and 2018. The shift occurred after the election when we had seen and heard from our community partners.

A plurality of parents said that their immigration status and President Trump are the biggest barriers keeping

Family Survey: A majority of immigrant parents think their children are experiencing more uncertainty about the future, stress, fear, and frustration since the 2016 election. At least a third think their children are feeling less hopeful and happiness since the election.



Now think about your children. Please indicate if you think they are feeling this emotion more often or less often since the election for President.

them from meeting their personal goals, as well as the biggest obstacles to their children achieving their goals. When we conducted the survey in the previous year, immigrant parents reported that they did notice a change in their children’s behavior. And of those that noticed the change, the majority believe that it was a result of what they had been hearing about immigration from President Trump, given this anti-immigrant rhetoric that was happening at the national level.

Survey results also told us that parents believe their children are worried about their safety. They’re stressed about the well-being of their family, they exhibit increased fear and anxiety, and they believe their children are worried about their family or someone they know being separated due to detention or deportation. When we asked where immigrant parents feel most comfortable and where they feel safe, they told us they feel safest in their homes.

Their churches or places of worship also rose to the top as locations where they feel safe from immigration enforcement.

However, it’s important to know that one in five parents reported feeling unsafe no matter where they were in the community. In general, since the 2016 election, the majority of immigrant parents say they felt uncertainty

about the future, stress, fear, frustration, anxiety and that they felt those emotions more than they did before the election.

A third of the parents said their children felt less hopeful and happy since the election. In addition to the survey, we worked with Lake Research to conduct focus groups of immigrant families. We focused primarily on areas in the state that were away from urban centers to try and determine if living in suburban areas or rural areas may have played a role or made a difference in the lives of immigrant communities.

Immigrant parents in the focus groups expressed mixed emotions about the current direction of the country, with most expressing confusion and frustration about what was happening. The focus groups also included children of immigrants. What was shared really captured what Dr. Zayas and Ms. Artiga commented on in their presentations, that it’s the trauma-inducing activity that our children are facing on a daily basis of uncertainty, fear and an inability to simply exist.

The Latino young man in Riverside captured it best when he said it’s like hanging from a string that can be cut at any time. We’re thinking about how the trauma and daily fear that these young people are experiencing hinders their healthy development overall.

As the administration went on, we actually followed Kaiser Family Foundation's lead and really tried to estimate the impacts of the public charge regulation here in California to determine what would happen to the work California had done to enroll more immigrant communities, more immigrant families into these public programs.

We partnered with kidsdata.org to do a state-level analysis, following what Ms. Artiga discussed. We found that an estimated 311,000 children would lose access to Cal-Fresh or SNAP, which is the food stamp program, despite remaining eligible because of the chilling effect that public charge has ensued.

An estimated 628,000 children would lose coverage from Medi-Cal, Medicaid or CHIP, despite remaining eligible. I want pause on that one in particular because California has done a tremendous job over the last couple of decades to boast that we had the lowest uninsured rate of children in the country. And yet, because of these anti-immigrant actions we're moving backwards. Children are dropping from the roles because of the fear and uncertainty associated with enrolling in public programs and what it may do to their parents' immigration status or what it may inflict on an application later on.

While this administration is trying to direct them at immigrant adults, the policy changes are having far-reaching consequences for child health and well-being, which highlights just how connected our families are

and how they must be considered in policy development. Finally, we also conducted focus groups around public charge and immigrant families to better understand what was happening, particularly around Latina, Black and API immigrant parents.

The concept of public charge, as we can expect, was familiar to more respondents, but many didn't know the exact details. Many had heard from friends, considered it mean spirited, ruthless and uncaring, and really identified that there was this anti-immigrant sentiment at the national level that it would harm families and communities. That reiterated what we know to be true, that there are negative impacts on access to critical health and social services for immigrant families.

I will close by showing what we have termed as high-level recommendations in our work moving forward. In particular, really thinking through what we can do as individuals, as community members, as policymakers to better support children and immigrant families. Because we know much of the damage is already done. These policies, whether they're in proposed form or on hold because of COVID-19, are really thinking through the damages to our families as a result of the anti-immigrant climate that's been established.

How can we strengthen community safety so that families feel secure and supported? How do we implement laws like AB 699 that require welcoming environments

Focus Groups: Immigrant families and their children feel unsafe and uneasy

"As a mother, I am worried. It keeps me up at night. Because of the president, Mr. Donald Trump, the kids are learning how to hate."

Latino immigrant parent, Riverside

"It's like hanging from a string that can be cut at any time."

Latino young male (16-21), Riverside

"I mean right now I feel like I live in Third World country. You know like in a camp sometimes the guard comes and catches people and sends them back."

API immigrant parent, Fresno

"I am scared that someone wants to remove me from my house... I may be at a store with my children and they arrest me, that is something that worries me."

Latino immigrant parent, Fresno

in schools in California for immigrant families? We need to Invest in community-based approaches and a community-based workforce.

This is particularly important knowing that community members, like promotores and community health workers have the trust of our communities. How can we sustain those workforces for the future to ensure that immigrants are better taken care of? We need to improve access, coordination and integration of services. Ms. Artiga highlighted this. How can we build and create community linkages between education and mental health services, and between legal services and health centers? Where are there safe spaces that immigrant families consider? How can we make sure that we're not adding additional barriers to accessing the services they need to be successful?

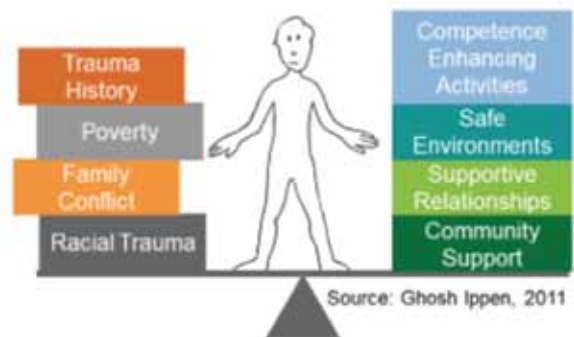
We need to build capacity of providers and educators that serve immigrant families so that they know their

rights, and they know what is and isn't true as far as legal protections for immigrant communities. And, finally, we need to educate and engage our communities about immigrant rights and building public will to take action because it really is on all of us to ensure that we're creating a community, a state and a nation that reflects our values.

I will close by emphasizing that immigration policy is a children's issue. It's multifaceted and with COVID-19 and the impact on immigrant communities, it really highlights just how vulnerable many of our families are, but also how strong and resilient they are. We need to think through what we can do together to support immigrant families, their children and the economic future of all of us given how connected we are. The well-being of children today is what impacts the future for all of us tomorrow. Thank you.

Supporting Child Wellbeing

- Strengthen **Community Safety** to Ensure Children, Youth, and Families Feel Secure and Supported in their Communities
- Invest in **Community-Based Approaches and a Community-Based Workforce** to Support Immigrant Families
- **Improve Access, Coordination, and Integration of Services** to Reduce Barriers for Immigrant Families
- **Build Capacity** of Providers, Educators, and Others Who Interact with Immigrant Families
- Educate and Engage Communities about Immigrant Rights and **Build Public Will** to Take Action



Healthy Mind, Healthy Future: Supporting Children in Immigrant Families



Thank you so much for having me here today. I feel really honored to be part of this conversation. A lot of the topics that are included in my presentation have already been touched on, so I'm going to try and move quickly through some of those.

For those of you who are not familiar with the Kaiser Family Foundation, we're a nonprofit organization that produces health policy research and analysis focused on the biggest health issues affecting our nation. All of our information and research is available publicly through our website at www.kff.org. So please feel free to search through the materials we have available there. I really just want to start, again, by providing the framework

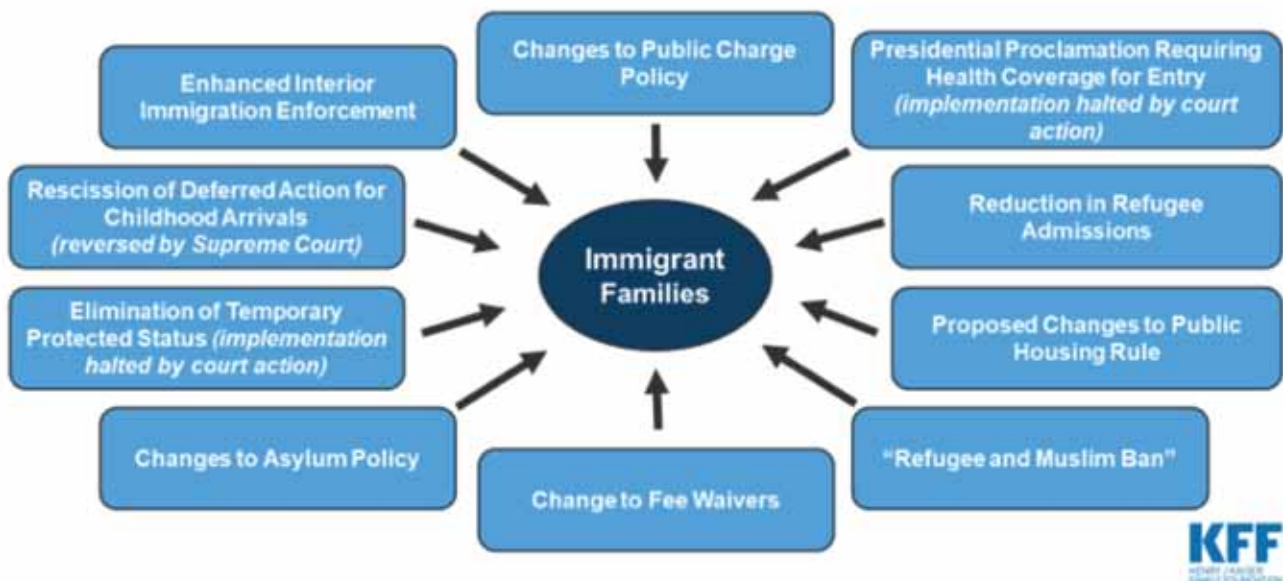
of just how much pressure is affecting immigrant families today due to the shifting immigration policy environment, and we heard some of this upfront.

There is such a broad array of changes that have been implemented under the Trump administration through different authorities. I think, even for us who are experts, it is difficult to keep track of all these policies and who they affect. I can only imagine how confusing and fearful it is for families, but really, if we look across these policies, we see three key themes.

The first is really restricting who and how many people can come into the United States, enhancing immigration enforcement actions, and then restricting access to public benefits. I think, as a family, across all these policy changes, we really feel those common themes. Over the past several years, KFF has engaged in a broad body of work that is designed to examine the impacts of these policy changes for both families and communities.

This has included a series of focus groups and interviews with families, as well as discussions and interviews with a broad array of service providers across sectors. Much of that work was conducted in California; in particular, with support from the Blue Shield of California Foundation. In addition to that work, we have also been

A broad range of policies are affecting immigrant families.



Growing fears and uncertainty are negatively affecting the health and well-being of families.

- Leading to changes in daily life and routines
- Increased mental health needs, including anxiety and depression
- Enhanced economic pressures, including difficulty affording food and other basic needs
- Provider concerns about long-term consequences on health and unrealized potential among youth
- Fears and feelings of uncertainty extend to those with lawful status

"We feel that in any moment a new rule could be issued leading to expelling us and sending us back." Arabic-speaking Parent, Anaheim, CA

"Before, there were many kids in the parks... but now... the kids spend more time inside these days, because we are afraid of being deported." Parent, Boston, MA

"I mean these kids are always fearful, always thinking their parents are going to be deported, constantly in trauma." Legal Services Provider, San Diego, CA

"When you're worried every day that your parents are going to be taken away or that your family will be split up, that really is a form of toxic stress... we know that it's going to have long-term implications for heart disease, for health outcomes for these children in adulthood." Pediatrician, MN



doing analysis of the implications of the public charge rule, specifically for enrollment in Medicaid and CHIP and use of health care services.

Across that body of work, we have just seen, consistently, a shifting in the policy environment has had really wide-ranging and significant impacts on both families and communities. One of the key themes that stood out across all of this work is the extent to which families have experienced significant increases in fear and uncertainty, and the extent to which that it's negatively affecting their health and well-being. I'll actually start with the last bullet here. I think you know we've been very focused on some of the issues affecting families who are recently transitioning into the country. But some of these feelings of fear and uncertainty extended to families who have been in the United States for decades and they cross all different immigration statuses to include people who already have green cards. There's a lot of uncertainty, confusion and fear that policies may continue to change in the future. What we're seeing in terms of the impacts of those fears is that families are making changes in their daily lives and routines.

For example, spending less time outside the home, engaging less with their community. We've seen sharp increases in mental health needs, including anxiety and depression and, in particular, really stark mental health needs among families where a family member may have been recently deported or detained.

We're also seeing enhanced economic pressures, including increased difficulty affording food and other basic needs, again, if a family member has been detained and deported and you lose a significant source of income for the family, but also if individuals are more fearful of working because of concerns about enhanced enforcement activity. And from the providers, we heard really significant concerns about the long-term consequences of this fear and anxiety for the health and well-being of children.

Again, I think everyone on this call is familiar with the issues associated with toxic stress and the long-term impacts on both physical and mental health. Service providers also pointed to concerns about unrealized potential among youth. We also heard that even though needs are increasing among families, at the same time they're increasingly fearful of accessing programs and services.

Families have a range of concerns about enrolling in programs and services—and using services—not only related to public charge but also about potentially putting undocumented family members at risk, as well as concerns about having to pay back benefits. So, there are multiple fears that affect families' use of services. In particular, though, the recent changes to public charge and housing assistance policy have really amplified those fears.

Families are decreasing use of programs and services due to fears

- Families have a range of concerns about enrolling in programs and utilizing services
- Public charge and housing assistance policy changes have amplified fears
- Providers and families report families are disenrolling from and declining to enroll in programs, including Medicaid and CHIP
- Enrollment impacts extend to individuals and programs beyond those affected by policy changes, including citizen children
- Providers are concerned about health and economic impacts of decreased program use

"I used to get Medicaid and the food stamps, but as I wanted to get my legal status—they even say that if you ask for help from the government, you'll be denied legal status." Parent, Houston, TX

"In my case, when I got WIC some years ago, the situation was different, it wasn't as intense as now. If I had to request WIC now, I wouldn't do it." Parent, San Diego

"...what we're seeing is a lot of women are very hesitant to now enroll in medical services. ... They're getting care here in the very last stages of their pregnancy and... the health of the mom and the child are impacted." Health Provider, San Diego



As was mentioned earlier, we already are beginning to see families begin to disenroll from or decline to enroll in programs, including Medicaid and CHIP. I think it's really important to emphasize that those enrollment impacts extend far beyond the individuals and programs that are directly affected by those policy changes, that chilling effect, so that they include citizen children and other programs that are not named, for example, in the public charge rule. Providers have expressed, again, concern about the health and economic impacts of that decreased program use. I think the quote here, in particular, about pregnant women putting off care until later stages of their pregnancy and the concerns about those health impacts, really underscores those types of concerns.

We've already covered a lot of what the details are in the public charge and admissibility rule, so I won't go over the details here. But again, one of the key expected impacts of the rule is that it will lead to decreased participation in Medicaid and other public programs, broadly, among immigrant families and their children beyond those directly affected by the rule.

We did some analysis looking at how many Medicaid enrollees live in a household where there is a noncitizen or the Medicaid enrollee's a noncitizen themselves. We expect that these are the families that would be at risk for experiencing increased fears that could contribute to

disenrollment. Here, you see that there is a total of 13.5 million Medicaid enrollees in these households.

If you look at different disenrollment scenarios that draw upon some previous experience related to policy changes, you could see under a low disenrollment scenario that two million individuals could disenroll. But under a higher one, you're looking at close to five million disenrolling from the program. Beyond those predictions and estimates of how many disenroll, we also have data from community health centers that are already reporting families disenrolling or refusing to enroll in or renew their Medicaid coverage.

Here you see from our survey of health centers in 2019, the share that reported some of their patients were refusing to enroll or disenrolling, as well as the share saying that patients were disenrolling or refusing to enroll their children in Medicaid. And beyond those enrollment impacts, we also started observing some changes in health care use with health centers reporting shares of their patients reducing seeking care, as well as reductions in care for children of immigrant patients.

Across the research that we did over the last few years, I think what we really heard was the growing needs in services for families' basic needs, like food and housing, as well as major mental health needs, but that there are gaps in these services. For example, with many families not receiving counseling or mental health services,

despite interest in receiving those services, families are experiencing a lot of challenges, including finding affordable legal help and often going into significant debt to obtain legal help or going without representation.

Families did identify some trusted resources that they still feel safe sharing information with, but capacity among those resources is limited. For example, they pointed to teachers and schools, churches and faith leaders, and providers. Families also indicated that ethnic media continues to be a really important source of information for them about policy changes.

I want to make sure we touch on what providers are experiencing among all this because this does extend beyond families to their broader communities and the providers serving them. We similarly heard that service providers are feeling increased pressures and strains, secondary trauma and burnout among staff, which were a real concern among service provider organizations. At the same time, they're facing increased need. They are finding it more difficult and complex to provide support, especially legal support, because the policy environment is continually changing.

Providers have tried to respond to growing needs in multiple ways, for example, by strengthening existing and developing new partnerships across sectors, and trying to expand mental health capacity in other sectors.

For example, increasing services and supports or mental health availability in schools and trying to identify and rely on trusted individuals and organizations to be the ones reaching out to families. Service providers also emphasize the fact that state and local leadership and policies can strengthen and underpin a strong community response.

In terms of what they pointed to for the future as needs to help fill the remaining gaps, they stressed the importance of continuing to build cross-sector relationships and make them more sustainable over time. Over the long term, a real need to increase the supply of mental health and legal services providers, the need to meet the growing demands on nonprofits and local governments, particularly as families increasingly turn away from sources of federal support. Again, as families are turning away from those federal programs, they emphasize the importance of maintaining access to services, including health care, and continuing to educate and inform families about policy changes to help them understand who is and who is not affected.

They pointed to the role that state and local leaders and philanthropy can play in helping to fill some of these needs, and they pointed to the importance of fostering leadership development within affected communities and trying to build on the strength and resiliency of immigrant families.

Providers are facing growing pressures and are responding to increased needs by enhancing cross-sector relationships and supports.

- Growing pressures on service providers and local communities, including secondary trauma and burnout among staff
- More complexity and uncertainty associated with providing services, especially legal support
- Providers have responded to growing needs by:
 - ❖ Strengthening existing and developing new partnerships across sectors
 - ❖ Expanding mental health capacity in other sectors
 - ❖ Increasing services and supports in schools
 - ❖ Utilizing trusted individuals and organizations to connect with families
- State and local leadership and policies underpin the community response

"It's a lot of just having to be in crisis mode and reactionary mode that is really not sustainable. Unhealthy for the people affected, unhealthy for the staff..."
Community-based Organization

"I do think that if it wasn't for building this cross-sector, multi-disciplinary, multi-agency network... we wouldn't have been able to do some of the good things that we've been able to do."
Legal Services Provider

"The other component that we are working with... is really building out mental health services and supports to our schools... how do we provide trainings to teachers to identify depression, identify anxiety and how do we react and what resources do we have in place?"
Educator



To wrap up, I think what we saw across our research is that the shifting policy and political environment is leading to increased fears and uncertainty that have far-reaching effects on families.

We see mental health impacts, such as stress, anxiety, depression and trauma. We see increased financial challenges. And at the same time these needs are growing. There's a reluctance among families to access assistance or services because of fears. Communities and service providers have stepped up and tried to respond to growing family needs and challenges that are largely built around enhancing cross-sector coordination and trying to enhance services and supports, but there are still gaps that cannot be filled by those efforts.

Looking ahead, they stress the need to continue to strengthen those cross-sector relationships and take

long-term steps to address those gaps in mental health and legal services. Continue to provide sources of trusted information and education, and build on state and local leadership and philanthropy to support efforts and, again, do not forget the strength and resiliency of the communities you are serving. Thinking about all this through the COVID lens, we're seeing this fear and uncertainty may make families more reluctant to access testing and treatment.

At the same time, the financial challenges may make it more difficult for them to isolate or quarantine and increase the risk of exposure to the virus. All of these challenges are now further amplified and exacerbated by the pandemic. And with that, I'll close, and I look forward to the questions and discussion.

MODERATED PANEL DISCUSSION

Moderator: Ignatius Bau

Moderator: Dr. Zayas, you shared with us this broad frame that this is not just the experience of immigrants and refugees when they get to the United States, but it is a whole cycle of the violence that they have experienced in their home countries, during transit, and the migration process itself, particularly for women, for whom sexual abuse and rape is, unfortunately, very commonplace. Talk to us about how all of us can better understand that cycle and the cumulative trauma, so that it is not just the acute family separation or deportation event, but the entire cycle of violence and trauma.

Dr. Luis Zayas: I think about it as a longitudinal experience. Most of us, when we encounter stress, oftentimes it goes away, or lingers a while, but it goes away eventually. But it is unimaginable, for many of us, to be in a situation like the young boy Danny with the drawing, who in his home country, every day, saw violence and death, signs indicating that if you speak up, you, too, will die. Teenage boys are being recruited into the gangs, and girls are being recruited for the purpose of being somebody's girlfriend in the gang. And this is constant, so that is part of a piling on, if you will, that leads to the accumulation of trauma that we see in ACEs, that has been well-studied. So, it is over time, the stacking up of these different experiences, where we have the profound trauma. Most of us, and many of the families I met, expect to be treated fairly. They knew they were violating an international border, but they also knew that the United States has laws that give people due process, and generally treat people well. Instead, what they experienced was a harsh environment, which added on to the trauma. When we think about interventions, as we do with any client or patient, we begin to peel off the layers as they are able to, and as we, as clinicians, are able to. That is how we can look at it and understand it.

Moderator: Ms. Artiga, you alluded to the fact that with COVID-19, a lot of these stresses have increased, especially with families who had been afraid to access health care, nutrition, other kinds of supports. Do you want to comment more, and maybe give us a preview of any future research that you might be doing to look at these particular effects of COVID-19, and the additional economic and other challenges that it is creating for immigrant families?

Samantha Artiga: We have all heard a lot about the disparate impacts of COVID-19 for people of color broadly. If we think about specific impacts for immigrants, they are facing an array of increased challenges and risks across the board. Due to increased financial challenges, they often are in a really tough situation of having to continue to go to work in order to meet basic needs like food and rent, while knowing that being at work is an increased risk of exposure. There are stories of individuals who are worried about exposure, or potentially feeling symptoms, who really do not have the flexibility to not go to work, because if they do not go to work, those basic needs will not be met. That is one set of challenges. On top of that, you have increased challenges such as increased reliance on public transportation that is also an increased exposure risk, and living in larger household sizes, often multi-generational households that also increases risk of exposure.

You have these multi-faceted ways in which risk for exposure is increased, and then on top of that, you have increased challenges to accessing health care, with higher uninsured rates, and less likelihood of having a usual source of care other than the emergency room. And then piled on top of that, you have this enhanced fear of accessing any services or support [because of the public charge regulation]. And at the same time, the sources of support and relief that have been provided by the federal government in response to COVID-19 exclude many immigrants from assistance. Therefore, they are left without a lot of the financial assistance that is available and have more limited access to some of the health care systems that are available. Some of this extends to legal immigrants if we think about the fact that there are lawfully present immigrants who remain excluded from Medicaid and CHIP, and food assistance and other programs. What you are seeing is, across an array of factors, increased challenges facing immigrant families that put them at increased risk of exposure, and also make it more difficult to access services and support that they might need.

Moderator: Ms. Alvarez, in some of the focus groups that you did, you also looked at populations other than Latino children and families. We want to broaden this conversation, and there is certainly, unfortunately with

COVID-19, a lot of anti-Asian sentiment that has arisen. We are certainly conscious, with the murder of George Floyd, of the importance of anti-Black racism that is still pervasive in our structures, in our society. There are Black immigrants and refugees that are doubly impacted by racism as well as xenophobia. Can you comment on some of the findings that you found from diverse groups of immigrants and refugees?

Mayra Alvarez: Absolutely. The fact that we are talking about ways in which we can better support immigrant communities, it is a shared struggle across various ethnic backgrounds as far as immigrant communities themselves. It gets lost in the narrative that we continually try to push back against. For many people across the country, the term immigrant is synonymous with Latino or Latinx communities and neglects the complexity of the immigrant community when it comes to Asian Pacific Islander communities, or Black immigrants. And even within those populations, the impacts of immigration, and the journey of immigration, their experiences here, are important.

As we consider the impacts of COVID-19 in particular, building on what Ms. Artiga said, we have to make sure that we are not continuing to consider opening our cities, opening our communities, our schools, our country, on the backs of immigrant communities and on the backs of communities of color. The opportunity for me to work at home and order food and get things delivered is because, most likely, you have a person of color or an immigrant doing those low-paying jobs that are making things possible. Recognizing that really highlights the inter-connectedness of these issues. As we are facing a moral reckoning in our country around racial justice, immigration and the intersectional nature of these issues, has to be considered. For example, Congress is debating the next package of relief for responding to COVID. How can we make sure that immigrant communities are front and center in that? We would not even be in this position if it were not for the work of immigrant families across the country. We have to make sure that everyone has access to health care, including emergency Medicaid, so that coronavirus testing and treatment is available. In addition, for the economic relief that is available through the Congressional legislation, how can mixed-status families be included? When you are thinking about the kids of these families, they are overwhelmingly U.S. citizen children, but they are being left out because Congress has chosen to do that. Thinking through how

these issues are so inter-connected will not only allow us to better serve children and families but make our collective fight for immigration justice and racial justice that much stronger.

Moderator: Dr. Zayas, you talked a lot about the impact on children, and what we know from adverse childhood events work is that these kinds of traumatic incidents that children experience have lifelong effects, over the course of their life and their health. If we understand some of these experiences as ACEs and as trauma, what impact might that have on these families over time?

Dr. Luis Zayas: This is not going to be a one-time fix for any of these children and their family. It is going to take time. Things will occur to them as they grow. Whether they stay in the United States or return, whether they become [U.S.] citizens, that trauma will be with them. It will need to be worked on both individually and in family therapy. It is the disruption in the family processes and the family systems that comes about from detention that we have to look out for. In detention—and I visited these detention centers—there may be four families in one cell, and for each family, let's say, a mom and two kids, there is no privacy. Mothers cannot read their child a bedtime story or say their prayers at night, make sure you include Tio Pepe, or someone in your prayers. These sorts of rituals that are so important for family functioning are simply lost. Mothers cannot cook for their children in detention. It is all regimented, they eat whatever is given to them by the cafeteria. The mothers no longer can discipline their children, that is done by the prison guards. You see what happens to families. In the long run, that will get played out with these families upon release. We need to help these families strengthen and reintegrate over time. We do know that ACEs, chronic mental health issues and stresses, affect our immune suppression systems. We know that ACEs lead to chronic illnesses, which shorten our lifespan. There is a lot of work to be done, and there are many organizations in our communities that are doing great work, helping one another.

One last point, I want to make that is right in your backyard so to speak, you have a hero. You have a hero in Judge Dolly Gee of the federal [district] court in Los Angeles [presiding over the Flores case]. She is a one-person, one-judge army fighting the federal government's attempts to continue to keep children in detention. We really have to applaud her work and support the work she is doing holding the government's

feet to the fire around how we treat these families. The number of injunctions that she has issued, and the number of times she has brought everyone back to the courtroom, the government as well as the advocates, to come back and talk over, and to try to find ways to end children's detention, and family detention, is really an effort. I just wanted to point it out because she is my hero.

Samantha Artiga: I can add to the points Dr. Zayas makes about the experiences among families in detention. In the interviews we did with pediatricians who were serving [immigrant] children and families, we similarly heard a lot of concerns about toxic stress, for a variety of reasons. Some of them had an immediate family member detained or deported, but it would not even necessarily require that to trigger an issue or concern about toxic stress. The fear is overwhelming and constant, of potentially losing a parent, of coming home from school one day and the parent not being there. We heard difficult stories about children sleeping in door thresholds so that they would make sure that when they wake up, their parents would be there. And this compounded by a lot of the increased economic stress, and in particular, increased food insecurity among families. These issues extend more broadly beyond what we are seeing in terms of the detention facilities.

Moderator: One of the themes that we wanted to raise is that trauma can help us understand all these impacts on the community. As Ms. Alvarez pointed out, oftentimes, an individual family will have individuals with multiple immigration statuses. It is not that there is an undocumented family here, and then a U.S. citizen family there. All these different policies are going to impact these families and communities, and more broadly, their extended families, in different ways.

Dr. Luis Zayas: We are presently conducting a study of U.S. citizen children who are now living in Mexico. The trauma does not end just because they are on the other side of the border. They are among an extended kin network, and they long for coming back home, to what they see as home. There are [many different groups]: DACA, U.S. citizen children, those in and out of detention, unaccompanied minors who have lost their parents or are seeking their parents. It is vast.

Moderator: We have talked a lot about families and the importance of parents in this conversation. But the

other [important people for immigrant children], before COVID-19 at least, were teachers in schools that had to both educate the children, but also understand the traumas that they were experiencing in their lives. Can you talk about the work The Children's Partnership has done with school districts and trying to educate both teachers and school officials about the needs of immigrant children?

Mayra Alvarez: Absolutely. We are proud partners with a variety of education partners across the state because we know how essential schools and early learning centers are for the healthy development of children. It is where they spend the majority of the day. So, ensuring that our schools and our early learning centers and the providers that are there, both teachers and other professionals, are best informed about immigration and its impact on the healthy development of students and young kids, is particularly important. We have a proud partnership with Californians Together, the California Association of Bilingual Educators, and others, to support implementation of [California] Assembly Bill 699. In 2018, California enacted a law that requires schools districts to be safe and welcoming spaces for immigrant communities, immigrant children in particular, requiring them to have a local policy to educate their workforce about [immigration issues]. As you can imagine, implementation of that law is not as robust as we would like it to be. Out of our 1,100 school districts in the state of California, about 10% have actually done something to address AB 699. It is us, as advocates and community partners and education partners, that are working to strengthen implementation of that law, not just making sure that a law is implemented correctly, but in order to create the environments that children need to be successful. That is part of what this conversation is about, how immigration and the understanding of immigration and its impact is a responsibility for all of us. How can we support teachers and childcare providers and early learning providers, with the right tools and resources to better serve children, to recognize a traumatized child? It is not asking, "what's wrong with you?" but "what happened to you? what are the experiences that you are undergoing that is making you act this way?" We also know there are disproportionate disciplinary practices among kids of color. Thinking about that context, thinking about the whole-child framework, allows us

to better take care of our kids and support their learning environments and their health development overall.

Moderator: Ms. Artiga, you had talked briefly about how as providers, whether we are health care providers or social service providers or educators, we are also experiencing the impact of these policies that may not directly affect us, but are affecting the immigrant families and individuals that we're serving. So, there is secondary trauma, and the burnout of trying to deal with the stress, just the whole environment.

Samantha Artiga: One very consistent theme we did hear from across service providers that represented different sectors—health care providers, legal services providers, social services providers, community-based organizations—all spoke to this issue of secondary trauma and burnout and stress. It reflected several factors. One is the increased demands and needs for services. They were working beyond their capacity, and that was leading to real stress and burnout. At the same time, many found it more challenging to do the work they have always done because policy continues to change at such a rapid pace. This was particularly true in the legal services sector where it is just so hard to stay on top of the ongoing policy changes, and to feel really confident in the services they are providing to their clients. So, you have the increased need, the increased complexity of the services that you are trying to provide.

And then on top of that is the secondary trauma; many of the individuals in these organizations have shared experiences with the families that they are trying to serve. Today, many people remarked on how watching the videos and having some of this discussion was difficult for them because it was close to them in terms of incidents they have experienced themselves. That same issue is playing out in terms of service providers working in the community, in terms of sharing histories

of experiences or, in fact, going through those similar experiences at the same time as the clients that they are trying to serve. This was a significant issue that was raised consistently across service providers. We heard about a range of ways organizations were trying to address this, but the takeaway is recognizing it as a need, and then prioritizing taking steps to try and address the challenges that arise from it.

Moderator: Dr. Papademetriou, we have had this very rich conversation about trauma. Maybe this is a little unfair, but because you have had experience talking to policymakers, to presidents, is trauma a framework that you think would resonate with them, and help them understand the experiences of all these adverse policies? Is this a way that we can be more persuasive in helping some of our policymakers understand how bad some of these policies have been?

Dr. Papademetriou: I think it probably can be. Trauma is going to become much larger than what it is that we have been talking about, because of the pandemic. Many more services that are trying to address trauma are going to become essential if our country is to move forward and get out of these many holes that we have built for ourselves. But as a realist, I also want to emphasize that we live in a deeply divided society. And during deep divisions, elections become much more consequential. Twenty years ago, 25 years ago, 10 years ago, you could have a Democratic administration or a Republican administration, and sometimes the differences were almost nonexistent when it came to our issues. Now, the differences are dramatic. So, let's not forget that part of the responsibility that we all have is to put our energy together. The election will be fought, and the outcome of the election can make an enormous difference in how all people, particularly people of color, how we treat difference, how we deal with immigrants and the attention to trauma will be addressed.



I want to echo what we have learned and shared today, that there is an intense interdependence of a whole set of issues that are being brought to bear by what Dr. Papademetriou described in his very sobering review of the fundamental remaking of the U.S. immigration system in this country. One would have never imagined that executive orders—some 50 in the last year and a half alone—could create such enormous havoc, not just in our immigrant families, not just among children, but in our community and society at large. As we close this session, it is important to reflect on a few big-picture takeaways.

One is Edgar Velazquez’ story. This young man has had a community of support. He is studying medicine at UC Davis under extraordinary circumstances, and yet is remarkably focused and resilient. We need the Edgars of the world to be able to provide the care and to be the backup for what others have described as a workforce that is pretty burnt out in all the ways it has been trying to protect our vulnerable communities.

Dr. Luis Zayas, you’re really thoughtful overview of how these policies are manifesting in terms of adverse childhood experiences, the impact of separation on young children and their parents. As Dr. Sergio Aguilar-Gaxiola said, the videos were quite painful to watch and yet so important, because those of us who do policy and work in this arena really do need to have our very close eyes on the real experiences that young people and parents are facing as a result of these immigration policies. So, thank you for the work that you do, and for those videos that will sit with us, as we recognize how important the work is going forward.

Samantha Artiga, I appreciate how much your work has called out the increase in mental health needs. Obviously, we are in a pandemic. And if I might be so bold as to say, we are losing the war on the pandemic, and part of the reason we are losing it is that we do not think of community and public health in a holistic way. I had a conversation, two days or so ago, with our [state of California] Secretary of Health and Human Services, who was lamenting the challenges that we have in addressing the COVID epidemic and its disproportionate impact in our Latinx and our Black communities in California. And this is true all across the country. It is incumbent on us, as we think about this pandemic, to recognize that none of the testing, contact tracing, isolation and quarantine that needs to be done to get control of this pandemic can be done in such an extraordinary culture of fear. Mayra Alvarez described the daily doses of fear, all of our speakers talked about what that culture of fear has done in our communities, and I would argue it is very much at play in terms of management of this particular epidemic. It will take very bold public will to take actions.

Dr. Papademetriou’ s commented that elections matter, notwithstanding his very sobering summary of how hard it will be to roll back many of these policies. Elections do matter. And by the way, the Census matters. We did not talk about it at length, but it is really important to know that intersection is critical. There will be a 10-year repercussion for the resources that we need as an entire community if we undercount a community that is under this kind of fear and disenfranchisement. How will we count 40 million people in California while we are in modified shelter-in-place, and have public charge and ICE raids?

Mayra Alvarez, in your comments about the intersectionality of these issues, you laid them out in a way of really looking at it from the eyes of children, but recognizing that we are also looking at it as a generational issue, for all of us as leaders in whatever capacity that we have.

I really want to thank all of the panelists. What we have heard today is that there is a layering on of toxic stress and trauma, and there needs to be a way to approach trauma in a way that heals our communities, and allows us to implement much more inclusive policies in all the arenas that were discussed today.

PART II: HOW HEALTH SYSTEMS AND PROVIDERS CAN DELIVER TRAUMA-INFORMED CARE TO IMMIGRANT FAMILIES



Photo: Olivier Douliery / AFP via Getty Images

August 25, 2020

Speakers

Fireside Chat:

Nadine Burke Harris, MD, MPH, FAAP
Office of California Surgeon General

Panelists:

Altaf Saadi, MD, MSc
Massachusetts General Hospital
Harvard Medical School

Andrés Sciolla, MD
UC Davis Health

Thu Quach, PhD
Asian Health Services

Presentation Slides: <https://health.ucdavis.edu/crhd/pdfs/events/part-II-symposium-health-systems-providers-trauma-informed-care-slide-decks.pdf>

Recording: <https://www.youtube.com/watch?v=sFx2ImzIOxI&feature=youtu.be>



For those of you who do not know the California Health Care Foundation, we are a statewide independent foundation which, with the bulk of our resources, has been focusing on how the health care delivery system can provide the best care that people need in California, when they need it, with a particular focus on low-income communities and communities that have historically been disenfranchised. We know that historical and continued oppression and structural racism results in widespread inequities in our society. There are countless examples of these inequities and how they manifest themselves in communities all over the country.

Today's conversation is both timely and highly relevant. We are in an environment where racism and xenophobia are maintained and intentionally exacerbated by a federal administration which, via executive orders and administrative policies, has created, in fact, a

human rights crisis at the U.S. Southern border. Family separation, zero tolerance and public charge are but a few of literally hundreds of executive orders that this administration has promulgated. For those who would like to review those, our speaker at the first part of this symposium, Dr. Demetrios Papademetriou, referenced the Migration Policy Institute report that details hundreds of these immigration executive actions that have been taken during the Trump presidency. These policies and their implementation and enforcement have created a toxic environment to immigrants, to their families and to our communities.

Today's Part Two session will focus on how the health care system and providers can deliver trauma-informed care to immigrant families and workers. Regardless of where you work, regardless of your place in society—whether you are a social worker, whether you are a clinician, whether you work in policy, whether you are an advocate—it is important for all of us to understand how our systems can and should be prepared to address toxic stress as a society, culturally and, of course, with immigrant families themselves.

The California Health Care Foundation is incredibly proud to be a sponsor of this symposium. Today's program is an exceptional lineup with our esteemed California Surgeon General, who is an expert in adverse childhood experiences, who you will hear from momentarily, and an esteemed panel. I look forward to the entire conversation today. Again, welcome. Thank you, all of you, for joining us.

Fireside Chat with Drs. Sergio Aguilar-Gaxiola and Nadine Burke Harris



Dr. Sergio Aguilar-Gaxiola: It is truly my genuine pleasure and honor to introduce Dr. Nadine Burke Harris, our first ever California Surgeon General. You may have read in your program her many international and state accomplishments. You will be inspired, as I am. Dr. Nadine Burke Harris is an award-winning physician, researcher and advocate dedicated to changing the way our society responds to one of the most serious, expansive and widespread public health crisis of our time, childhood trauma. She was appointed as California’s first ever Surgeon General by Gov. Gavin Newsom in January 2019.

Dr. Burke Harris’ career has been dedicated to serving vulnerable communities and combating the root causes of health disparities. Joining research from the CDC and Kaiser Permanente, Dr. Burke Harris identified adverse childhood experiences, or ACEs, as a major risk factor affecting the health of her patients. In 2011, she founded the Center for Youth Wellness and subsequently grew the organization to be a national leader in the effort to advance pediatric medicine, raise public awareness and transform the way society responds to children exposed to ACEs and toxic stress.

She also founded and led the Bay Area Research Consortium on Toxic Stress and Health to advance ACEs screening and treatment of toxic stress. Dr. Burke Harris has been featured on NPR, CNN and Fox News, as well as in *USA Today* and the *New York Times*. Her TED talk—and I would strongly recommend that you watch it if you haven’t—how childhood trauma affects health across the lifetime, has been viewed more than six million times. Her book, *The Deepest Well: Healing the Long-Term Effects of Childhood Adversity*, was

called “indispensable” by the *New York Times*. I am truly honored that I will engage now in conversation with Dr. Burke Harris. A warm welcome to you, Dr. Burke Harris. We are delighted with your participation.

Dr. Nadine Burke Harris: It’s good to see you.

Dr. Sergio Aguilar-Gaxiola: You are well-known for highlighting the impact of adverse childhood experiences, or ACEs, and toxic stress and trauma, on children’s health. Can you describe that impact on children’s mental and physical health, both in the short-term and over the lifetime of the children, when they are adults? This is of key relevance right now, given not only the pandemic, but also in California now, with the fires as well.

Dr. Nadine Burke Harris: Yes, this is something that, for me, came out of my experience as a pediatrician, caring for kids in a vulnerable community. What I was seeing was that my patients who had the most significant histories of adversity were also my patients who had not only some of the things that we would expect, like trouble paying attention and learning in school, but also things like very high rates of asthma or autoimmune disease or other health conditions.

I will never forget something that happened early in my career that really highlighted this connection between adversity and health. I was sitting down with a patient who had asthma. I was talking with her mom. I was saying, “Okay, let’s go over those asthma triggers one more time. What did we miss? Because we had been working on all these things. There are no pets. There are no other asthma triggers.” I remember this mom said to me, “You know, doctor, I noticed that my daughter’s asthma tends to act up every time her dad punches a hole in the wall.” That was one of the things that drove me to dive into looking at the science of how early adversity affects health and well-being.

It turns out that, when we experience something scary or stressful, the body’s natural biological response—the fight or flight response—gets activated. That is great if it is once every once in a long while. It is designed to save our lives from a mortal threat, and then it shuts itself off. That stress response activates so many parts of our body—our brain, our blood pressure, our heart rate. If you think about all the things that you think about, how you feel when we feel scared or stressed.

If that happens too often, the stress response is activated over and over and over again. It goes from being adaptive or life-saving to maladaptive or health damaging. High doses of adversity, especially during the critical and sensitive periods of early childhood development, are associated with long-term changes to the structure and function of kids' developing brains, their developing immune system, hormonal systems, and even the way our DNA is read and transcribed. All of those changes are what are now known by scientists as the toxic stress response. That is what leads to increased risk of things like diabetes, asthma, heart disease and stroke.

Dr. Sergio Aguilar-Gaxiola: One thing that I really love about how you put it, is that it is so relatable. I think that the audience can relate to the examples that you provide. You are a great communicator. I appreciate and do thank you for sharing that information in a relatable manner.

Dr. Nadine Burke Harris: Well, thank you.

Dr. Sergio Aguilar-Gaxiola: In this symposium, we are trying to frame the experiences of immigrants—immigrant children, immigrant families—as another way that ACEs, toxic stress and trauma are experienced. For example, that the detention and deportation of a parent has parallels to having a parent incarcerated. Could you please comment on this framing?

Dr. Nadine Burke Harris: Yes, absolutely. When we talk about the traditional ACEs, we look at the categories used by the CDC and Kaiser when they did the study. It includes physical, emotional and sexual abuse, physical and emotional neglect, or growing up in a household where a parent was mentally ill, substance dependent, incarcerated, or there was parental separation or divorce, or domestic violence. Those are the 10 traditional criteria. I think that immigration was one that they did not necessarily think about at the time.

One of the things that I think is really important is that, when we look at our community of immigrants, they represent a particularly high-risk population for several reasons. Number one, many immigrants are fleeing situations where they have been experiencing high doses of stress or adversity. For example, last year, I testified before the Department of Homeland Security, talking about the Trump administration's policy of separating kids from their caregivers. What we see is that, for so many families, immigrants and refugees are leaving a very, very difficult situation. That is why they are leaving their homeland to begin with.

Even for those who aren't fleeing a scary or dangerous situation, just the process of immigration—and I will have to say, as an immigrant myself—the process of leaving home, leaving all of your relationships and your connections and your social connections, and all of these things, and moving to a new place, in and of itself is a stressor. We recognize it is a stressor, and we recognize that, when it comes to our body's biological response to stressors, when those stressors are buffered by safe, stable, and nurturing relationships and environments, and particularly from a trusted caregiver, that reduces the biological impact of that stressor on our physiology.

When you look at something like a policy that separates children from their caregivers, you take families who may already be at high risk from whatever situation they are leaving. It is a stress, just the journey itself, the process of migration itself is a stressor. Then, when they get here, the risk then dramatically exacerbating, the health risk. I cannot overstate this. Dramatically exacerbating the risk to brain development and to infection risks, to the immune system, to the hormonal system goes profoundly up when you remove that capacity for buffering care.

That is what we see for many of our immigrant populations. Even for our immigrant communities who do not experience any of that. It's just the process of immigration, coming to a new place, leaving your trusted relationships, leaving your social networks, and then having to go through the process of re-establishing that, is a time of vulnerability. For anyone experiencing this time of vulnerability what we know is that the relationships and environments that they encounter make a really big difference in terms of outcomes. That is really something that is important for all of us, both as health care providers and as policymakers, to keep in mind when we are looking at the immigrant experience.

Dr. Sergio Aguilar-Gaxiola: Thank you so much for that comprehensive response. I am an immigrant myself, and it resonates so much with my own experience, and what I have learned through the years also, in terms of the research that we are involved with.

What can physicians and other health care providers do to become more aware of ACEs, toxic stress and trauma?

Dr. Nadine Burke Harris: I am so glad you asked that question. Here in California, we have recognized that adverse childhood experiences and toxic stress represent

a public health crisis. When we say a public health crisis, I mean it affects a lot of people. Across the U.S., we see that about two-thirds of our population have experienced at least one of the 10 traditional adverse childhood experiences. Anywhere between 13% and 17% have experienced four or more. Here in California, about 63% have experienced one, and a little over 17% have experienced four or more. We have created an initiative called ACEsAware. The initiative focuses on training our health care providers to recognize and respond to adverse childhood experiences and toxic stress as risk factors for poor health, behavioral health and social outcomes, and understand how to respond with trauma-informed care. It is built on these science-based principles.

Last year, the National Academy of Sciences, Engineering, and Medicine released a consensus report. In that consensus report, they talked about toxic stress as being a major risk factor for health challenges. They recommended screening for adversity as a way of doing early detection and early intervention, because what all of the research shows us is that early detection and early intervention improves outcomes. What ACEsAware is doing is giving providers tools on how to screen for ACEs and how to respond with trauma-informed care, how to assess for toxic stress and how to respond with trauma-informed care.

Here in California, providers can also get reimbursed. Our Medicaid providers can get reimbursed \$29 per screening. Anyone though, any health care provider, can go to the [ACEsAware.org](https://www.acesaware.org) website, take the training for free, and get continuing medical education and maintenance of certification credit for doing so. We are encouraging all of our providers to do that. I am really pleased—since we launched the initiative in January of 2020—more than 13,000 providers have taken the training and have become ACEsAware. We are really excited about that.

Dr. Sergio Aguilar-Gaxiola: That's great. You were ahead of me because I was about to ask you a follow-up question, if there are screening tools and clinical interventions that could be used, and certainly there are.

Dr. Nadine Burke Harris: Yes, that's right. There is one thing that I think it is really important to highlight, which is to dispel the myth that there are no interventions for addressing the toxic stress response. It turns out that there

is quite a bit of data that show that things like regular exercise, balanced nutrition, mindfulness interventions, good old-fashioned mental health, sleep and, probably most importantly, healthy relationships, target all of the biological derangements of toxic stress. They reduce stress hormones. They reduce inflammation, and they enhance neuroplasticity. When we are talking about these interventions, we are seeing data that these interventions can actually reverse some of the changes that we see to our epigenetic regulation, our erosion of our telomeres, the bumpers on the ends of our DNA. These interventions actually help to address the biological impact of toxic stress down to the molecular level.

Dr. Sergio Aguilar-Gaxiola: Thank you so much. One of our staff just posted the [ACEsAware.org](https://www.acesaware.org) website. I hope that our audience accesses those remarkable resources that you have posted, that your team has posted.

There is another question. What are some individual, family and community-level responses that families experiencing trauma can do to mitigate these impacts, and build resilience, healing and wellness?

Dr. Nadine Burke Harris: There is a lot of stress going on right now, especially in the context of COVID-19. One of the things that my office did was make available the California Surgeon General's Playbook: Stress Relief During COVID-19. It is available at [covid19.ca.gov](https://www.covid19.ca.gov). The strategies and interventions that we highlight are really based on the research on what helps to regulate the biological stress response, which include healthy relationships, maintaining our social connection, even during a time when we have to be physically distant, is so critically important. Regular exercise, I cannot say enough how much that helps to regulate the stress response, release healthy hormones and metabolize the stress hormones. Mental and behavioral health care is critically important. Oftentimes, I think that we recognize the importance of our regular health care, but the body does not stop at the neck. Addressing our mental and behavioral health, even preventively, is really important. Thinking about what it looks like to maintain our wellness, our mental and emotional wellness, is really critically important.

Dr. Sergio Aguilar-Gaxiola: In the chat I see that Sheila James from the Office of Minority Health out of DHHS Region IX. She is one of the leaders in that organization who says, "The Surgeon General's Playbook is a great resource. I have shared it with many organizations." Thank you, Sheila, for your comment.

You mentioned the ACEsAware training, and you also mentioned the stress-busting playbook. Are there any other resources that you would like to share?

Dr. Nadine Burke Harris: Yes, one thing I want to highlight is that within the ACEsAware website, there are quite a number of resources for providers and others who are interested in doing this work. In addition, the CDC has launched a pretty big initiative to raise awareness about ACEs and toxic stress. Those of us who are public health nerds will know that the CDC releases something called the *MMWR*. It is the *Morbidity and Mortality Weekly Report*. In November of last year, the CDC dedicated an issue of the *MMWR* to adverse childhood experiences and toxic stress. For public health people, that is like getting the cover of *Vogue*. It is a big deal. There are excellent resources on the CDC website, so that would be another resource as well.

Dr. Sergio Aguilar-Gaxiola: Wonderful. How about CalHOPE?

Dr. Nadine Burke Harris: Yes, oh my goodness, thank you, thank you! CalHOPE is another resource for mental health and behavioral wellness. It is created by our Department of Health Care Services. Folks can go to the CalHOPE website, calhope.org. That is a great resource.

And I want to highlight that California's covid19.ca.gov website has a whole page on emotional well-being. For anyone who is struggling or needs access to resources, under the emotional well-being page of covid19.ca.gov, there are quite a few resources there.

Dr. Sergio Aguilar-Gaxiola: Yes, the beauty about this interactive session is that the audience is posting CalHOPE, posting resources from other agencies, some of them in Spanish. It is just terrific. I really thank you because you are triggering a lot of these responses that are being shared right now, and that we will be sharing.

Dr. Nadine Burke Harris: One thing I want to highlight is that all of the resources on covid19.ca.gov, including the Surgeon General's Playbook on stress relief, *estan tambien disponible en espanol*.

Dr. Sergio Aguilar-Gaxiola: Excelente. I'm on the same cloud, by the way, the public health nerds. It resonates with me.

I have a question. One thing that I have known you to be an advocate for is the importance of resiliency. Can you say a few words about that?

Dr. Nadine Burke Harris: Yes, absolutely! Especially now, when our families and communities are experiencing so many stressors and challenges, there are a couple of things that I find to be really exciting. There are a couple of pieces in terms of having a level of self-compassion and giving ourselves a break. One of the pieces of the science and the research about ACEs and toxic stress that is so important is that it allows people to recognize, "Wait a minute, you know what, my body is just having a normal reaction for all of the things that I've been going through."

The thing that I find most exciting about this work is what the science also shows us is that, when we do have things like safe, stable, and nurturing relationships and environments, when we do have these connections, and when we practice this self-care, and when we care for each other, it actually makes a profound difference in terms of our health. There was an international research study showing that kids who were institutionalized, who were in foster care, who were randomized into high-quality nurturing caregiving, actually showed normalization of the white matter structures of their brain. When they did MRIs, they saw that the effect of this nurturing care was healing of the developmental trajectory of the brain. It is so powerful! It is so incredible to see that. The message that I want to send out for children, for families, for parents, for caregivers, for individuals is that we do have the power to heal. We have the power to heal ourselves and each other. I think understanding that is critically important.

Dr. Sergio Aguilar-Gaxiola: That's remarkable! This has been a treat, certainly for me and I'm sure for the audience as well. It sets the tone for the rest of this session, but also for the rest of the symposium. A heartfelt thank you to you and to your staff, your team who was fantastic in helping us. Thank you for all you do. We greatly, greatly appreciate it!

Dr. Nadine Burke Harris: Thank you for having me. Thank you for hosting this important conversation, and for the incredible work that you do every day. I am very grateful to have the opportunity to be a part of this conversation.

Dr. Sergio Aguilar-Gaxiola: You make us all proud. Absolutely.

How Health Systems and Providers Can Deliver Trauma-Informed Care to Immigrant Families



Thank you for the opportunity to speak at this symposium, which has been so great, and I have learned so much from the previous speakers. I'm really delighted to be here. I'm going to dive right in and focus in on what health systems can do to provide trauma-informed care for immigrant patients. As a clinician, my starting point is always the patient. I want to begin by discussing a patient I saw in early March. One of the sites that I see patients serves a predominantly immigrant population in the city where one in three residents identify as Hispanic or Latinx.

This woman was pregnant and experiencing debilitating headaches, so much so that she had gone to the emergency department a few months before. Between that initial visit and when she came to see me, her chart was filled with multiple notations of her not showing up for appointments. When I asked her about her headaches, I found out that she was a survivor of intimate partner violence and applying for asylum. At this point, I asked her if I could refer her to the medical legal partnership that exists in our health center. She said no. I pressed, and she kept saying no. Eventually, she shared that she did not want to get government help because of the public charge rule. To be clear, the Trump administration's new public charge rule can deny green cards to immigrants perceived as dependent on public services like Medicaid. This public charge would not have applied to her because it doesn't apply to asylum seekers.

This medical legal service is not a government service. It was something that's offered by our clinic alone. She remained really, really scared. Her story is a good

starting point for two reasons. One is that her experience is supported by so many studies that have shown, over and over again, how policies of exclusion, as well as perceptions of exclusion, are linked to both emotional and physical health outcomes for immigrant patients.

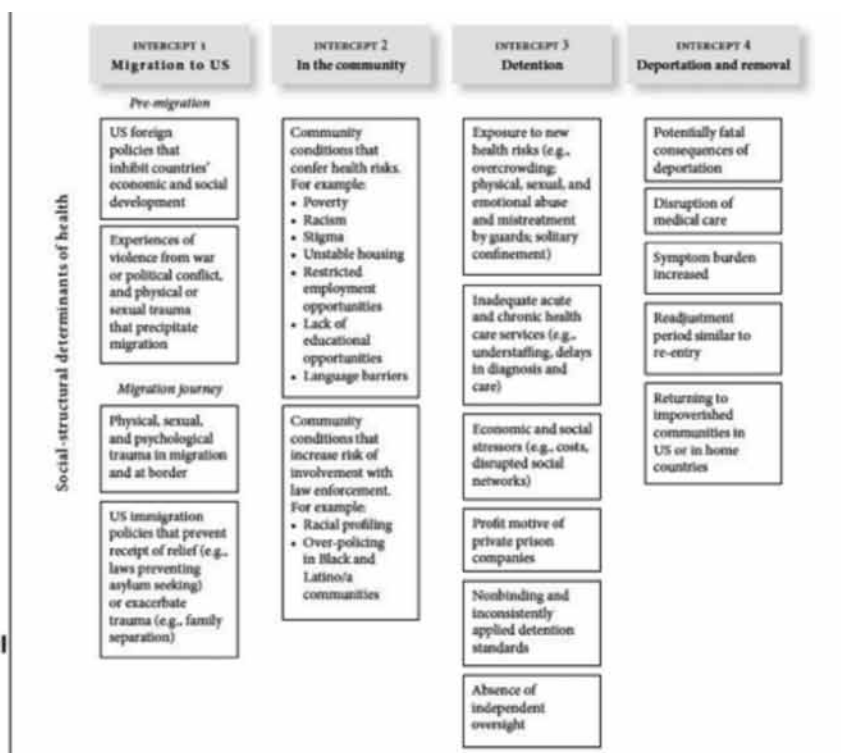
In addition to increased anxiety and worsening health, which has already been discussed in this presentation in earlier talks, studies have shown that fear of deportation is associated with increased markers of inflammation and increased cardiovascular risk factors, like high blood pressure.

When the 2016 U.S. presidential election happened, researchers began to identify association between Trump's election and decreased health-seeking behaviors and worsening health for immigrants and their families, especially among Latinos in the United States, irrespective of immigration status, as measured by pre-term births of U.S. Latina women, avoidance of health care, and an increase in traumatic experiences and mental health conditions, including in children and adolescents.

The second reason I started with the patient story was because it shows how offering immigration-informed care goes hand in hand with offering trauma-informed care. As it's already been alluded to, these individuals are facing pre-migratory trauma from their native countries, trauma from the migratory experience, and trauma that occurs in the post-migration context that may or may not involve detention.

The above figure is from a model my colleagues and I, including Dr. Patler at UC Davis, proposed. We call it the Immigration Intercept Model, and it borrows from the Justice Intercept Model that's used to identify community interventions for people moving through the criminal justice system. I think it's a helpful frame to think about the totality of potential trauma someone could experience, including for the patient whose story I began with. This policy climate of increased immigration enforcement and increased anti-immigrant rhetoric led to my research question, which was, what can health care facilities do? The product of our research is now publicly available as a toolkit in YouTube videos and in academic publications. I'll show you a brief segment of the introductory video just to set the stage.

Saadi et al. **Understanding US Immigration Detention: reaffirming Rights and Addressing Social-Structural Determinants of Health.** *Health Hum Rights.* 2020 Jun; 22(1): 187-197.



Hi, there. I'm Dr. Altaf Saadi. I'm a doctor and researcher passionate about immigrant health. For the past two years I have been researching and documenting the relationship between the needs of immigrant patients and what clinicians and institutions can do to meet those needs. Immigrants have been under attack since the 2016 presidential election and its aftermath. During this time, clinicians and health systems across the country started noticing immigrant patients were changing how they access health care.

On one hand, not showing up to visits or being afraid that accessing care could jeopardize them in some way; on the other, coming in with more anxiety and mental health issues from their increased worries. Health care facilities and clinicians began implementing new policies and programs because their goal is to care about your health, not your immigration status.

For my research, I became interested in understanding what, specifically, these new policies and programs were so that hospitals and clinics, nationwide, could replicate these same actions with the hope of protecting and welcoming immigrant patients in the health care setting. After interviewing 40 people across five states, I broke down these actions into three categories: what could be done at the institutional level, provider level and the patient level.

We'll stop there, but I encourage you to check out the videos and the toolkit on the website. Essentially, to summarize, here, thus far, the academic publication adjusted from three categories to five major domains. I'll just go through them very briefly. One category of risk reduction strategies that can happen in the health care system or clinic that you might be practicing in is thinking about ways to reduce the risk of immigration enforcement on or near facilities. This might include designating public and private spaces that limit where immigration enforcement may or may not be able to go without a valid warrant signed by a judge. The second category is concerns around immigration status related information disclosure. That includes thinking about how, if at all, information about immigration status is acquired or documented in medical records. One category is thinking about risks associated with patient level stressors.

Primarily, those are legal stressors and thinking about ways to address them, but at the same time, thinking about resiliency promotion as a component. Support health outcomes are associated with stress and worsened when events are perceived as uncontrollable, so providing patients with tools and resources is really critical here. The fourth category is addressing stressors among health personnel.

Nationwide, nearly one in five health care workers are immigrants, and thinking about them needs to be part of the solution. Lastly, thinking about coordinating risk mitigation, either through having a designated point person or taskforce that's at your facility charged with addressing this very evolving and very complex space that is the intersection of health care and immigration policy. I'm going to show a segment of another video just so you guys can get a flavor of, specifically, how this operationalizes on the ground.

I found that there were six common actions health care facilities were taking at the patient level. Here they are in no particular order. One, educating patients about legal rights. Whether by using community health workers, community-based immigrant organizations, or just having know-your-rights cards in waiting rooms or clinic exam rooms, the same way there are pamphlets about diabetes or hypertension. Two, pursuing collaboration with trusted legal partners, whether through a formal medical-legal partnership, which is having a lawyer embedded in the health care team to refer patients to who have legal immigration issues or increasing access to them through resource fairs or resource guides. Many immigrants can get caught up in fraudulent legal schemes, so knowing trusted local legal sources if very helpful.

Three, promoting affirming care messages to express to all patients that they are welcome. Best practices depend on the local context, like whether this should take the form of a poster or be disseminated using social media, radio or television advertisements. Using sanctuary language can be ambiguous and falsely reassuring or have different meanings in other languages. Steering clear of this language avoids confusion or providing false reassurance.

Four, incorporating deportation preparedness into larger emergency preparedness planning. This includes having parents identify alternative adult guardians to avoid foster care or compiling medical information for the patient and family members. Many community and legal organizations have checklists for this, so there's no need to reinvent the wheel. In parts of the country where there are concerns for hurricanes or other natural disasters, it is good to identify which services are available regardless of immigration status, all just to plan ahead.

Five, finding ways to nurture immigrant community empowerment and engagement. Examples like community advisory boards, youth and peer support programs, media or advocacy training, or get-out-the-vote campaigns. Connecting with community-based organizations can be helpful here too. It's good to invest in these community partnerships.

From: **Assessment of Perspectives on Health Care System Efforts to Mitigate Perceived Risks Among Immigrants in the United States: A Qualitative Study**
 JAMA Netw Open. 2020;3(4):e203028. doi:10.1001/jamanetworkopen.2020.3028

Table. Health Care Facility Risk-Reduction Strategies

Category	Policies and actions
Risk of immigration enforcement personnel on or near facilities	<ul style="list-style-type: none"> • Implementing a policy that limits cooperation with immigration enforcement personnel • Designating public and private spaces • Pursuing alternative models for providing health care services (eg, telehealth)
Risk of immigration status-related information disclosure	<ul style="list-style-type: none"> • Limiting acquisition and documentation of immigration status in medical records • Ensuring protection and confidentiality of patient information • Offering alternative payment models
Risks associated with patient-level stressors	
Legal stressors	<ul style="list-style-type: none"> • Pursuing medical-legal collaborations to meet the legal needs of immigrants • Educating patients about their legal rights • Incorporating deportation preparedness into larger patient emergency preparedness
Resiliency promotion	<ul style="list-style-type: none"> • Promoting affirming care messages • Finding ways to nurture empowerment and engagement (eg, advocacy skills, media and story-telling skill-building programs, and voter registration) among immigrants
Risks associated with practitioner-level stressors	<ul style="list-style-type: none"> • Providing supportive services for employees who are immigrants • Educating and offering clinicians health-focused training for providing care to immigrants
Coordination of risk mitigation	<ul style="list-style-type: none"> • Designating an immigration point person or task force

Building Immigration-Informed, Cross-Sector Coalitions: Findings from the Los Angeles County Health Equity for Immigrants Summit

Atif Saadi , Mary L. Cheffers, Breana Taira, Rebecca Trzasky-Sin, Parveen Pamar, Shamsher Samra, Janina L. Morrison, Sural Shah, and Todd Schwebel

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Adopt the concept of "Immigration-Informed Care"

We propose the concept of "immigration-informed care," building upon "trauma-informed care,"¹⁸ to describe health care settings that are primed with the knowledge and resources to meet the health needs of immigrants. Trauma-informed services encompass core principles of safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, and cultural competency and humility across all service providers, programs, and agencies.¹⁷ Trauma-informed services also utilize an intersectional approach that addresses the compounding impact of culture, history, race, gender, location, and language on trauma.^{19,20} As such, systems that incorporate a trauma-informed approach into their daily practices would offer services such as: routinely screening for trauma exposure, using evidence-based and culturally responsive assessments and treatments for mental health symptoms, providing resources to families and clinicians on the treatment and impact of trauma exposure, engaging in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma, emphasizing collaboration across service systems, and maintaining an environment that addresses secondary traumatic stress among staff members.

In addition to the core principles of trauma-informed care, relevant for this highly trauma-exposed population, components of "immigration-informed care" include appropriate language services, clearly delineated referral pathways for undocumented patients, culturally and structurally competent clinicians trained to discuss sensitive topics without inciting fear,^{20,21} and institutional policies that ensure the physical and psychological safety of immigrant patients, such as avoiding documentation of immigration status in medical records and limiting cooperation with law enforcement.^{22,23} Consequently, immigration-informed care would have a positive impact on patient care and patient-clinician partnerships as has the

Six, pursuing alternative models for providing health care services, for example, telemedicine services so patients can have video sessions with clinicians if they're too afraid to show up to clinic, or out-of-pocket payment plans for those who might have concerns about enrolling in public benefit programs like Medicaid. With effective planning, strong leadership, and a concerted effort to support the immigrant communities that have been targeted in this environment, we can advance a health care system that effectively serves all patients equally and promotes positive health outcomes for everyone.

In addition to the videos, we have a toolkit that goes through the other policies in detail as well. Obviously, this was the backdrop, and then COVID-19 hit, and everything transitioned. As you know, a lot of immigrant communities, nationwide, were impacted disproportionately. I think I heard it best described by someone who said the immigrant communities were "both essential and exposed." I want to go back to my clinical practice, again, to describe how I saw this impacting patients. Of course, we had a rapid shift to telehealth services that many of my patients are low income, without broadband internet access, or have limited English proficiency and struggled with navigating digital platforms that were created with English speakers in mind. For the undocumented immigrants in particular, there was fear of privacy and security risk in which they didn't know who had access to Zoom when we were doing televisits, or didn't know if our telephone conversation was being recorded or if the information was being shared.

I had many patients who declined to sign up for our patient portal despite my pushing. The reason didn't become clear to me until I had a patient who very eagerly joined. I was trying to figure out why, and he said, "Oh, of course, doctor, I'll sign up. I don't have to

worry about anything because I have my papers." I think his comment really captured the reverse of the fear that many of my patients had about accessing some of these new services we were pushing that we might otherwise take for granted.

I mention the second story because I want to emphasize how it is now more important than ever to establish immigration-informed practices wherever we are. The idea of immigration-informed care is something we developed that really builds on the idea of trauma-informed care, so to describe health care settings that are primed with the knowledge and resources to meet the health needs of immigrants. In the previous sections of the talk, we heard about some of the principles of what trauma-informed services need to include—safety, trustworthiness, transparency and peer support.

In addition to those core principles of trauma-informed care, components of immigration-informed care would include appropriate language services, clearly delineated referral pathways for undocumented patients, clinicians who are trained to discuss sensitive topics without inciting fear, and institutional policies like the ones I outlined that ensure the physical and psychological safety of immigrant patients and health care staff.

I'm going to end by sharing two additional resources beyond the ones that I offered at my study website, which is doctorsforimmigrants.com. One is a sanctuary doctoring toolkit that was created by some colleagues in Chicago. The second is an additional toolkit that was just recently released by some partners I have worked with that focuses on additional policies to consider for border cities. With that, I will wrap up. Thank you to funders from California Initiative for Health Equity and Action. Please be in touch and I really look forward to the conversation in the Q&A.

Understanding Trauma-Informed Care and Building Resilience in Immigrant Families to Address Mental Health Needs



Good afternoon, everyone. I'm actually still touched and reverberating from the video that we just watched. I found it quite moving. Also, I'm quite relieved to hear the good news of the end. Today, I will be talking to you about trauma-informed care and resilience when working with immigrant families to address their mental health needs. I appreciate everybody being here and inviting me to address these important issues. I'm especially honored to follow in the footsteps of Dr. Aguilar-Gaxiola and his dialogue with our Surgeon General Dr. Nadine Burke Harris.

I'm showing you here a model of trauma-informed care developed by Sheela Raja from the University of Illinois, Chicago. The most important point that I would like to highlight in her model of trauma-informed care,

represented by this pyramid, is that the base of the pyramid is what she called trauma universal precautions based on patient-centered communication skills, and understanding the health effects of trauma, which is what we've been discussing a lot during this session.

Borrowing from the universal precautions that were developed in the 1980s during the AIDS/HIV epidemic, the idea is that anyone who comes through the doors of our agency, clinic, hospital or any setting can have a history of trauma exposure. We don't need to ask, necessarily. You can see that the top of the pyramid is the screening, the red triangle there. You don't need to ask to assume that someone may be exposed to trauma and act accordingly. Act accordingly means many things, of course the patient-centered communication skills, but also modifying some features of your system. A different issue that I think is important to highlight in this pyramid is understanding your own history. We'll talk more about that, including what Dr. Nadine Burke Harris already said about self-compassion and self-care.

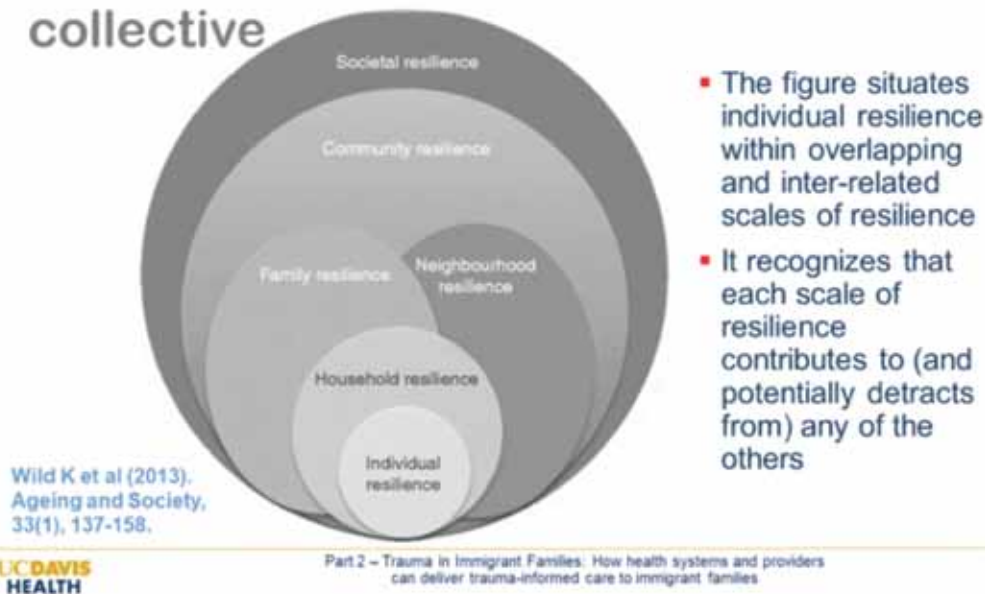
The Substance Abuse Mental Health Service Administration has the most widely known definition of trauma-informed care as a provider, program, organization or system that realizes, recognizes, responds and resists—the four Rs. The first two are mostly centered on knowledge of individual providers, so realizing the

SAMHSA's definition of TIC

A [provider,] program, organization, or system that is trauma-informed

- Realizes the widespread impact of trauma and understands potential paths for recovery;
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices, and actively
- Resists re-traumatization

Resilience as contextual and collective



- The figure situates individual resilience within overlapping and inter-related scales of resilience
- It recognizes that each scale of resilience contributes to (and potentially detracts from) any of the others

widespread impact of trauma, understanding potential path of recovery, but also recognizing the signs and symptoms of trauma. I will share with you some information later about that.

The second two Rs (respond, resist) center more on things that the system can do, such as changing policies, procedures and practices to resist traumatization. SAMHSA also has six principles of trauma-informed care. I don't need to emphasize enough here that safety, the first principle, has to be paramount in the care for immigrants and refugees.

The principals of trustworthiness and transparency might be something that many of our clients and patients from this population may have specific barriers to, because of their trauma history it's difficult to learn to trust, and the importance of transparency is very prominent. Likewise, collaboration and mutuality, empowerment, voice and choice.

The final principal is what we call intersectionality, the fact that many of the cultural, historical, gender, race and other social groups can interact in their vulnerability, as well as their resilience with regard to trauma.

I would like to add also to these principles one that is not officially in SAMHSA, which is building on strengths and enhancing resilience. You've already heard about this, but I believe it's very important when we talk about trauma to simultaneously talk about resilience.

One last encapsulation of trauma-informed care is this quote, very well known for many of you, I'm sure. Our program director said it best when he observed that we had stopped asking the fundamental question, "What's wrong with you?" and changed it to "What's happened to you?" Here we can see that there's a very critical shift between judgment and detachment of "What's wrong with you?" as a clinical approach, especially when we focus on symptoms and problems, to the curiosity and compassion stance that is implied in the question, "What has happened to you?" Now, when we talk about what's happened to you, we need to make a distinction between the "big T" traumas and the so-called "little T" traumas. We often think of trauma as things like a tragic death, an accident, a deportation such as the one depicted in the video we just watched. Those are big T traumas, and we cannot miss them.

I submit to you that those big T traumas are really the tip of an iceberg, if we think of an iceberg as the biggest portion of it submerged under water. Those are represented in this metaphor with the little T traumas, which are much more common. Now, some examples: there are many more of the little T traumas that we don't think of as structural stigma. I will tell you more about structural stigma stemming from the intersecting isms (like racism) and phobias (such as homophobia). Government-sponsored displacement, seclusion and segregation has a long sorry and sad history in this country.

Public charge rule and DACA recession or the threat of recession are laws that don't protect same-sex couples. In addition to that, we have macro- and microaggressions based on race, ethnicity, national origin, social class, gender expression, sexual orientation, religion, among many others. The importance of considering both types of traumas is because stress response is the same. Regardless of the type of T trauma, you have a stress response that is triggered in what is also called stigma. Sociologists talk about three levels of stigma.

Starting with the individual level, when we internalize, for example, the fact that something is a certain way. Many of you may be familiar with the literature on stereotype threat when we activate certain biases that society and culture are giving us with regard to gender, race or religion. The interpersonal level that we were describing before, such as microaggressions, and the structural level represented by cultural values, state policies, judicial practices and laws. These all trigger a stress response.

I want to summarize part of the research called biological embedding of stress given by little T or big T traumas. I want to focus on the two brains, if you will, the right and the left that represent the most important brain outcomes of early life stress. In plain English this means that the rational brain, the brain that allows us to make

distinctions between the logical things that allow us to navigate the world, and the emotional brain represented by the amygdala. That connection can shift in early life stress, in which the connection of the prefrontal cortex, the rational brain that can inhibit the threat sensitivity of deeper structures in the brain, is weakened.

The combination of these two effects of early life stress leads to a cascade of hormonal and chemical changes in the body that is represented in the center by low-grade inflammation. The overproduction of these chemicals is associated with inflammation, called cytokines, that are responsible for the increased prevalence of physical and mental illnesses in those exposed to trauma. Now, is stress ever good? Indeed, there is positive stress.

Dr. Nadine Burke Harris highlighted some of the of the research that has shown that toxic stress can become tolerable or even positive, and we can reverse those effects when a committed adult is present in the lives of children. In fact, this dovetails with another field of research that is posttraumatic growth, PTG.

As time progresses after a traumatic event people can succumb to their trauma and develop PTSD. Also, they can recover and go back to their baseline, which we call resilience. At the top line, we have someone thriving. That is to say they can achieve an even better level of functioning after trauma.

Summary

- How can all health providers help to identify and respond to the mental health needs of their immigrant patients?
 - Implement trauma universal precautions to avoid retraumatization
 - Recognize unapparent manifestations of exposure to trauma, adversity and chronic stress
 - Educate patients on the science of resilience and adversity
 - Identify resources to mitigate negative social and structural determinants of health

I want to make this complex concept of resilience as a concentric circle overlapping, in which there are different domains of individual, household family, neighborhood, community and societal resilience interconnected, and they can detract from one another.

In summary, what can mental health providers do for immigrants and their families from the perspective of trauma-informed care? First and foremost, we need to learn how to have trauma-informed conversations about exposure to adversity. I say conversations because it doesn't need to be a screening or checklist. This has to encompass not only individual adversities, but also community level across development and generations, including history. Second, identify goals and strengths that are important and relevant to our individual clients, communities and families.

Third, build and sustain interdisciplinary teams that can be helpful when it comes to integrating and coordinating those mental health services to other needs,

such as physical health, socioeconomic, educational, occupational or legal. How can other health providers identify and respond to mental health needs of their immigrant patients? I think, once again, going back to Sheela Raja's model, implement trauma universal precautions. Recognize an apparent manifestation of exposure. These can include for children something like ADHD. For adults it could be somatic presentations. We need to be familiar with those presentations.

Educate patients. We can all do this. It is the job of providers to educate patients on the signs of resilience and adversity. Identify resources to mitigate negative social and structural determinants of health.

I want to emphasize things that teachers, social service providers and family members can do to support trauma-informed approaches for immigrants and their families. I know that we'll have time to ask questions, so I'm going to stop here. Thank you.

Responding to the COVID Pandemic



Hello, everyone. Thank you for the opportunity to share some of the work at Asian Health Services. Asian Health Services is a federal qualified community health center started in 1974. We are really rooted in the communities that we serve. We've become a trusted source for information. We provide medical, dental and behavioral health, as well as a whole host of other services to about 50,000 patients. We do so in English and 14 different Asian languages. During this period of COVID, which I'll be talking about, we try to respond to this pandemic and be rooted in the communities that we serve.

While the Chinese and Cantonese speaking population is by far the largest, in no way does that take away from

the smaller communities that we serve, and the different languages that are needed. With each language comes with it different experiences, different needs, different historical and current trauma. As a Vietnamese refugee myself who came here as a child, it may seem like I have similar experiences to other Southeast Asian refugees, but my experience is so different from the Cambodians, the Mien and the Laotians that came here.

It's with that lens that we try to provide for the diverse communities that we serve. Unfortunately, when the pandemic hit it was a perfect storm of so many issues that came up. Years before that, we were organizing the fight against public charge at Asian Health Services with our partners through One Nation and working with others across the nation. At that time, we were targeting individuals who were seeking lawful permanent residents and penalizing them for using basic services, like health care, food assistance and housing assistance, something that many of us have depended on in the past and have returned back to this nation.

Unfortunately, even though we tried to block it in the courts, that rule was implemented on February 24th right before the explosion of the pandemic.

With that, you had all of these anti-Asian attacks that were going on, blaming Chinese and Asian Americans for the virus and then all of the impacts that came with

The Perfect Storm AAPIs went underground

- Anti-immigrant public charge policy
- Anti-Asian Attacks
- COVID-19
- Chinatown restaurants closed
- People masked up even BEFORE Shelter in Place
- Testing barriers
- Shortages in PPE
- Unemployment/ economic challenges



it. In Oakland Chinatown, where Asian Health Services is located, as well as across Alameda, we were seeing restaurants closed down and people being discriminated against.

Asian Americans were wearing masks, which is very common in Asian countries and in our communities but they were being targeted and blamed for doing so. In the beginning of the pandemic, we all suffered from the lack of testing and PPEs. In our communities, we were also experiencing it firsthand and trying to figure out how to respond. Like many other communities, the economic challenges and unemployment were really rampant. All to say that Asian Americans went underground. I wanted to clarify here that I use Asian Americans and Pacific Islanders, but in this presentation I mostly share about the experiences of Asian Americans.

I want to acknowledge that the experiences of Pacific Islanders are very different. I hope that there'll be an expert to speak about that. For Asian Health Services, we had to make a rapid and radical transformation literally overnight, and we saw that our visit numbers went down to less than 10% during that period. We knew for the safety of the patients and our staff, we had to arrange for work from home and for telehealth so that we could keep the care of our patients, first and foremost, in mind.

That required us to make a lot of changes, especially dealing with a community with a lot of language barriers, as well as a digital divide. It was huge for us. We're happy to say across our medical, dental and mental health, we were able to rapidly bring back our visits to 90% of the volume that it was through telehealth. I want to point out the picture that you see on the lower right is our 95-year-old patient. She would never have thought she would go on video to speak to her doctor, Dr. George Lee, our CMO at the time, but we got her on. This is the kind of work our community health centers do. We respond rapidly, and we are there for our community.

Despite what we did, a narrative was being framed around us when it came to the needs of these populations. This is data pulled from Alameda County. Of course, it reflects the different case rates and numbers. You can see that, for Asian Americans, our case rates for COVID were the lowest when compared to the other populations. That is not, in any way, to take away from all of the disparities that were experienced by the other populations. If you look at the same graph, but for testing rates by race/ethnicity, you can also see that Asian Americans have the lowest testing rate.

The problem is while others were getting tested, our communities were not coming forward to get tested. We

AHS
Rapid and Radical Transformation

- Visits down to 9% initially
- RAPID AND RADICAL TRANSFORMATION
- Hundreds Laptops
- Hundreds iPhones
- Mobile Wifis
- New Protocols
- Trainings
- Medical, Dental, Mental Health Leadership
- Now ^ 80-90% volume

wanted to understand why that was. We were hearing so many stories from our own patients about the fear, the stigma and not knowing where to get tested. We had talked to hundreds and hundreds of patients, and we knew this was a problem. At the same time, our colleagues at UCSF and others—researchers—were showing emerging data that highlighted that, among those who are COVID-positive cases, Asian Americans had a higher death-to-case ratio, what we call case fatality. You can see that this was happening in some parts of California, like San Francisco, Los Angeles and Santa Clara, throughout California, as well as in other states. When compared to the overall case fatality, Asians really stood out. Yet, we were seeing a lot of this highlighted as a disparity for our population. At the same time, we heard about the rising hate crimes targeting Asian Americans, blaming them. So many stories were shared. This just shows you some of the reports that were coming out from the FBI and from others.

At the same time, there were many, many incidents that were not reported. Earlier, you heard about the iceberg of some of the crimes and the trauma that was being experienced, but imagine all those that were underneath that. So much was not reported, not shared for fear of stigma and everything else—and language barriers too. At Asian Health Services, we decided to step up. I led a team to conduct our own survey. We knew these things were happening, but it was important for us to document them. I set out to do a survey.

I was hoping for 500 people within two months. I was very fortunate that, given our reputation in the community, we were able to get over 1,300 people to participate, most of them being our own patients. This is just a demographic profile of the participants. As you can see, the vast majority were self-identified Chinese with some Vietnamese, as well as other Asian American groups. Over half of them consider themselves not fluent in English. Eighty percent of them are foreign born. The majority of them live in the Alameda County, which is where our health center serves our many residents.

I want to thank the California Health Interview Survey, CHIS and Dr. Ninez Ponce for sharing some of her questions with us. We started asking questions about who was getting tested. We found that, in this sample, only 3% said that they had gotten tested, with a very small number that reported a positive test—a very small sample.

When we asked why they didn't get tested, we found that 49% of them said that they could not find a place to get tested, and about 44% didn't think they had been exposed. At the same time, we saw that 36% of them had lost their regular job, and about a quarter of them had reduced work hours. This also shows you all of the economic challenges that were being faced by this population. When we asked the survey participants about anti-Asian hate, 6% of them reported that they had experience some form of anti-Asian hate, whether it was verbal or physical. This ranged in age from 16 to 74. Through our staff and in talking to patients, we've heard a lot about physical abuse as well. When asked about mental health issues, 25% said that they actually experienced depression, and about 75% of them said that they were stressed. Only 5% of them had talked to their doctor or a mental health professional.

Now, based on the literature for Asian Americans to say that, when a quarter of the sample says that they're depressed, that's saying a lot because Asian Americans do not report mental health issues as often as other groups. When we asked about what they were doing to avoid getting infected, 73% of them said they avoided leaving the house entirely. About 8% of them said they avoided seeking health care and 19% of them avoided public transportation.

We asked about wearing masks, because we knew that was very common, but very important behavior. Forty percent of them were wearing masks before shelter-in-place. Forty-one percent said that they wore a mask when shelter-in-place happened, but before it was required, and the rest reported wearing a mask by the time the government required it. All of this was very interesting information for us and confirms what we knew.

We set out to have a more comprehensive response and we understood that, in order to get people tested, we had to provide outreach and education that considered all of the different cultural nuances and language barriers, as well as the trauma they were experiencing. Once we got to testing, we could build out to contact tracing and really get them the case management and support we knew our community needed.

We are happy to say that, last week, we were able to launch the first Asian multilingual, multicultural testing site open to the community. We are testing about 200 individuals per day. It's free, regardless of insurance and immigration status, but we have the language support there.

In the picture, the young lady standing in that white suit is Tiffany Quan, our newly minted nurse practitioner. She has been working at Asian Health Services since 2013, first as a front desk receptionist, then as a medical assistant, then she became a nurse. Recently, she received her nurse practitioner degree. She is our swabber doing the test. She speaks Cantonese and Mandarin. She knows the community. It's not just about the testing but having the people from the community serve the communities as well. In addition, we launched a COVID helpline assisted by our own bilingual and bicultural staff who know the community, can schedule the appointments and help them with results. They are doing case management, referring callers to mental health specialists and the resources as needed. Our staff

members understand that it's more than just the testing, but identifying all of the services that are needed for our community who, for so long, have been overlooked.

Our next step is to get into case investigation and contact tracing and working with our county. It's really important that, as a trusted health care provider, we are the ones working to call our community, understanding the fear, the stigma and the trauma they experience, and being able to explain to them the importance of prevention and also linking them up to the resources that they need.

I want to end with the last piece, which is that our challenge and goal was to prevent our populations from being simultaneously blamed and overlooked for COVID-19. With that, I'll turn it back to Ignatius.

COVID Community Testing Site



- Located in Oakland Chinatown
- Launched 8/18
- Asian Multi-lingual and Multi-cultural in Alameda County
- Free, regardless of insurance, immigration status...

MODERATED PANEL DISCUSSION

Moderator Ignatius Bau: We have multiple current events happening. Dr. Saadi referred to all the immigration policies that impacted immigrant and refugee communities over the last three years, and then we had COVID-19. Now, we have some of the wildfires here in Northern California. Let me go back to Dr. Quach. Can you talk more about how COVID, and especially the anti-Chinese racism, was experienced as additional trauma by some of the patients that you are seeing and serving in your community.

Thu Quach: We have been seeing higher numbers of people who have experienced this. Many of them, as you saw from the survey, were just holed up in their house. I anticipate that, if they were moving around, the question of whether they experienced emotional or physical abuse, or attacks would have been much higher. Based on what we were hearing from our own patients and our staff, we have seen cars try to run people over in front of grocery stores. This is the type of trauma they are experiencing: getting on a bus and being yelled at to sit in the back, the microaggressions. There's also the physical and traumatic experiences that add to the fear that many of them have experienced. Many of them are immigrants and refugees, or children of immigrants and refugees. All of this triggers them, to no end, in terms of those experiences they have had.

We have heard from our senior patients, who shared about being inside their homes and not knowing when it is night or day because they are so fearful of going out. When our staff called these patients, they were so thankful to have an outside person speak to them. This idea of having these attacks, being blamed for COVID, and then being ignored when it came to services because of the model minority myth is a huge problem for our community. It feels like we are launching two battles here. I want to share some sad stories in terms of patients who have attempted suicide. Fortunately, none of them were successful. This is what we see on the ground. Being able to sound an alarm and be a solution and really raise those voices is the challenge that many of us advocates are facing right now. That's in addition to trying to get the culturally, linguistically and trauma-informed care that our communities so desperately need.

Moderator: Let me turn to Dr. Saadi and stay on the COVID theme for a moment. Obviously, in following public health practices, if people are exposed, they

need to self-quarantine or self-isolate at home. For many, that is a challenge. Their housing situation may not allow them to do that. They may be in a family, multi-generation households. They may not have stable housing. Can you talk a little bit about how that, in itself, those environmental issues, also create additional stress for immigrant and refugee communities?

Dr. Altaf Saadi: The stresses are on multiple levels. One is the mental health consequences of being in isolation and quarantine, and severing social ties that are so critical for someone's mental well-being. We see increases in anxiety, depression, loneliness. There is also incredible economic strain. We have had, just in my clinic, people being either required by their employers to prove, through multiple tests, that they can go back to work, and then coming in and asking us to provide letters so they can go to work earlier than we would recommend because there is such significant economic strain during this time.

I would say, just from a physical space perspective, even with my [telehealth] clinic appointments, I have found it difficult for patients to have private appointments. I had an appointment with a patient who had to lock herself in the bathroom to be able to talk with me. She was scrunched into this small bathroom in her room. Other times, I have families that have multiple children, or there are multiple people in the household who are trying to be in school, trying to have doctors' appointments. It can be really challenging in that small physical space. All of these things, we need to think about what we are seeing in terms of immediate aftermath, and then also think of some of the ramifications that are going to persist over long time periods, like the increases in anxiety, depression and loneliness.

Moderator: Dr. Sciolla, do you have any tips or suggestions to help immigrants themselves, to explain this concept of trauma, which may not be something that they necessarily have heard about? How do we help parents understand that as something that their children may be experiencing? Also, especially in the social media world where young people may be talking to each other, are there any tips for adolescents and young people on how they can talk about it among their peers?

Andres Sciolla: I am going to address the second part first by telling you that there are many resources,

many professional organizations and government organizations, such as SAMHSA, the Substance Abuse and Mental Health Services Administration, that have special lists of resources for youth and peer support. There are also community-based organizations targeting youth. They are so important; they are leveraging the natural need for socializing among peers of youth to enhance that power to assert a positive socializing influence.

In terms of the language and how to explain, that is a difficult paradox. It is an easy and difficult issue because fear and threat are universal. All of us have the experiences, but the language and the way we make sense of that varies throughout the world and different cultures. That is a challenge. My personal advice would be to stay away from clinical labels—including trauma—until we are sure that the patients are understanding the same thing that we are. There are many communities and groups within those communities for whom even the word “abuse” is not something they feel comfortable with. Whenever we are having conversations about these issues or asking about them, I would be very careful with the language.

Be descriptive. Also, introduce the idea that we have, in the body, our survival mechanism. We all need to stay alive by detecting promptly and responding quickly to threats in the environment. The threats come in many guises. That system is automatic and responds in a matter of seconds. Most individuals across cultures and languages have a sense of what the body does when it is under threat. We have expressions like “butterflies in our stomach” in English. There are multiple ways to convey that. People can find a common language around fear. The body responds to fear. From there, from the body, help others to understand that there are parts of the brain that are deeply connected to everywhere in the body to prepare for fight, flight or freeze, to describe the basic responses.

How our perception, how our mind perceives threat, can trigger those responses even in the absence of those actual threats. In my experience, it has been very helpful to use metaphors and proverbs or sayings. Most of my work has been with Spanish-speaking immigrants or refugees. So, I go back to my first language, which is Spanish. I know many sayings, popular sayings that people can quickly understand, so grab what you want to say in a non-technical way.

Moderator: Dr. Saadi, we talked a lot about the impact on children. Dr. Quach talked a little bit about the impact on older adults and seniors. There are obviously many diverse populations that are experiencing this. There are some questions in the chat about immigrants with disabilities, an intersectional multiple identity. There is also the particular experience of immigrant women. When you talk about that life course of trauma and violence that began in their home countries, a lot of the asylum seekers are women with their children, fleeing various kinds of violence in those home countries. Do you want to talk about immigrants with disabilities and immigrant women?

Dr. Altaf Saadi: In terms of immigrants with disabilities, linking to people with disabilities more broadly, research in past pandemics have shown that disabled people find it harder to access medical supplies during pandemics. That becomes even more challenging as resources become scarce. Imagine, in the initial moments when there was a lot of fear, and people were buying a lot of things in stores, that typically placed disabled people at a disadvantage. There are a lot of policies and fears around rationing medical care that, a lot of times, intensifies a lot of discriminatory attitudes towards disabled people during times of crisis, and obviously can worsen anxieties about getting sick and needing to get medical care, and being fearful about what it might mean if you do get sick, and how a hospital might think about rationing medical care during times of crisis. This goes to a larger point that, for some individuals, there are additional compounded vulnerabilities that we need to be attentive to.

In terms of women who are in domestic situations that involve intimate partner violence, and even outside of the immigration context, studies have shown that because people are more at home during times of pandemics, we sometimes see an increase in substance abuse. There is more time at home with a potential abuser that we see an uptick. I know that [domestic violence] hotlines have released [data showing] an uptick in calls that they have been receiving. For immigrant women, what is compounded in this context is that we have seen continued immigration enforcement during the pandemic that has exacerbated existing fears in immigrant communities.

I wanted to make a comment about the protests and calls for racial justice that we have been doing, and the tragic police brutality that, for a lot of patients I have care of, has

also worsened their trauma because they have witnessed or themselves have been subject to police brutality. And to see it hit home in a very different way in a place that they thought they would be safe has been really difficult. I know that was not part of your question, but I thought it was missing in the conversation, and I just wanted to make a point to that explicitly.

Moderator: Thank you for introducing that, and integrating that awareness of structural racism, as Dr. Hernández alluded to in her introduction, and how those responses are also a critical part of how we are developing these kinds of responses.

Let me turn to some of the positive approaches that many of you have shared. Dr. Sciolla, you framed resilience in multiple levels, that it is not just about individual characteristics. It is also about the support, the networks, the community, organizational resilience that we see in communities as well. Can you talk a little bit more about some of those organizational strategies or community-level strategies to build resilience, to build a sense of self-advocacy and self-efficacy around some of these issues?

Andres Sciolla: One of the wonderful phenomena that has emerged in this country, with regard to trauma, community and resilience is part of a long tradition in this country of community organizations, and helping each other that, interestingly, in other countries are more collectivistic, are not cultivated as much because of the unity, usually, of a clan, a family or similar group, a church. Here, there is a long tradition of being based in neighborhoods or locations. Many organizations are springing up to disseminate the idea that communities can get organized to enhance and coordinate services and resources for resilience. As I said in my model, resilience is not only a capacity of an individual, but it is also the ability that we have to mobilize resources around us, and for communities to provide and be responsive to those needs.

One of the most successful resources I am aware of is called the ACEs Connection. Some of you may be aware of it. It's about adverse childhood experiences, acesconnection.com. They have built a platform organized throughout the country, and now internationally, encouraging the emergence of local communities that organize around resilience. We have one here in Sacramento called Resilient Sac and, next to us, in another county is Yolo County ACEs Connection

that is very active, too. Those are the examples I can think about off the top of my head, based on this idea of resilience as an interactive process.

Moderator: Dr. Quach, the response that you described at Asian Health Services to set up this testing and now enter into contact tracing, is an example of that kind of community resilience, of finding those resources, building those resources, providing the information, as well as the testing, that is backed up by the medical staff and the health services that you can provide. How have you, as an organization like Asian Health Services, been able to, in the context of this trauma, in the context of COVID-19, build that kind of trust or maintain that kind of trust? You talked a little bit about the inability to get people out of their houses. Talk a little bit about what you have done and what has seemed to work for you.

Thu Quach: Because we have been around for 46 years and have built that long track record with the community—a very diverse immigrant, refugee community—that has gone a long way. It is not just the trust, but that our 500 staff members were actually hired from the communities that they serve. I cannot tell you how important that piece is, because when you look at so many of the issues that we face, whether it is anti-immigrant policies, whether it is a pandemic, culture trumps geography. The culture trumps so much. We have been able to put out there, in the midst of fear, of stigma, that Asian Health Services is here for you. We opened a testing site, we speak the language, we have providers that you know and staff that you can trust. In the moment when we opened up, people who had not come out for testing were ready to come out. That speaks to the trusted partners and the trusted sources.

We have not changed too much of our mantra around culture and linguistic competency since we opened, to understand that is a heart of so much. It is not just language. It is not just culture. It is understanding immigrant and refugee experiences, the fear, the loneliness, the isolation, and then also seeing that their doctors and their nurses and their medical assistants are from the same communities they are from. It goes a long way.

When we opened up the COVID helpline, which is an added piece to the testing, we got 200 calls that week from people just asking questions: It's free? I don't have to give my immigration status? I don't have to give my insurance? They finally have a place they can call and ask

questions. Since many of these immigrants are refugees who come from places where their governments were the ones that attacked them, it is important to link up to a community resource that they trust, that they know has been out there. Right now, as we are speaking, my staff are out there doing 200 tests, and people are not afraid to show up because they know that Asian Health Services' name is attached to it.

That is true of Asian Health Services, but it is also true of so many of the other clinics and community organizations. We really have to lean on those CBOs who have developed those inroads. Particularly in times of crisis, we are needed more than ever to bridge that gap. We serve Asian Americans. I know that there are Pacific Islanders. I know that there are other immigrant groups that need it. I think it is important to build on that infrastructure, and to know what is really there.

I want to describe how we ask questions, because with the bilingual and bicultural staff, it is not just about language and culture, it is about understanding the people. When my staff go through the questions they have to ask to make an appointment, they will tell me, "That is going to trigger someone. This is going to make someone hang up [on the phone call]." So, we work around it, we say it is optional. You can provide this [information], but if you are uncomfortable, you can say something else, and I will pass it through. It is important that we understand the people we are speaking to, and we let them know they have choices and that we are not there to monitor them, that we are there to help them, taking those approaches to serve the communities we serve.

Moderator: The statistics you shared about adapting to telehealth, that it was very minimal, but now it is the overwhelming majority of your visits. So, there is adaptation that a lot of health care providers have had to undergo as well.

Let me turn back to Dr. Saadi. In your research, you looked at many kinds of policies, and you have helped frame all the different kinds of strategies an organization, a health care provider, a hospital, a health system could adopt. Did anything stand out for you about a hospital or a health system that seemed to do this well, that was operationalizing the kinds of things you were recommending?

Dr. Altaf Saadi: I would elevate the work of Federally Qualified Health Centers (FQHCs) because they are, as

Dr. Quach alluded to, tied to communities, community partners and CBOs. I went to 27 different institutions across five states in California, Texas, Illinois, Florida and New York. Definitely, the pattern that became evident was that FQHCs were leaps and bounds ahead of county [providers], academic medical centers, and those connections to community organizations were so central.

At some of the other facilities, their first step was, "Well, let's connect to those CBOs because we need to get connected to the community. We need to know how to adapt our policies. We need to know what the trusted information to get out there is." For them, that was their first point of action. Everything else followed several months later. Whereas those centers, and particularly the FQHCs, already had those preexisting relationships and were able to hit the ground running. When Dr. Quach was speaking, I wanted to give her a standing ovation because she was just so spot-on in terms of how critical those community partnerships are.

Moderator: In every immigrant and refugee community, there are those counterpart organizations that have always been there. Some of them are formal, like community health centers, but there is going to be a lot of informal networks, faith-based networks and organizations, as well, that are often the first place that a lot of immigrants and refugees go.

Let me turn back to Dr. Sciolla. There is some good conversation in the chat about your allusion to using metaphors in one's own language, in Spanish, for example. Are there any other examples in which we can tap into culture in a way that helps not only explain what trauma is and trauma-informed care, but also can use culture as a way of healing, as a way of also helping people through the trauma that they are experiencing?

Dr. Andres Sciolla: There are a couple of general concepts that have been very helpful to me to understand and take care of refugees and immigrants from multiple countries. One of them is acculturation, the whole field of acculturation, which can be a little bit technical at times. In summary, there is a consensus that acculturation is a process that can lead to better (or not so good) outcomes in terms of mental health. One of the consensuses is that becoming bicultural is better than not. Individuals who live a life only among peers and trying to preserve, as much as possible, their original culture in the host culture may not be the best strategy in the long term. This is not

a clean process; it is a messy process. But by and large, being bicultural and bilingual can help one tremendously in navigating this process, because by retaining some elements of culture we can become more resilient than if we relinquish all that heritage and try to adopt blindly, if you will, the values and morals of the host culture. I often tell patients, “Think of a Chinese menu in which you have many offerings, and you pick and choose what you really want; you do not need to adhere to everything in the culture, but you can pick and choose.” That is one concept that has helped me, acculturation, the idea that you can become fully bicultural and bilingual.

The other has to do with sociology and longstanding research in trying to understand why some cultures seem to be so different than the vast majority of cultures around the world. Our world places such a value on the community and the family, as opposed to this extraordinary phenomenon in the history of humankind, of Western Europe and its cultural satellites, that privilege so much the individual and privacy, and things like that. It is also a complex issue because it comes with a gift, but also vulnerability.

Let me give you a short anecdote about this. When I was working in a stand-alone community clinic, county-contracted, in Northern Sacramento for several years, I had the honor of taking care of many Mien and Hmong patients. The county asked providers, once a year, to ask in the client treatment plan, “What are your strengths?” After years of establishing a rapport with interpreters, we would laugh because we knew the answer to this question. Most patients were absolutely puzzled by this question. They had no concept of personal strengths.

Their idea of themselves is their family and their community. Eventually, I worked around how to tap into those strengths, but through another door, if you will, by asking them about their family, and the things that they value in their lives and want to preserve.

It is important to be mindful of this distinction between collectivistic cultures and individualistic cultures. This helped me to tailor and translate my messages. In many collectivistic cultures, it is so important to preserve the order of the family that, when a perpetrator is in the family, it becomes a very challenging situation to break. Providers can be more effective by being mindful of how difficult is to, for example, confront a perpetrator or change the dynamic.

We can do a lot of work by educating and helping to model bicultural approaches. For me, this has been especially important for sexual minorities, LGBT individuals, and women to be able to be assertive and selfish. They say, “Dr. Sciolla, it’s not good to be selfish. I’m a mother. I need to worry about everybody.” I said, “Well, there’s something about self-care. You have to develop that part of you that, maybe is not something that in your culture of origin was valued or considered. In this culture, you have room to grow in that direction.”

Moderator: Those are all great examples of ways that we can adapt the language and adapt the concepts, and not necessarily use a scientific or the technical terms but be effective communicators, which was the key on the bottom of Dr. Raja’s pyramid of patient-centered care. I want to thank the panelists for a terrific discussion.



Thank you very much. That was really an extraordinary program. I don't know exactly how you do a standing ovation on Zoom, but from top to bottom, this program today has been absolutely rich.

We began with our California Surgeon General's remarks about understanding both the basic biology and the biologic response to chronic stress and toxic stress. She framed very nicely the ongoing conversation that we had. I had the incredible opportunity to go online and to take the adverse childhood experiences (ACEs) training for clinicians in California. For any clinician attending today's program who hasn't done it, I highly recommend it. It's an incredibly useful tool. My big takeaway from Dr. Nadine Burke Harris' remarks is that in the Centers for Disease Control definition of toxic stress and ACEs, immigration ought to be recognized as part of the conditions that lead to chronic stress, conditions that include abuse, neglect, parental separation, incarceration and domestic violence. That was a theme that ran through the entire program.

The program identified so many models and tools for clinicians of all types to be able to tap into. The one thing that I heard from all of the panelists, which was quite striking, is the science of resilience. It is not just about doing appropriate screening, but also about building on the strengths of individuals, the families and communities—the strengths of immigrants—in order to fully tap into the science of resilience, to build on it and to continue to use that evidence as a treatment modality.

In her remarks, Dr. Thu Quach called out this whole concept of understanding our own culture and our own history. All our speakers—all of us—have a history of our own immigration and our own cultural history. It is important for us to be self-aware of that because that is something that helps us, as clinicians, be more sensitive

to those we are trying to serve and care for. I just love hearing, Dr. Quach, in commenting about the photos doing COVID testing, that your nurse practitioner there started off as a receptionist, and then a CNA, and then an RN, and now the nurse practitioner who pivoted to be able to do COVID testing and, I'm sure soon, contact tracing as well. I think that really does speak to community resilience, the notion of economic development, jobs and job training, and getting people exposed to health care careers. Dr. Altaf Saadi also remarked that one out of five health care workers is an immigrant. That story of your nurse practitioner is such an important one about our delivery system, and how it is trying to respond in COVID, and respond more broadly to structural racism. Finally, I found it to be incredibly beneficial, Dr. Quach, that as an epidemiologist, you emphasized the importance of being able to do research in a community-based setting.

Dr. Altaf Saadi, I had never heard of immigration-informed care, but the way in which you have built upon trauma-informed care and made it relevant to immigrants who are subject to so many acts of stress and violence, whether it is through policies or through practices, countries of origin, coming here, seeing racism manifest itself in our police force. The framework that you put together for immigration-informed care was really quite extraordinary, and I learned a tremendous amount from your presentation.

Lastly, Dr. Andres Sciolla, you talked a lot about systems and organizations and programs. I think it is really important as we think about how we collectively work together to mitigate the stressors that exist by virtue of policy and/or practice. I think your framework and describing it so aptly says we really need to do this work at multiple levels. The Asian Health Service clinic is a great example of a clinic having a mission. A pandemic breaks out, and it pivots to do the kinds of things that are needed to be done in the community.

In that way, today's entire program was incredibly uplifting at a time when one might well argue that racism is, in fact, a public health emergency in this country, and that the policies that are being promulgated that we talked about at the top of the program are promoting racism. Dr. Quach talked about this and how she described it in the communities in Chinatown in Oakland at the outbreak of COVID, with the President referring to the COVID-19 virus as the "Chinese virus."

These are all examples of the way in which racism is manifesting itself in our country.

Yet what we heard today was the resilience of immigrants from all of those who were part of the program today, who do the research, build the evidence, put in practice, and continue to learn and document, and bear witness to what we are seeing today from the federal administration that has promulgated toxic stress. Not just on immigrants,

but on all of us, as we bear witness to blatant racism.

This was quite an extraordinary program, with a lot of resources for people to tap into. I could not have been more pleased at being able to participate today. I want to thank the entire team that did all the logistics, and thank our panelists again. This was really an extraordinary presentation by all of you. Thank you, very much!

PART III: FINANCIAL IMPACTS AND POLICY SOLUTIONS FOR TRAUMA IN IMMIGRANT FAMILIES



Photo: Mandel Ngan / AFP via Getty Images

September 22, 2020

Speakers

Panelists:

Jeffrey Hoch, PhD
UC Davis

Tanya Broder, JD
National Immigration Law Center

Cynthia Buiza, MA
California Immigrant Policy Center

Presentation Slides: <https://health.ucdavis.edu/crhd/pdfs/events/part-III-symposium-financial-impacts-policy-solutions-slide-decks.pdf>

Recording: <https://www.youtube.com/watch?v=aoafzpO6fFg&feature=youtu.be>



This is the third and final installment in a three-part symposium, which began earlier in the summer with an introduction to the policies that are creating an epidemic of trauma in immigrant communities. The second part took a deeper look at how those policies impact people on an individual or human level, and the types of trauma-informed interventions that can be deployed to support individuals and families. Today, we are going to take a look at how this trauma manifests on a population level, and the impact that it can have on entire systems and the economy, as well as the kind of systemwide solutions that are most likely to be effective in response. I am very much looking forward to what our distinguished panel of speakers have to tell us about these systemwide problems and solutions as they relate specifically to families experiencing trauma as a result of anti-immigrant policies.

Before we do that, I wanted to take just a moment to put today's conversation into the context of what we know about the impact of trauma at a broader level. Untreated trauma is a major contributor to some of the greatest social challenges in the country, and indeed in California, and it puts a huge burden on our public systems. Let's start with health care. Health care is the single biggest line item in the California state budget. In the most recent data available, which dates back to 2013, the health-related costs of Adverse Childhood Experiences in the state of California totaled over \$10.5 billion per year. Yes, I said \$10.5 billion. The total costs that we can see beyond health care were estimated at over \$100 billion.

And it would be wrong for me to proceed without noting that mental health is particularly important in an economic context. Every extra poor mental health day in a single month is associated with over \$50 billion in lost earnings nationally. Every single day. That makes mental health one of the costliest forms of illness in the nation. It is also worth noting that Adverse Childhood Experiences are not just linked to health care costs. They are also linked to many of the biggest challenges facing our society: homelessness, poverty, interactions with the criminal justice system, all of which are positively correlated with childhood trauma, and all of which create real costs to individuals, families and the social infrastructure that we all depend on to thrive.

At the human level, while the impact on an individual is staggering enough, I wish I could say that it stops there. Sadly, we know that parents who have experienced childhood trauma, and are therefore more likely to find themselves unemployed, living in poverty, or convicted of a crime are more likely to raise children who grow into adults with the same experiences. The kind of trauma that we are seeing in immigrant families in 2020 is driving an inter-generational debt that our children, and indeed our grandchildren, will be paying for time to come.

There has to be a better way. We have to be able to imagine and implement systems to prevent harm and to promote healing. Money is not the problem here. We throw plenty of it at symptoms, and it is time to put the emphasis where it needs to be, on solutions. This is true generally in California, and it is especially true when it comes to dealing with the impact of trauma on immigrant families. I was happy to learn this week that, in a 2020 scan of foundations by Grantmakers in Health, 87% reported investing in trauma and resilience efforts.

I am looking forward to learning more about the economic impact of Adverse Childhood Experiences on immigrant populations today, as well as the challenges that are presented by the federal landscape in which we are operating. Mostly I am looking forward to learning about the ways California is responding. With that, and with great gratitude for being here, I will hand things back to Dr. Aguilar-Gaxiola to get us started. Thank you!

Financial Impacts and Policy Solutions for Trauma in Immigrant Families: Cost matters



It's my pleasure to have the opportunity to speak with you a little bit about cost and cost analysis. I want to ask you to consider the person who said, "I want to learn more about costs." If you guessed "no one," then you're right, but I promise you, as a health economist and a professor at UC Davis, I'm going to try very hard to share with you why I think some research on cost could be very helpful in trying to help you be more successful in obtaining what you want to obtain.

We're going to be talking about how you can use cost research to make the case for a problem. We'll be talking about how we can use cost research to actually

advocate for a solution and last, but not least, we'll be talking about how you can use cost research to actually show the value of what you're doing and potentially protect it from those who may not believe they should be investing in such things. I'm going to start next by asking you to think about why costs? Well, costs—you can see on the bottom right of the slide—produce what we call a burning platform.

You might say, "Why do we need a burning platform? How does that focus attention?" Well, the quote on the left explains. If your house is burning, wouldn't you try to put out the fire? It's possible that calculating the costs related to some particular issue might actually help focus people on the fire that's burning. In addition to which, maybe it's not your house in flames. Maybe it's the neighbor's next door. That's also really important to you or it should be because if your property's on fire you get it, but if it's your neighbor's house or property that's on fire, then you know soon enough yours is going to be in danger as well. Cost analysis helps us understand that there is a burning platform and that we must do something about it. Next, I'm going to be talking about why costs? Costs show the burning platform, but what advantage do they have? Here's a slide where you can see many, many bad

Summarize all the "bad" in one number and call it COST

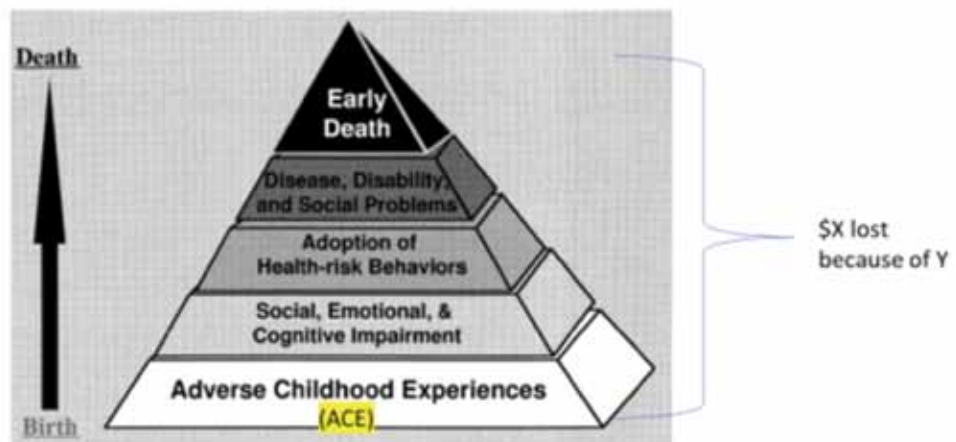


Figure 2. Potential influences throughout the lifespan of adverse childhood experiences.

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults
The Adverse Childhood Experiences (ACE) Study
Walter T. J. Froneo, MD, PhD, et al. *Journal of the American Medical Association* 2010;304:2738-2745

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10.5 billion reasons to care

Results

Among adults in California, 61% reported ACEs. Those ACEs were associated with \$10.5 billion in excess personal healthcare spending during 2013, and 434,000 DALYs valued at

RESEARCH ARTICLE

Adult health burden and costs in California during 2013 associated with prior adverse childhood experiences

Ted R. Miller^{1,2*}, Geetha M. Waehrer¹, Debora L. Oh¹, Sukhdip Purewal Boparai¹, Sheila Ohlsson Walker¹, Sara Silverio Marques¹, Nadine Burke Harris¹

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4986705/>



things that might be happening related to trauma. You might have adverse childhood experiences, or ACE—and you can see that at the bottom of the pyramid—but that leads to bad things, like impairment or risky behaviors or disease and disability and social problems and even early death, so there's a lot of bad problems.

If there were a way to summarize it all in one number, it might be a more efficient way of talking about the burden of this or the total burden that this actually puts on not only people themselves, but also to society. This way of taking all the bad things and summarizing it in a number, this is what you can use cost for. You can summarize all the bad in a number and call it cost and then be able to say, “We lost this much money because of this. Trauma is responsible for this much lost,” and it summarizes everything all at once. This is part of the appeal of using cost, and I'm about to give you an example of how people can do that with cost and trauma.

In the example we have here, I like to call 10.5 billion reasons to care. This is an article that Kara Carter made reference to, and we've heard about from the Surgeon General in California as well. She's the senior author. The article is called “Adult Human Burden and Costs in California During 2013,” so it's during one year. What's it related to? What's causing this? Well, it's being caused by prior Adverse Childhood Experiences. This is the ACE stuff we were talking about. Now her estimates based on numbers are that among adults in California, about 60% report ACEs or adverse childhood experiences, so three out of every five.

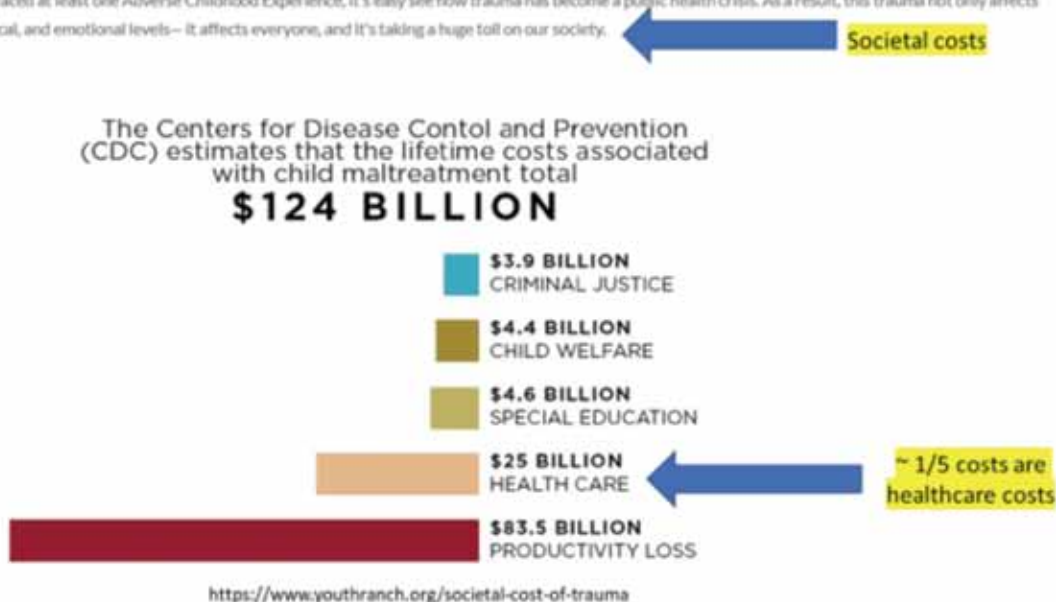
Who cares? Well, those ACEs are associated with \$10.5 billion in health care spending. This is health care spending that didn't need to happen, but because of the ACEs we have an increase, an excess, if you will, and that's just in 2013. This is a lot of money and the idea here is illustrated in the picture on the right. It's not to paint a hopeful portrait. It's not to advocate for the good that your organization is doing. It's to instill panic and say, “Look, there's a burning platform here. This is something that affects a lot of people, and it costs a lot of money.” If you're interested, the article you can see is cited here at the very bottom of the slide, but next I want to make sure you're clear that when we're talking about cost, it's not just health care costs.

Work by the Centers for Disease Control and Prevention (CDC) reveals that nearly two thirds of adults have faced at least one ACE and it's easy to see how it's becoming a crisis. A lot of people are having these experiences, but it's a crisis not only because it affects the individual on a mental, physical and an emotional level, but it's also a problem because it's affecting society. Here is the concept of cost perspective. The reason it's affecting society is not just because the person's getting the cost, but it also is permeating through other areas.

You can see health care. It looks like it's at \$25 billion. You can see that bar right there, but the total is \$124 billion. What does that mean? That means about one out of every five dollars is being spent on health care, but there's still \$100 billion of cost that's related to this. There

The use of cost to “show” a problem

With nearly 67% of adults having faced at least one Adverse Childhood Experience, it's easy to see how trauma has become a public health crisis. As a result, this trauma not only affects individual people on mental, physical, and emotional levels—it affects everyone, and it's taking a huge toll on our society.



are costs that fall on the criminal justice system, on child welfare, special education. Look at the productivity loss. It's gigantic. It's huge. That's more than all of the other categories, and that's not a health care thing. That's a workplace thing. That's why it should be important to people, because it's going to affect not only the health care segment but it's going to affect the economy and all of us as well.

Next, we're going to see a case being made in the workplace. This is taking a look at the impacts of ACEs on the workforce. We're comparing employees who have no adverse childhood experiences to employees who have ACE scores of four or higher. The ones that have more adverse childhood experiences are more likely to report serious financial problems. They're more likely to be absentee at their jobs, and they're more likely to have serious job problems. This means that not only is the person suffering, but also the economy and the business will be suffering as well.

Business is being affected, and you can see how we're able to knit together stakeholders to look at costs and see the different perspectives and how it's affecting all of us. This leads Dr. Block who says that Adverse Childhood Experiences are the single greatest unaddressed public health threat facing our nation today. That's ACEs for everyone, right? Let's see how it looks next for immigrants.

What we know so far is that trauma has multiple impacts with multiple costs, and these impacts are going to be to different sectors through different time periods. Now I want you to do the following thought experiment. Just think about it. If you're thinking about immigrants, do you think it's going to be more or less likely for them to have experienced trauma? Remember the previous analysis, the previous research was about everyone. Do you think immigrants are more or less likely to have trauma? Do you think that trauma is going to be more or less severe? Do you think immigrants are going to have more or less resources to cope? Think about that.

If you think that trauma's a problem, just looking at costs, just looking overall—remember three out of five people have ACEs and they're associated with this giant cost—then it's possible that for immigrants it is going to be an even bigger problem and perhaps worthy of more attention. If you thought it was important overall, it might be really important for this group.

Next, we're going to see what we might do after we've used costs to perhaps calculate a cost of illness or a burden of disease. This sparks interest and now decision-makers or policymakers want to know what we should do. Everyone comes to those decision-makers and policymakers with problems. Why is yours special? Well, it costs a lot, but what should we do? Let's see what we

can do next to try to make that case. You might go to the literature. You might look around. You might actually have knowledge of different ways to screen for trauma or treat trauma or maybe even find a way to maintain people as they are coping with trauma, but what should you do first?

Next, we take a look at your options if you have multiple choices. Should you invest in prevention? Maybe treating people with trauma or maybe maintaining people who have been treated and are doing well now, but if we don't maintain them, it could be a setback. If you can pick what you want to do, do you know for whom you want to do it? Do you want to look at the elderly, the adults, the kids? Now why do you have to choose? Well, you've got scarce resources. That's what the health economists tell you. Scarce resources mean you have to choose.

Let's say you're going to choose kids, and let's say you're going to work on prevention. Great. The decision-maker, the policymaker, the person in charge wants to know, "What should I do? Should we do program M or program N?" Oftentimes, people look at which is maybe more effective or you might think I'm here to tell you about cost, so I'll tell you look at the costs only, but the way to make smart shopping decisions is to look at both the extra cost and the extra effect. You want to look at what you get and what it costs. Because people haven't done a lot of collecting of the data, we have to make models instead.

Next, you'll see what models I'm talking about. We've got time on the horizontal. That's talking about yesterday, today and the future. Then you've got the thing you're interested in on the vertical. In this case, it looks like it's number of husbands, and you can see in the cartoon it shows the researcher saying, "As you can see, by late next month, you'll have four dozen husbands. Better get a bulk rate on wedding cake." We can come up with really helpful advice when we make these models.

Sometimes when you're looking at two options, they may look different, but when you do the research the outcomes are actually the same. If they produce pretty similar results, you might also want to compare the costs. Are you paying a whole lot more for something that's basically the same or maybe you're only paying a little bit more for something that's hugely different? This is why people do these studies and publish these studies.

Let me share with you what the review found. This was a review for trauma-informed care for adults involved in the correctional system. It was a review of the cost effectiveness studies and what they found. I quote. "No relevant studies were reported on the cost-effectiveness." Yikes, okay. In this setting, it wasn't possible to find any research showing the value of doing one thing over the other. I believe you will be in a stronger position if you are able to support your claim of value with evidence. The economic evidence punctuates the value of what you believe in.

Impacts of ACEs on the Workforce:

When compared to employees with an ACE score of 0, recent research has found that employees who have an ACE score of 4 or higher are:

- 2.3 times more likely to report serious financial problems
- 2.5 times more likely to be absentee
- 3.6 times more likely to have serious job problems
- 6 times more likely to face clinical depressions

Business is affected

(In the Workplace Toxic Stress & Aces at a Glance, 2017).

"ADVERSE CHILDHOOD EXPERIENCES ARE THE SINGLE GREATEST UNADDRESSED PUBLIC HEALTH THREAT FACING OUR NATION TODAY."

-Dr. Robert Block, former President of the American Academy of Pediatrics.

Cost burden of trauma

- Trauma has multiple impacts with multiple costs

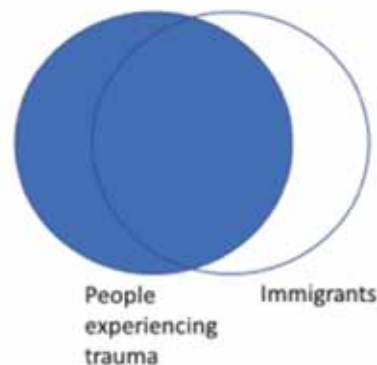
- to different “sectors” over different time periods

- For immigrants,

- Likely more or less trauma?
- Likely more or less severity of trauma?
- Likely more or less resources to cope?

- So, if you think trauma is a problem...

Among adults in California, 61% reported ACEs. Those ACEs were associated with \$10.5 billion in excess personal healthcare spending during 2013, and 434,000 DALYs valued at



On the next slide, I will remind you that this punctuation of value happens in a lot of different areas. Frequently it happens with drugs. Decision-makers are trying to decide whether they should fund a new drug or not, and the drug company might punctuate the value by saying, “Here’s the extra cost, and here’s the extra effect,” and the academics will get together and do their academic stuff, but at the end of the day, the decision-maker needs to decide, “Is the extra cost worth the extra effect?” If you haven’t done the research to demonstrate the extra effect, then all they’re focused on is the extra cost.

You can see how punctuation is important. Don’t take it from me. Take it from Rachael Ray. “Rachael Ray finds inspiration in cooking her family and her dog.” Punctuation is important. Remember to punctuate the value proposition of the thing you believe in. You’ll see how you can quickly do this. Here you can see two programs: one is the pink jellybean and the other is the white marshmallow. You can see on the horizontal axis you’ve got patient outcome. Clearly, the white marshmallow is better. You can see more. Just a little bit more, but you can see more outcome, but that’s only part of the story when you’re shopping.

You’ll see that if you consider cost as well, you can see the white marshmallow is way more expensive. If you draw a line from the jellybean to the marshmallow, you can see it’s super steep. That means there’s a lot of extra cost and very little extra outcome. This is not a good

way to spend money, especially if you don’t have a lot of it. If you do have a lot of it, contact me after this talk. My contact information is at the end.

Cost-effectiveness analysis is the science of connecting the dots. You get the dots; you connect with a line. If the line is steep, that means a lot of extra cost for not much extra outcome. If the line is flat, that means you don’t have to pay that much, and you sure get a lot. Next, you’ll see how this might look on a summary slide when you say, “Hey, this is the extra cost and the extra effect.” If you throw a dart and it hits, it shows you, “Oh, we’re in the area where we’ve got extra effect and we’ve got extra cost,” so that’s great, but how do you know if it’s a good amount of extra effect for the extra cost?

If you draw that line from the origin, you can see the slope and if you compare it to the side we saw previously, you’ll see how that previous slide had that super steep line and this one’s flat. This is the case you want to make, that we have a little bit of extra cost and that’s okay, but we’re getting a whole lot of extra effect. When the decision-maker makes her decision, she will need to draw a line that divides the quadrants. All the things underneath the line are considered good value for money. They’re worth it. You can plot your dot and say, “Oh, look. It looks like it’s more costly and more effective.” Can you see the dot? That’s your data. It’s underneath the line. The line was the decision-maker’s values. The dot is your data.

Sometimes, though, your dot will fall above the line and, in that case, even though you're more effective, the decision-maker doesn't think it's worth it, but if you happen to have a dot that's underneath the line, then it's cost-effective. The story here in a nutshell is your data produces the dot and the decision-maker produces the line. If the dot is underneath the line, it's worth it. There are three ways to get a dot that is not underneath the line to be underneath the line, but we don't have time for that for right now. I just want you to understand the arbitrary nature.

The data will give you the dot. The arbitrary political part is where you draw the line. I will remind you that cost-effectiveness analysis is just the art of smart shopping. You want to create something that conveys how much better it is and you want to answer the question how much more it will cost. We've talked about costs to talk about a problem, and we've talked about costs as helping inform whether a solution's cost-effective: you look at the effect and the extra cost.

The third thing I want to remind you before I conclude is the last step. After you've talked about how bad something is by computing the total cost burden of illness, cost of disease and after you've done a search, perhaps through the literature or talked with clinicians or service providers about what you can do, and after you've made a model or actually run the numbers to see if this is good value for money, there's something you absolutely must do and it's something many people forget. That is a real-world evaluation, because let's say

you do get the money to run your program. You need to protect it by analyzing the actual value. You need to find a way to evaluate it so you can comment on the real-world cost-effectiveness. In the real world, this is a good use of resources. However, if you're unable to do that research, you are unable to make the case for the value of what you are doing.

The real world's important because it's not happening in a controlled environment and a decision-maker might have thought, "I want to fund this," but then she's wondering, "How does this really work?" If you collect data in the real world, you can say, "With real people and real providers and real institutions, this is what we're seeing. We're seeing this extra cost and this extra outcome in the real world." This is important because while you're thinking about doing this type of study, you're thinking about: "What is the outcome we really care about? What is success for this group? Which cost perspective should we look at? Who is actually winning and losing with this?" Because potentially, the winners might need to reimburse the losers.

In summary, today I talked about costs as a way of making the case for a problem, as a way of trying to argue for the cost-effectiveness of a potential solution, like a new treatment or new intervention. I also tried to remind you that you might want to think about costs when you're actually doing something so you can study the actual costs and the actual outcomes and make the case that what you're doing is good value for the money.

Federal Immigration Policy Changes, and State and Local Responses



I will talk about recent changes in federal immigration policy, and some actions that state and local governments, health care and social service providers, and community members can take to address them.

Restricting Immigration to the U.S.

In just over three and a half years, this administration has adopted hundreds of policies that restrict legal immigration to the U.S. The Muslim ban was the first highly visible action—when members of the public rushed to the airport to express opposition and welcome

families as they arrived. Since then, the administration has reduced refugee admissions dramatically, dismantled the asylum system, curtailed due process at the border, imposed quotas on immigration judges and implemented a “zero tolerance” policy that led to family separation and detention. It terminated Temporary Protected Status for hundreds of thousands of people who have lived in the U.S. for decades, as well as the Deferred Action for Childhood Arrivals Program (DACA). The executive launched attacks against diversity visas and family immigration, and restricted employment visas. Citing the pandemic as justification, the administration imposed a ban on most other immigrant visas, and effectively ended asylum at the southern border.

The National Foundation for American Policy estimates that legal immigration will have fallen by over 49% between fiscal year 2016 and 2021, due to the Trump administration’s policies. These sweeping measures were aimed not only at restricting immigration, but at changing the face of the U.S. population.

Expanding Enforcement in the U.S.

At the same time, the administration ramped up enforcement actions in the U.S., targeting all undocumented individuals indiscriminately, without priorities. ICE con-



- ▶ Going after everyone - No enforcement priorities
 - ▶ Worksite and Community Raids, Detention
 - ▶ Enforcement at or near sensitive locations and courts
 - ▶ Targeting activists, sponsors of “unaccompanied” children, denaturalizing citizens
- ▶ Attempts to deny funding to localities that limit entanglement in federal immigration enforcement
- ▶ Chilling applications for status or relief (USCIS memos)

ducted worksite and community raids, increased its use of detention and initiated enforcement activities at or near sensitive locations like churches, health care centers and schools. The presence of immigration agents in courthouses intimidated survivors, witnesses and people seeking to defend or assert their rights. The administration targeted activists and sponsors of unaccompanied children, and even threatened to denaturalize U.S. citizens. Federal agencies attempted to deny funding to localities that limit their entanglement with immigration enforcement. The new policies chilled access to services and status for eligible applicants, who feared they would be placed in removal proceedings if they sought relief.

Noncriminal arrests by ICE have doubled since 2016. Even if the number of individuals ultimately removed from the country did not increase, the enforcement actions terrorized immigrant communities and families. In the face of this trauma, however, many immigrants and allies pushed back.

Deferred Action for Childhood Arrivals (DACA)

The Deferred Action for Childhood Arrivals program represents a powerful organizing victory by immigrant youth, who continue to fight not only for themselves, but for their parents, family and community members. In September 2017, this administration issued a memo

terminating DACA. Students, educators, businesses, states and localities across the country challenged the termination. As a result, two-year renewals for DACA continued and over 645,000 DACA recipients were living in the U.S. as of March 31st of this year.

The cases went all the way to the Supreme Court. In the video, immigrant youth cheer as they descend the steps exiting the court. At that time, it was not clear whether DACA would survive. Remarkably, the Supreme Court vacated the 2017 memo. But a month later, acting secretary Chad Wolf issued another memo. Rather than restoring the original DACA policy, Wolf's memo effectively doubled the cost of DACA. It offers one-year renewals instead of two and does not allow new applications.

The fight did not end. In November 2020, a district court found that Mr. Wolf had not been validly appointed and therefore lacked authority to issue the memo. Stay tuned for updates.

As the Supreme Court recognized, the DACA program has been incredibly successful, allowing immigrants to obtain jobs with health insurance, pursue higher education, buy homes and support their families and communities, including as essential workers providing health care and other services during the pandemic.

Deferred Action for Childhood Arrivals (DACA)



- ▶ **Memo Terminating DACA (Sept. 2017)**
 - ▶ Litigation filed → two-year renewals continued
 - ▶ 645,610 DACA recipients in US as of March 31, 2020
- ▶ **Supreme Court Vacated 2017 Memo (June 2020)**
- ▶ **New Memo by Acting Secretary Wolf (July 2020)**
 - ▶ No new applications, one-year renewals
 - ▶ Challenges to Wolf memo and to Wolf's appointment filed
- ▶ **Challenge to initial 2012 DACA memo pending in Texas**



Public Charge

The administration's public charge policy also was featured in the video. People who are deemed likely to become a public charge can be denied entry to the United States or lawful permanent residence (a green card).

The Department of Homeland Security and the Department of State issued new rules that make it more difficult for low- and moderate-income families to immigrate, based on a range of factors considered in the public charge test, including a person's age, income, health, education or skills, family situation and even their English-language ability and credit history.

The new rules also chill access to benefits, even though most immigrants who face a public charge test are not eligible for the benefits that are counted in the test. This point is important because the fear extends well beyond the immigrants who may be subject to a public charge determination.

Recognizing this harm, the organizing to oppose this rule has been phenomenal. Over 266,000 comments were submitted, with the vast majority lodging opposition. Lawsuits filed in five different courts effectively delayed the rule's implementation until February 24, 2020. And the litigation continues.

The Department of State's rules governing applications processed abroad are currently blocked, but the

government has asked an appellate court for permission to implement them. The Department of Homeland Security's rules for applications processed in the U.S. are in effect while the litigation proceeds. Please stay tuned for updates.

An impressive coalition continues to work on public charge and related issues, not only to reverse the rules, but to make sure community members know how they may or may not be affected, so that they can seek services with some confidence.

The Invisible Wall

Although the physical wall largely did not materialize, the invisible wall of administrative policies makes it very difficult for low- and moderate-income families to immigrate, to naturalize, or to secure critical services, and deprives immigrant families the opportunity to thrive and live with dignity. Some of the policies on this wall have gone into effect or have been challenged; others are still anticipated. There may be opportunities for the public to weigh in and to oppose future rules.

The Pandemic

The COVID pandemic has exposed long-standing disparities in access to care, financial support and safe working conditions that disproportionately harm Black, indigenous, Latinx and low-income communities of color, including immigrants. Immigrant families and

Public Charge Ground of Inadmissibility



People deemed likely to become a public charge can be denied entry to the US or lawful permanent resident status (LPR status or a green card)


DHS and DOS Public Charge Rules make it more difficult for low- and moderate-income families to immigrate or get a green card, based on a range of factors considered in the test.

Chills access to benefits, even though most immigrants who face a public charge test are not eligible for the benefits counted in the test.

Organizing, 266,000 comments & lawsuits effectively delayed rules' implementation until 2/24/20, and

Litigation continues! DOS rules currently blocked. DHS rules allowed to resume while the litigation continues. Stay tuned for updates.



PUBLIC CHARGE Ground of inadmissibility (DHS and DOS litigation ongoing)	PUBLIC CHARGE Ground of deportability (Anticipated DOJ proposed rule)	SPONSOR DEEMING SPONSOR LIABILITY Potential expanded use (White House, CMS, FNS, & ACF memos, revised forms, potential AOS regs)	NOTICE TO APPEAR Referral to Removal Proceedings (USCIS Guidance)	HEALTH CARE PROCLAMATION Low Income immigrants denied entry if can't show proof of certain health coverage (WH Proclamation litigation ongoing)	FEE WAIVERS and FEE INCREASES Reducing access to fee waivers; Increasing fees USCIS fee waiver rules enjoined; fee increases proposed
CITIZENSHIP QUESTION IN CENSUS 2020 Chills civic participation and would limit funding for programs that depend on accurate count (SCOTUS decision)	ACCESS TO PUBLIC HOUSING Closes door to mixed status families (HUD & USDA Proposed Rules)		ROLLBACK OF ACA 1557 Reversing civil rights protections in health care (Court ordered HHS to maintain protections re gender identity)	DEFERRED ACTION FOR MEDICAL EMERGENCIES Attempts to end protections for people seeking life saving treatment (DHS Resumed policy)	

The Invisible Wall Graphic (Updated Sept. 2020)

others were excluded from federal financial relief, like the stimulus checks and unemployment insurance benefits.

The good news is that states, cities, private donors and nonprofit groups stepped up to offer immediate relief. Short-term housing and economic support programs were established in states and localities across the country. Advocates are exploring revenue-raising strategies to address longer-term needs. Racial justice and criminal justice conversations intensified during these months, with a renewed focus on dangerous detention conditions and harmful policing practices. States and localities increasingly recognize that our public health and economic recovery depends on investing in health care and economic support for all.

California's Immigrant Policies

California has adopted an array of inclusive state and local policies that promote the physical and financial health of its residents and serve as a beacon for the rest of the country. The state expanded eligibility for health care and essential services, restored access to driver's licenses, improved access to higher education and professional licenses for immigrants, strengthened the rights of workers, consumers and tenants, and limited its entanglement with federal immigration enforcement.

The state invested significantly in legal representation, which exponentially increases the chances of securing immigration relief. It took steps to protect access to courts, and has begun to divest from mass incarceration, and to invest in services that allow people to thrive. Collectively these policies protect health and safety, advance economic opportunity and help residents feel more comfortable engaging with government agencies.

State and Local Responses to COVID

Health care. At least a dozen states have clarified that testing, diagnosis, vaccines (when available) and treatment of COVID symptoms is covered under their existing emergency Medicaid programs. In California, people with restricted Medi-Cal can get testing and treatment of COVID symptoms. Across the country immigrants, regardless of status, should be able to receive those services through community clinics and/or public health departments.

Nutrition assistance. To ensure that families with school-age kids have access to nutrition assistance, advocates have urged Congress to extend the pandemic EBT program. They have conducted outreach to help families understand which services they can receive, any risks of getting benefits and to make sure that care and services are linguistically and culturally accessible.

COVID Pandemic Exposes Disparities and Exacerbates Harm

- ▶ **Disparities** in access to care, financial support and safe working conditions disproportionately harm Black, Indigenous, Latinx and low-income communities of color, including immigrants.
- ▶ **Immigrant families and others excluded** from federal financial relief.
- ▶ **States, localities, private donors, and non-profit** groups stepped up to offer immediate relief, but need longer term strategies for raising revenue.
- ▶ **Racial justice** and criminal justice reform conversations are also advancing.
- ▶ **Recovery** from public health and economic crises requires an investment in health care and economic support for all.

Inclusive State Policies Promote Physical and Financial Health



- ▶ **Expand Access to Health care and Essential Services** for immigrants
- ▶ **Restore access to** driver's licenses
- ▶ **Improve access to** higher education and professional licenses
- ▶ **Strengthen** workers' rights, tenants' rights, and civil rights laws and policies
- ▶ **Limit Local Entanglement** in federal immigration enforcement
- ▶ **Protect privacy** of patients, drivers, students, workers, consumers
- ▶ **Invest in Access to Counsel** and **Protect Access to Courts**
- ▶ **Divest from Mass Incarceration**



Economic support. This year, Colorado and California extended the Earned Income Tax Credit to residents who file with an individual taxpayer identification number (ITIN). New Jersey imposed a tax on millionaires that will fund a rebate of up to \$500 for parents, regardless of status. States across the country established short-term cash or rental assistance programs that serve immigrants and other excluded workers, with some combination of federal, state or private funds. Some cities are experimenting with basic income programs. Most funds were depleted very quickly, highlighting the overwhelming need. But the initial response, fueled by effective organizing and a growing understanding of our interdependence, offers some hope.

Inclusive State Choices

This series of maps demonstrates that, when given a choice, most states opted to provide health care to federally eligible children and pregnant women, and to offer access to higher education and financial aid to students, regardless of their status. Although a smaller number of states issue driver's licenses to undocumented immigrants, those states are home to over 50% of foreign-born residents in the U.S. This reveals a different view of the country: despite the rhetoric at the national

level, states and localities regularly adopt measures that promote collective health and well-being.

Health Care and Social Service Providers Can Play a Key Role

Health and social service providers were instrumental in securing the public charge clarification that we're fighting to restore. Medical professionals documented the individual and public health consequences of the fear that prevented families from seeking care. Service providers can continue to play a role in shaping inclusive policies by describing the harm of restrictive measures and the benefits of improving access. They can monitor how policies are implemented and educate families about available programs. Finally, they can advocate to ensure that immigration and health care policies are responsive to families and public health needs and address the barriers to care.

In the coming year, we can bring our local experiences and organizing to the national stage. We can advocate for inclusive health care and economic recovery measures, ensure that immigrants are integrated into any progressive policy platforms, and fight to protect existing immigration pathways and benefit programs. All of you can comment

COVID Responses: Health Care, Nutrition, Public Charge

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Health Care

- ▶ **COVID Testing and Treatment:** *At least a dozen states* clarified that testing, diagnosis, vaccine and treatment of COVID-19 symptoms is covered under emergency Medicaid; testing and treatment should also be available through community clinics and public health departments.
- ▶ **Access:** ensure that care is linguistically and culturally accessible and secure.

Nutrition Assistance

- ▶ **P-EBT**– Advocate for extensions and increased funding for other nutrition programs
- ▶ **Outreach** – to ensure that all families are aware of available programs that they can use safely

Public Charge

- ▶ **Federal:** Support efforts to halt implementation of public charge rules (during pandemic and beyond)
- ▶ **Outreach** to families to ensure they have access to accurate information.

on proposed regulations, whether as an individual, as a health care clinic, an educational institution or as a state or local agency. You can participate in litigation as an expert, as a friend of the court or as a party. You can also share your expertise and experience in the media.

We now have an opportunity to envision new immigration, health care and justice systems. By collaborating with other states and localities, health care and social

service providers, and community members, we can make change from the bottom up while improving the daily lives of all residents. Together we can send the message that investing in the country's residents pays off, not only economically and socially, but politically as well.

We at the National Immigration Law Center look forward to working with all of you. Thank you.

Economic Support and Housing Assistance



State Earned Income Tax Credit (EITC)

- ▶ **Colorado** and **California** extended to all ITIN filers!

Short-Term Disaster Assistance

- ▶ **States:** **AL, CA, CO, CT, IL, MA, NJ, OR, WA** and others established short-term cash or rental assistance, with some combination of federal, state, private funds.
- ▶ **Cities/Counties:** Alameda County, Austin, Baltimore, Boston, Chicago, Denver, District of Columbia, Fort Bend County, Houston, Los Angeles, Louisville, Minneapolis, Montgomery County, New Orleans, New York City, Philadelphia, San Antonio, Santa Clara County, Tulsa and other localities created similar programs

Influence the National Debate



- ▶ **Support Inclusive Health Care and Economic Recovery Measures**
 - ▶ Integrate immigrants into all progressive policy platforms
- ▶ **Protect existing immigration pathways and benefit programs**
 - ▶ Comment on any new regulations
 - ▶ Participate in litigation (as experts, friends of the court, parties)
 - ▶ Share your expertise and experience in the media
- ▶ **Envision new immigration, health care and justice systems**
 - ▶ Collaborate with other states & localities, health care & social service providers, & community members to make change from the bottom up, while improving the lives of all residents
- ▶ **Send the message** that investing in the country's residents pays off economically, socially and politically.

Immigrant Protections in California and the Road Ahead



Thank you UC Davis and everyone for this very timely and important conversation. Before I talk about the system of protection that California has built for immigrants—and Tanya already alluded to some of them already here—I would like to say a few words about this current moment and the state that California’s immigrants are living. Not to mention the fact that they comprise 27% of California’s population because 27% of our population is foreign-born and over 2 million residents in our state are undocumented immigrants, yet

they are going through historic, unrelenting, multifaceted crises compounded by the anti-immigrant policies of the current administration.

I always like to say that life was already hard for immigrants in the United States before the 2016 election, but it just got infinitely harder for them with the current crisis. What are the ways in which this is manifested? They’re left out of most federal relief packages unless they perform essential work during this pandemic. They are disproportionately impacted by COVID-19 with the number of Black and Latino immigrants either dying or being infected with the virus, losing homes and not having sufficient access to health care, food and digital technology. Many existing protections we worked so hard for over the years have been taken away at the federal level by this administration.

To date, immigrant children and their families are going through deeply traumatic experiences from family separation policies. Many are still not reunited with their parents and many are not getting the health care that they need, especially in detention. They are also disproportionately impacted by the climate-related crises that’s plaguing our state, especially agricultural workers



The State of Immigrants in California

- Going through historic, unrelenting, multi-faceted crises.
- Left out of most federal relief packages.
- Disproportionately impacted by the pandemic.
- Many existing protections have been taken away at the federal level.
- Still living under a two-tier system despite CA’s inroads in creating pro-immigrant policies.
- Many immigrant children and their families going through extremely traumatic experiences from family separation policies.
- Disproportionately impacted by climate related crises plaguing the state.



who have to continue working the farms as wildfires rage across California. Overall, many immigrants are still living under a two-tiered system in our state, despite California's inroads in creating pro-immigrant policies.

If this is the stark picture that immigrants are living, you are probably wondering what has the state done to help them. In California, movement building and political power has been critical for immigrant communities. The immigrant justice movement in coalition with civil rights organizations, farm workers, students and unions have won significant gains for all Californians, regardless of immigration status. As a result, landmark policies that expand language access, a statewide legal protective services program called One California, state licensing certification for undocumented lawyers and business owners as well as state drivers' licenses have been key steps in recognizing the rights of our immigrant residents.

There are almost 100 pro-immigrant policies, big and small, that have been enacted in California for the last 20 years since Prop 187. I cannot mention all of them in my presentation, but I will mention a few recent critical policies that my organization and our partners, including the National Immigration Law Center, have worked on that are helping to protect and preserve the well-being

of this population. I want to start with the Health4All campaign. California leads the nation in ensuring immigrant access to health coverage insurance and the safety net.

One signature campaign that aims to make access possible is the Health4All campaign that was conceived of by a coalition of health care human rights organizations, and it's cochaired by and the Health Access California. This campaign aims to make access possible for many immigrants, regardless of immigration status. We started with the Health4All Kids and have continued with Health4All Young Adults. These are medical expansions that provide state-funded Medicaid coverage to low-income children and young adults through the age of 25, regardless of immigration status.

Today, more than 200,000 children are able to access life-saving care because of the Health4All campaign. However, while California has taken important steps to expand immigrant access to health care, many are still left out, including seniors or elderly immigrants who need this access very much today. We are working hard to ensure that this opportunity becomes accessible to everyone to ensure that our policies are truly inclusive.

Next, I want to talk a little bit about economic justice campaigns and how the state has been responsive. We

The California Response

- A constellation of pro-immigrant policies that has provided minimum level protections for vulnerable immigrants.
- A well-organized immigrant rights movement that is better resourced, smarter, and deeply rooted in the lives of impacted communities.
- A vision to center racial justice issues and Black lives to address root causes of inequality.
- Re-evaluation of what is possible given the lessons of the pandemic and the ongoing governance and political crisis. #NoGoingBack



also work on issues that try to improve the economic well-being of immigrant families, from reforming and mainstreaming our workers' development programs to creating an equitable worker justice system in the future of work and the future of workers, especially in our increasingly automatized economy. One campaign that we are very proud of that Tanya alluded to earlier is the California earned income tax credit, or CalEITC. It is a refundable tax credit that boosts the income of families and individuals with low earnings from work so they can better afford the basic necessities.

CalEITC helps mitigate California's high cost of living for people who live under poverty conditions, and it's modeled after the federal EITC, which has been cited as one of the more effective tools for reducing poverty in families. In the past, many people who worked were excluded from CalEITC, including people who use an individual taxpayer identification number. However, recently through four years of advocacy with our partners, the governor signed a proposal to include additional filers in the CalEITC just last week, which will benefit up to 600,000 people, including 200,000 children under the child tax credit. This development is a lifeline for many low-income immigrants who are especially vulnerable to the impacts of the current economic crisis.

Now I'm going to talk about what we do to protect immigrants from unjust detentions and deportations. California has enacted policies to prevent local law enforcement from improper Immigration and Customs Enforcements (ICE) holds, creating transparency between local law enforcement immigration authorities and the public, disentangling information and resource sharing between local law enforcement and federal immigration authorities and making budget investments in legal protective services. However, there is much to be done to ensure that all Californians know and can exercise their rights. In many counties and cities throughout the state, local law enforcement still works directly with ICE and immigration authorities to arrest and deport people in violation of current state law.

They find many workarounds in these laws, so the state must do more to ensure that all people know their rights, can exercise their rights, and have access to legal counsel and proper due process. I just want to name some of these policies and laws that are now helping to protect many immigrants who are under fear of detention and deportation. In 2014, the TRUST Act was enacted, which limits local jails from holding people solely to begin the deportation process. The TRUST Act sets a minimum standard across the state to limit hold requests



The California Response: Advocates

- Organized actions and mobilization across the state to defend CA's health equity and pro-sanctuary policies. i.e. SB 54 and ACA Defense.
- Growth and expansion of regional coalitions building advocacy infrastructure in underserved regions and winning local campaigns.
- Greater sophistication and capacity to engage in rapid response and crisis communications strategies.
- Building common cause with other sectors for greater intersectional work. i.e. Immigration and LGBTQ allies.
- Organized and mobilized philanthropic community with greater flexibility and rapid response capacity.

in certain circumstances. In 2015, CIPC along with our partners helped to create the One California program.

One California is a state-funded program to support free and qualified education, outreach and application assistance for immigrants eligible for naturalization or affirmative immigration relief. Since then, the program has expanded to include legal representation for immigrants in deportation proceedings, legal service for deported veterans and capacity building for immigration services in underserved regions. Every year the state allocates somewhere between \$45 to \$75 million for the continuation of this program.

More recently, you probably heard of the California Values Act, which limits resource sharing and cooperation between immigration enforcement and local law enforcement with limited exceptions. Together some of this network of policies has helped to protect or limit the exposure of immigrant families in the criminal justice system. However, more needs to be done because as I pointed out earlier, and you've already seen in the previous situations of these symposiums, the immigrants in our country and in our state are going through an unbelievable amount of strife.

I cannot finish my presentation without sharing with you very specifically what is going on with immigrant families under the pandemic. We know now that this pandemic has laid bare even deeper vulnerabilities in immigrant populations. As I said earlier, many immigrants are left out of federal and state relief packages, yet many of them are working on the front lines. On April 15, Gov. Newsom announced an unprecedented \$125 million in disaster relief assistance for working Californians. This first-in-the-nation assistance involves statewide public-private partnership that provides financial support to undocumented immigrants impacted by COVID-19. California will provide \$75 million in disaster relief assistance and the \$50 million will be raised by philanthropic partners.

I would like to round off my presentation with the following call to action. Knowing what we know now about the brokenness of the system we're living in, it is imperative that we work towards a California that will address racial inequities and anti-Blackness in all its forms. What we know now is that our state was built on structures designed to maintain the privilege by intentionally excluding and marginalizing others. It cannot continue if we want to survive as a society and build the

A BRIEF HISTORY OF #HEALTH4ALL
Decreased all Californians should have access to quality health care.

2010
Affordable Care Act is signed into law, expanding healthcare access for millions of Americans and millions more, while excluding undocumented immigrants.

2014
Health4All program is introduced for the first time in California state legislation.

2015
SB 75 (Sutcliffe), also **Health4All Kids**, is signed into law, expanding Medi-Cal eligibility for all income eligible seniors, ages 18 and younger in California, regardless of immigration status.

2016
Health4All Kids is implemented, initially leading to over 250,000 children (and counting) enrolled into Medi-Cal.

2018
SB 879 is passed to allow undocumented seniors age 65 and older to enroll in Medi-Cal and **AB 2065** (introduced) to do so for young adults ages 19-25 (pending retroactive support among the state legislature last year) and the passage of the Governor Jerry Brown's emergency to fund the expansion through the state budget.

2019
Health4All Young Adults passes with support from newly elected Governor Gavin Newsom, expanding Medi-Cal eligibility for undocumented immigrants age 21 and younger and making California the first state in the U.S. to extend coverage to undocumented adults.

2020
Health4All Young Adults is implemented in January. **Health4All Kids** is included in Governor Newsom's 2020 budget, potentially expanding Medi-Cal coverage to over 25,000 undocumented people over 65.

Despite numerous governor's vetoes in support of SB 879 (Sutcliffe), the proposal to include undocumented seniors age 65 and older did not pass this year.

CALIFORNIA IMMIGRANT POLICY CENTER

The CIPC Response: Safety Net For All

- Health4All
 - Health 4 All Kids
 - Health 4 All Young Adults
 - Health for All Seniors (pending)
 - Food for All
- Protecting Immigrant Families (PIF)
 (Campaign against Public Charge)

Economic Justice

- CalEITC (CA Earned Income Tax Credit) for ITIN Filers
- Protecting Immigrant Workers
 - Combatting the use of E-Verify
 - Fighting Document Abuse and Discriminatory Audits
 - Building Equity Into Our Current and Future Economy
 - Workforce Development



Access to Justice and Fighting Mass Detention & Deportation

- The California Values Act SB54
- The TRUTH Act AB 2792
- The TRUST Act AB4
- Dignity not Detention Campaign
- Ending ICE Transfers
- LA Justice Fund and regional equivalents



Immigrant Integration

- One California: Immigrant Services Funding
- Drivers' Licenses AB 60



COVID-19 & Immigrant Families

- Disaster Relief Assistance for Immigrants (DRAI)
- California Immigrant Resilience Fund (CIRF)
- No Going Back: Together for an Equitable and Inclusive Los Angeles
 - A blueprint for renewal and recovery.



What's Next?

- Address racial inequities and anti-Blackness in all its forms.
- End the two-tier system for immigrants.
- Build an inclusive economy that prioritizes those who are historically left out and stuck at the bottom of the social strata.
- Create a better, universal health care system that works and centers communities that have suffered historical neglect, especially Latino and Black immigrant populations.
- Streamline integrated access to health and mental health services regardless of immigration status.
- Support access to education for all communities, especially those that are impacted by the current digital divide.

California that we want. We also must end the two-tier system for immigrants by making health care, education, good jobs, housing and other essential needs accessible to all immigrants, regardless of immigration status.

How can we do this? Here are some examples. We need to aspire to build an inclusive economy that prioritizes those who are historically left out and stuck at the bottom of the social strata. We need to create a better universal health care system that works in communities that have suffered historical neglect, especially Latino and Black immigrant populations. We need to streamline integrated access to health and mental health services regardless of immigration status, especially with what we will see as an epidemic of mental health issues that are already coming up, but we will see more stark illustrations of that as the months and years go on.

We need to support access to education for all communities, especially those that are impacted by the current digital divide—poor families in underserved regions of California that do not have access to full online learning because they don't have access to Wi-Fi. We need to start treating digital access like it is electricity—something that is now so fundamental to

the daily life and daily needs of Californians and of its immigrant populations.

I want to close out my presentation by saying that only through a bold and decisive vision, based on these principles and the ones that we have heard from the previous panelists, will we ensure that we can make the California dream accessible to everyone, not to the few privileged ones and especially those who have the least among us. With the knowledge that we know now about the consequences of the multilevel crises we're living, we really can't unknow these things and this is a call to action to work with us—advocates, state workers, our legislature and the state government—to ensure that we can limit the harm that we have seen caused by inequitable policies throughout the years.

I will post my email address and some resources on the chat box, so that if you want to know more about our work and access some of the resources that we have online, you can access them. We have a lot of materials that are available in more than 20 languages, because we have centered on language access as part of our mission. Hopefully, we can have a more robust conversation with you later. Thank you, again, for giving me the opportunity to be part of this conversation.

MODERATED PANEL DISCUSSION

Moderator Ignatius Bau: Let me start with Dr. Hoch. In your presentation, and in the study that Kara Carter also cited, you said there are 10.5 billion reasons to care about trauma and the effect of trauma on Californians. But that just seems like such a huge number. Help us use that number in a way that makes sense to policymakers and decision-makers. Within a health care system, within a legislature, how do we use a number that big to really describe the importance of paying attention to trauma?

Dr. Jeffrey Hoch: The game has multiple stages. The first stage is to try to get attention for your issue. It may not be important to a particular decision-maker, but if you attach a cost and if that cost is large, then wow, they are going to start to pay attention. The other thing I spoke about in my talk was perspective and it is possible that the costs are large and if they are only in one segment or one area, then it may not resonate so much with the decision-maker. But if these are big costs and they are in a variety of different areas, I would imagine a savvy politician would see that he or she could get a lot of leverage out of this because by acting on this issue, it is possible to reduce a lot of costs for a lot of people.

Step one of the game is to pay attention to me, but step two has to be once you have got the opportunity, to meet with the decision-maker, step two has to be: What should they do? Who is in favor of trauma? No one, but I don't know what to do. What would you recommend we do? Maybe the things you are asking of me, I don't have the power to do. That's the federal government. That's someone else, but I suspect this specific ask might be a great idea for stage two.

Stage three is going to be: No, we can't do it, because it costs money. From my perspective, it's silly in my opinion to set the bar so high as to suggest whatever your solution, is going to save money. That to me seems an unnecessarily high bar. Another option might be to say, "Yes, we do need this investment. However, look at what you get as well as what it will cost." Now the discussion is not, "Will you save money?" Now the discussion is, "Is this a good use of money? is this a wise investment? Do we get something and, if so, how much?"

The costs from my perspective, at least in the article I showed, were fantastic for saying, "Look, there's a lot of burden and we just measured in dollars, but there's a lot of burdens for this issue, and so you should pay

attention." It is great for step one, but if you are in the "What should I do" market, or the "How do I show that doing A is better than doing B market?" if you are to that next step, you need more than just "Trauma costs a lot."

Moderator: I'm going to turn to Ms. Broder. Oftentimes, we say in advocacy it is both numbers and stories, so how do we also document the harms, the impact of trauma on immigrants? As providers in particular, how do we do that with confidentiality, with assuring them that we are not going to expose them even more to greater harm? Can you describe some of the ways in which we can share those stories safely and confidentially?

Tanya Broder: There are so many ways that health providers document the harm. There is no need to expose people. You do not need to have names. You do not need to have identifiers, and you do not even need to detail what a person's immigration status is if you do not want to ask that question. I never recommend asking more than is necessary and is comfortable in a safe space. We have heard from a lot of health care providers about their patients who were pregnant and just in a general way, what the fear has done to their pregnancy, to their childbirth situation, to everything else. If individuals want to submit their information, they can do that completely anonymously, and there are a lot of impressionistic and even documented harm that folks have been able to do without compromising their relationship or the safety of their patients.

Moderator: Particularly on the public charge issue, the Protecting Immigrant Families campaign had a lot of great examples of ways in which folks could report those kinds of harms that were then used in the litigation. Protecting Immigrant Families is a great resource for that.

I'm going to turn to Ms. Buiza. Consistent with the notion that we heard from earlier panelists that this is about resilience, it is about fighting back against these policies, but it is also building up the capacity, as you said, to withstand these multi-layered, multi-pronged attacks on immigrant communities. Talk a little bit about the work within immigrant communities themselves. You work with a lot of local coalitions and sometimes that work does not get profiled or highlighted because we are focused on legislation or we are focused on litigation. Talk about the on-the-ground work in immigrant communities themselves.

Cynthia Buiza: One of the best kept secrets of our work is the work that we have been doing with nine regional [immigrant] coalitions across California. This is an eight-year-old project that CIPC has been engaged in, out of the recognition that many and so much of the resources, both from philanthropy, but also from the State, has been concentrated in gateway cities like Los Angeles, San Diego and San Francisco. It is part of the reason why we initiated it because we have seen a movement of many immigrant families in the inland regions. These nine original coalitions encompass Southern California, the Central Coast, the Central Valley and Northern California, and what we have seen is the level of deep organizing that has been happening in these areas from very under-resourced coalitions. We saw the potential there of making sure that these coalitions and these networks become their community's first responders.

If you look at it from a health systems angle, you want networks of communities that are already familiar with the conditions that immigrants live in to be available in those places. The experience that we had with DACA when it was first implemented a few years ago was that many people had to brave the risk of taking the train or taking a bus, fearful for their lives because of checkpoints, just to come to Los Angeles and San Francisco to apply for status. If these networks of capacities are available in the regions, you do not expose people to unnecessary harm, especially right now when there is so much fear because of the chilling effects of these anti-immigration policies discouraging immigrants from accessing benefits and programs that are available to them in California.

It is the first step to resilience, to look closer in your communities. Examine the resources that are already available there. It is everything from whether it is networks of promotoras, or networks of community associations to take care of immigrants. Immigrants are very creative. We bring these community associations with us wherever we go. Are there local community foundations that are willing to help the programs that you have? Does your county have enough savings that you can advocate that they can allocate some of your city and county budgets to, for example, the language access needs of immigrant populations? There is so much that can be done if we examine what is already there, the available infrastructure. At this time, when resources are scarce, the State is reducing the budget already. As agencies and organizations, we need to be very creative in working with impacted populations as long as we are

clear that we are also making sure these are safe spaces in which to partner with them.

Moderator: Dr. Hoch, this may be a hard question for you to answer in the funding world and to some extent, in the policy world, we often think about these issues as direct services. What does an individual immigrant, or an immigrant family, need? Do they need mental health services? Do they need health services? Do they need housing? What Ms. Buiza is talking about is much more organizational, like infrastructure and networks. Those are harder to describe in economic terms what the value is. It is much easier to say, "I'm helping 100 people," as opposed to "I'm building the capacity of this organization." Can you help us with any language in the work that you've done, maybe not on this particular issue, but in terms of thinking about policy? Is there a way that we can make a stronger argument for the value of this kind of capacity in communities, the value of networks, the value of trusted sources of information?

Dr. Jeffrey Hoch: Yes, you are right, so much of what really matters is very difficult to measure. It is a huge step to be able to imagine it, or to realize that there is something valuable here. This is why it is so important to draw together a large number of people into our symphony of folks working on this issue, because everyone will have a different perspective. From my perspective, unless you are really in it, you do not necessarily know the concept of the value that is being generated.

You have to talk to the people who are doing this every day, the people who are living through it. They have a gist, a general sense of what works and what does not. But because the people you are trying to influence may not have gone on that path, it is very hard for them to imagine what you are talking about. That is assuming they are going to take you at face value. If they have beliefs that might not make them inclined to find this a high priority, then the fact that they have not gone through it, and those extra beliefs make it an even harder challenge for you. This is why beyond just imagining, "Oh, this could be a sense," and beyond just telling the story from my perspective, if we are able to quantify, or at least name some of the things that are going on, then we can start to get them organized.

We may not be able to roll it up into one number, but if we can see multiple benefits of involving multiple services in a way that we have not before, at least it tells

us where to look, where we might want to start to collect. You could argue that what we are currently doing is not working, because if it were, we would have solved this. That means we are going to have to go somewhere new, and somewhere new is uncomfortable. It means doing things differently. It may even mean putting me out of the business I am in. That is why thinking about who can win and who can lose is important.

Recent work that I have done looking into options for homeless people has convinced me that maybe not always the right way is one organization doing that one thing. You need a group of people who are going to come together. And from an economist's perspective, you only get the people coming together if they all think they can win. If you need someone who is going to lose in your solution by coming together, we need to find a way to make sure that people are able to benefit. Even the ones who have to give and they have to lose, they need to be able to be compensated by the winners.

It could be money, but it could be something else so that we see we all have something to gain. If it looks like one of those parties is going to lose by this whatever new thing you are going to be doing, they will fight you tooth and nail. The idea being that we all gain, and the idea being "let's find a way to make it work, and then maybe we can even document it" puts us on the right track. Even if we cannot get the exact perfect numbers, at least we are thinking about what we think the benefit is, and who will gain, and how do we make sure that some of those gains are spread to others. There may be many people who do not quite understand all of the gains of what we are trying to do. Even seeking to try to collect the information might make people aware.

Moderator: Ms. Broder, one of the polling questions we asked was whether folks had ever submitted public comments, and about 3 in 10 that responded had, so talk to us about that process, and what it entails, and how individuals and organizations can get involved and why it is important, the public charge example being in line with the impact that it had.

Tanya Broder: That was a great example. What happens in the normal course of things is that an agency that is proposing to do something will publish that proposal to the public. The point of it is that the public gives input into what they think about the rule, and what it might cost and the harm and the benefits and everything we have been talking about. [The agency] is required to

review all of the comments, and to take time and respond to them. It is not required to follow the comments, but it needs to take them into account in making its decision.

What happened in the public charge context—and I've never experienced this at all at the nonprofit where I work—is literally 266,000 individuals or groups spoke out. In all of the court cases, the vast majority of the comments were recognized as being opposed to the rule for every kind of reason. Folks were amazing at developing micro-sites, localized in different languages for different communities where individuals would come forward. If they were not comfortable, the provider might submit it for them. If they were comfortable, they could submit it under their own name, and everyone had something to say about it. It was really helpful in gathering up public opposition to the rule, as a political organizing tool to get people to work with each other and build an infrastructure to oppose the rule. Then it was absolutely essential in the cases that were filed, to at least delay the rule, if not block it altogether, because the courts looked to the comments and looked to what the agency did, and in many cases said, "You did not take this into account, you did not take into account the effect on the public health care system of this rule."

It's really useful. I encourage everyone to do it. The folks I work with have made it super easy because it is not always obvious how to do it. Just a click of the button right in your comments. We are expecting more bad regulations to come forward, so there will be chances through the Protecting Immigrant Families campaign at www.protectingimmigrantfamilies.org to weigh in. For example, if there is a public charge ground of deportability rule that comes forward in the coming weeks, we will definitely need to do this again.

Moderator: Ms. Buiza, in your overview, you shared how California has been an alternate voice, and has tried to put in measures to both block some of these bad policies, but also to develop state solutions. Some of them are policies, like the TRUTH Act and the Values Act in terms of what state and local governments should or should not do, but as you noted in the response to COVID with the disaster relief funds, some of it is money. Talk a little bit about that combination of both policy and money making a difference.

Cynthia Buiza: I do want to commend both the State and the philanthropic community here, because in the recent years, especially after the 2016 election, both entities

have stepped up in creating rapid response mechanisms so that for these ongoing emergencies we have, there are resources. Now we are moving in this period of maximizing how much we can push the lever of State-private partnerships, nonprofit and philanthropic and State partnerships, so that we can cover as much ground in this very multi-headed immigration problem that we have. There is no one-size-fits-all here. There is the need to embrace how complex it is to create these opportunities for the nearly 2.4-2.5 million documented immigrants and other immigrants living in California.

A very specific example that triggered some of these recent partnerships is the One California program because it did not exist before, but now there is a network of almost 200 direct service and legal service entities participating across the state that has expanded our capacity to provide affirmative legal services, as well as immigration and naturalization services. It came out of a conversation between advocates, philanthropy and the office of then-Gov. Jerry Brown. There is a lot of room for experimenting, pushing and bold visioning around what it is that what we can do, especially now that the problems have been laid bare by so many of the crises that we are living.

That means the response has to be proportionate, based on resources, based on capacity, based on commitment and political will, but also in making sure it is accountable. All of these four factors should exist in how we think about the new ways in which we could partner with each other, especially with the State, in problem-solving a lot of the challenges that California's immigrants are facing, in relation to the broader problems that California is facing.

Moderator: Dr. Hoch, what really struck me about the data was, while we think about the direct health care costs—and there are clearly some health care costs from the ACEs studies—the overwhelming majority of those costs were lost economic productivity. As you noted in your overview, this is something that business communities should care about. This economic impact is something we may not be thinking about. This is my segue into talking about COVID and the economy and the future. In this conversation that we are having about what a post-COVID world look like, is there a way we can slide this impact of trauma into that, and say, “As we re-make the economy, we need healthy workers, we need workers that are not traumatized to be effective and the

most productive workers, and so there is an obligation collectively for us to pay more attention to this issue”?

Dr. Jeffrey Hoch: I completely agree. We have transitioned from calling people immigrants, now we are calling them workers, employees. Do we want employees who are healthy or not, do we want people who are sick or not? A huge amount of the costs of trauma or of COVID-19 comes in terms of productivity costs, which only happens if people are not productive. You can think about this in terms of how we want our economy to work, or how do we want to treat sick people in general. That way of framing it takes us in an interesting direction, because we have switched the label to be about people who are producing something the economy finds as valuable. I am not saying we should view people this way, but the moment you switch it to that kind of discussion, it seems even more difficult to deny someone who is sick to get care, or to deny someone who is helping make goods and services that you value. It seems harder because it seems like we may be more integrated in that way. Someone else's welfare might be linked to my welfare in terms of what is good.

Moderator: Ms. Broder, let me take that one step further. There is this argument that is being made in the post-COVID relief packages—and we expect that there will need to be additional legislation and additional federal funding—trying to frame immigrants as essential workers, as important to our recovery, not just our continued day-to-day life that get us our food, that are still driving the buses for the people that need to take public transportation, working in meatpacking industries and farms. Talk about how, as long as both COVID and the long fight back to economic recovery will [last], that immigrants are going to be important.

Tanya Broder: The first point is just the point that many people have made already, especially with those of us in California you have heard so long. It is not that immigrants live isolated all by themselves out here, and citizens are over here. We live together in families and communities. We depend on each other every day, our health is inter-connected and our recovery is inter-connected. It goes beyond whether it is somebody who is essential day-to-day to making sure we can eat and have health care, or whether they are coming up with a vaccine that is going to [protect] us.

We can't live without each other, and we are dying right now. It is literally a life-or-death moment when all the

things that we have known about for a long time have been exposed, and it is really about time. What has given me heart and some hope is that we are having the conversation in a more serious way than ever about the need to cover everybody on the health care side, about the need to support each other economically. Even at the federal level, there has been the kind of debate that I would not have seen earlier, across the bipartisan divide, about the need to support mixed status households. I do feel like we are advancing that conversation, even as we are facing the biggest crisis ever in my lifetime.

Moderator: Ms. Buiza, both you and Ms. Broder also referred to the other crisis of this moment in time, after George Floyd, with our national increased consciousness of racism, of anti-Blackness in this country, and how this has permeated so many of our institutional structures, the opportunities that Blacks have or don't have in this country. Talk a little bit about centering this work around racial justice in this broader vision of what our society looks like, which includes welcoming and integrating immigrants.

Cynthia Buiza: Thank you for that question. I can only speak to the process that my organization is now going through, because we are literally right now engaged in a deep conversation around not only what solidarity, deep solidarity with Black Lives Matter means, but how we embrace lessons from the last few months, as the racial issues that have come up brought home the fact that our system is broken. We need to make an attempt to make a serious break with the brokenness of those systems, and it has to start somewhere.

For us, it is thinking deeply about everything from the language of our [personnel] handbook, how we hire, what is the kind of hiring pool that we look at, how are we anchoring our mission in the knowledge that there is no true. I am going use these lofty words—freedom and liberation. We need to recognize how tied our communities' histories are with the history of slavery and racial inequity in this one country.

It is a very tough conversation because, as civil rights advocates, we have made these assumptions that we were already people that fight for this issue, or as an organization that has been working on immigrant rights for 23 years, we were a racial justice organization. But as we have engaged in this learning process, we are learning so many new things that are revealing to us many ways in which we can center the lives of Black immigrants.

For example, as an immigrant rights organization, how can we share resources with our partner organizations that are Black-led?

How can we also make sure that we are resourced as an organization to deal with these changes that we are going through? It starts small, but it is sincere. It is decisive, and we will hold ourselves accountable to that commitment. I would rather speak authentically about this than make sweeping statements about how we are going to do this. It is not easy, especially when you are also being asked to lead at a very difficult moment when your communities are experiencing several crises at the same time, that are compounded because of those family separation policies. But those policies did not start in 2016; they started way back, with millions of people that have been deported. Using the lens of complexity, grounding your organizational values in racial justice, and making a unique, sincere effort to realize it in your organization and how you talk to your partners about it.

Moderator: We have been talking throughout the symposium about trauma, and a lot of that trauma is caused by enforcement activity by Immigration and Customs Enforcement and by Customs and Border Patrol. Now there is a conversation about policing, and whether there are alternatives to policing, whether there are other ways that we can use the resources that we put in policing and in mass incarceration, to actually make our community safe rather than using an enforcement philosophy. So, is there the same conversation, whether there are alternatives to immigration enforcement that are not punitive, that are not about mass incarceration of immigrants?

Tanya Broder: It aligns with all the things that we have been working on for all these years, and it is time for us to do it. There are fiscal groups that have documented the costs. You don't need it, but they have documented the cost of detention. Now, in the face of COVID, when there is no reason for people to be incarcerated, and to give each other and the people who come in and out of detention centers sicknesses when we could take that money and people could be with their families, supporting their families, moving forward, whether it is in the immigration process or whether it is in the returning to communities, everyone is going to be better off.

I really respect all of the work other people have been looking at for years, that can come out now and be implemented now, on restorative justice, on alternatives,

whether it is in the schools, or whether it is in the criminal justice system, to try and find ways to do better and help people have true opportunities to succeed, to thrive in our communities together. It is only going to benefit all of us. It is not really going to be an individual solution. I am excited to see this work come to fruition, and I really respect all of the people who have been working on it for decades.

Cynthia Buiza: Tanya named the broad strokes responses, and that includes reforming our immigrant and criminal justice systems, but one thing that I do want to flag from working in other parts of the world is we should look at some of the models of community-based reconciliation and restorative programs in West Africa and Southeast Asia. I worked on such a team after an independence movement there, and they have a very good model for how you deal with conflicts and tensions in society around violence and rule of law. I think we as a country, who pride ourselves with a lot of expert knowledge on a host of big issues, have a lot to learn from other countries that have had success, successfully done this, including case studies from Rwanda, Uganda and in other parts of the world.

Moderator: Dr. Koch, there is a point in the chat which you responded to, but I wanted to give you the opportunity to articulate more, how sometimes we also forget the cost of not doing something, of just going with the status quo and the way the system has always run. We are having that conversation about some of these issues, like policing, that just putting more resources into police is not the solution, as opposed to stepping back and thinking about other alternatives.

Dr. Jeffrey Hoch: If you wanted to draw a picture—remember the two dots that I connected with a yellow line—you cannot connect the two dots to look at the [change in] slope if you are not looking at two things. One thing could be usual or standard practice, and the other one could be this new thing you want to try. But you cannot draw the line if you are only talking about the costs of the new thing, or if you are only looking at the effectiveness of the current way of doing it. The type of ways of showing value involve comparative investigations, where you look both at the extra cost and the extra effect, but you can only do that if you are comparing one thing to something else. You can always make something look attractive by wisely picking the comparator and saying, “I want to pick this or choose

that,” but if we are talking about changing what we are currently doing, then starting with what we are currently doing ought to be a good starting point, and then asking, “Can we do better?”

Moderator: Ms. Buiza, I love the notion of “no going back.” A lot of people say, “Let’s go back to pre-COVID times,” and many of us are saying, “That was not a great system, that was not a great time, there wasn’t fairness and opportunity and equity, so let us reimagine a future that is very different.” Say more about what that future looks like and how all of us can work towards that very different future, of not going back to the awful way that things were.

Cynthia Buiza: I want to make a little plug for a report that is exactly that title. I was part of the Committee for Greater Los Angeles that drafted a report called “No Going Back,” and I’m going to share the link. It is a more than 100-page report done with UCLA and USC that looked at what was the before, now and after. We specifically looked at immigration issues because we covered the entire spectrum of systems and infrastructures, we looked at vulnerability. We created a vulnerability map with everything from geographic location, education, youth organizing, housing access, access to economic and business opportunities. It’s a big report, but on immigration, when we say, “no going back,” it does not mean that what we built does not matter. In California, we have progressively moved from the time of Proposition 187 to now, where we are aiming to provide a system as inclusive as possible that is accessible for immigrants. What remains, of course, are these two systems of existence, where the rest of the California population can have access to health care, whereas we will have to work so hard for the same access for immigrants; it took us five years to cover all immigrant young adults and children under Medi-Cal.

If you connect that with the immense role and contributions that immigrants play in our state, it is significant. Let us dismantle this two-tiered system of justice, of access to the safety net, because we have learned it is doable as long as whatever is feasible in the state can be done because we know that we will always run into preemption issues. That is where we have to work hard to fix our immigration system, but what is doable in California has yielded significant quality-of-life outcomes and social determinants of health outcomes for many immigrants.

We can't go back to the way things were, because we knew they were not working. These are some baby steps because they are not going to be done in a year, especially when we are dealing with an economic recession in California. The big bold ideas have to start now because people are struggling with what to do. At the end of the day, we have been saved by our need to respond to emergencies, but we will not be in emergency mode for a long time, and that is where a lot of the hard work has to start, with rebuilding.

What is that? Is it a 10-, 20-year project? I don't know, but we are starting with a rethinking of law enforcement. That's amazing. That is "no going back." We also want

to start challenging Silicon Valley to provide digital access to everyone in California. Can we advocate for something like the rural electrification project of years ago, where Wi-Fi is something that families do not have access to, so their kids cannot go to school? It's a big conversation. We are willing to have it with you, but it starts with making sure that we are committing to not repeating the broken systems of the past.

Moderator: Thank you for those inspiring words, and that call to action. If we were live, I would ask everyone to join me in giving the panel a great round of applause, so we'll have to do that virtually.



It is a daunting task to try to close or wrap up what was a very interesting, very informative seminar. I certainly learned a lot. I will start by thanking everyone for joining us today, all of the participants that we have had here, as well as our panelists.

For me, I am struck by two things that underpin the conversation that we had throughout the afternoon. The first is: Let's go back to where we started the series of seminars around adverse childhood experiences and ACEs. In addition to the traditional ACEs we have studied, the everyday uncertainty immigrant families face compound the ACEs that have been well studied. For example, not being sure where you can go in the future for support and help, and being uncertain what the public charge rule might mean for you, or the impact of family separations, or many of the immigration policies that we have heard about. The second thing that really underpins the conversation is the layer, or ways in which the COVID-19 crisis has really laid bare the inequities that we see, with both the disease and the economic burden being born disproportionately by Black and Latinx communities in California.

I want to thank all three panelists and pick out a few things that I heard. First, I really extend my thanks to Dr. Jeffery Hoch for making health economics accessible to all of us and, dare I say, fun. I deeply appreciate that, and I particularly appreciated the connections you made between ACEs and the immigrant population, and helping us understand the complexity of the decision-making process that policymakers encounter when they are trying to weigh what can be seen as cost-benefit analysis, but can also be seen as the drivers of real improvements to the lives of individuals in the communities we live in. Prioritizing interventions, as you helped us understand, is really difficult, and giving us the framework for accountability at how the decision-

makers weigh things up was tremendously helpful as we moved through the rest of the seminar.

To Tanya Broder: I deeply appreciated you reminding us how expansive this administration's immigration policies have been, and how widespread their impact. The idea of an invisible wall of administrative policies was new to me. It may not be new to most of you, but to me it was new and certainly a visual that I will take with me. It is an incredibly impactful way of describing the problems we are facing. I also think it is easy to forget how much is in our individual ability to control, and so I also appreciated you reminding us of things that the State health and social service providers and, indeed, us as individuals, can do, and the power of our individual and community voice when used and deployed in collective ways.

Finally, to Cynthia Buiza: Thank you for bringing a vision of hope to us as we wrapped up this thinking, reminding us of the long list of things California has achieved, as well as a reminder of the work that we have to do to get to a safe and equitable future for all Californians. I deeply appreciated the honesty with which you approached the complexity of the need for us to address anti-Blackness and the intersection with the history of intertwined oppression in the U.S. I think that was very thought-provoking for us, both as you reflected on your own institution, and the work that we all have to do as we try to drive towards greater health equity across the board.

If there was one thing that I was going to take away from all three parts of this symposium, it would be this: The concept of trauma is a really useful way to understand the complexity of cumulative experiences that are affecting immigrants and immigrant communities at large. Rather than taking on the individual impacts of policy one by one, or day-to-day life, understanding that these communities are experiencing trauma at its broadest level, and that has an impact at the individual, the community and the broader society level is incredibly helpful. I think the symposia also provided me with more information about providers, individuals and systems, about what they can do and how they can stand up and respond to that inter-generational trauma.

I want to thank the Center for Reducing Health Disparities for pulling us together and creating this opportunity for shared learning. I particularly want to thank Dr. Sergio Aguilar-Gaxiola for bringing us together, Ignatius Bau for moderating our panels, and our three panelists for bringing a tremendous wealth of knowledge and expertise. On behalf of the California Health Care Foundation, thank you all for joining us!

PROCEEDINGS REFLECTION

Closing Reflections on Trauma-Informed Care and Services for Immigrants

Over the course of this three-part symposium, we heard remarkable presentations and thoughtful discussions about how to better understand the experiences of immigrants, refugees and asylum seekers through the lens of trauma-informed care. Adverse childhood experiences (ACEs) and trauma are useful frameworks to understand the experiences of immigrants and immigrant families living with fear and toxic stress, feeling constantly threatened by potential immigration enforcement and deportation. For immigrant children who have parents or other family members arrested, detained and deported, this trauma is the most extreme. These experiences intersect with, and are compounded by, other forms of ACEs and trauma, including the poverty and violence that many immigrants experience in their daily lives and in the neighborhoods where they live.

While immigrants to the U.S. always have had challenging migration journeys, compounded by the additional challenges of integrating into new lives in a new country, those challenges have been exacerbated in particularly harsh and even cruel ways during the past four years. The policy attacks on immigrant communities have been relentless: from the unthinkable policies of intentionally separating immigrant children from their parents and imprisoning them in cages, to creating instant uncertainty for over 645,000 young “Dreamers” by rescinding the Deferred Action for Childhood Arrivals (DACA) program, to instilling widespread fear and chilling effects through the public charge regulation that has scared immigrants away from health care providers and nutrition programs that would sustain their families.

And then beginning in spring 2020, the entire nation—and the entire world—were locked down in battling the most widespread pandemic ever known. Immigrant communities have not been immune to the additional health, economic and social impacts of COVID-19. The detrimental effects include racist hate crimes against Asian Americans, fueled by irresponsible and intentionally false political rhetoric blaming and associating China with the virus, the disproportionate prevalence of COVID-19 among Latinx populations, and the exclusion of many immigrants from Congressional COVID relief programs.

The pandemic also has been used as an excuse to close the U.S. borders to refugees, asylum seekers and even family-based and employment-based immigrants, cementing the final bricks in the “invisible wall” of exclusionary policies that had been methodically built over the past four years, with the ultimate goals of keeping ALL immigrants from entering the U.S. and deporting as many as possible. The fear, toxic stress and uncertainty that immigrants already had been experiencing were compounded and multiplied again by all the additional burdens created by COVID-19.

On the other hand, the COVID-19 pandemic has raised our national consciousness about our collective reliance on immigrant workers, now recognized as “essential”—restaurant workers, farmworkers, meat packers, delivery drivers, janitors, small-business owners—who were often invisible and so easily overlooked. The pandemic also has resulted in undeniable evidence of the persistence of racial and ethnic disparities in health status, access to health care and health outcomes, especially among Black, Latinx, Native American, and Native Hawaiian and Pacific Islander populations. The nation also has gained a greater understanding of comorbidities, and the inter-connectedness of employment, housing and food security as social determinants of health.

In addition, the nationwide protests and national reckoning about structural racism and anti-Blackness after the murder of George Floyd in May resulted in deeper dialogues and, more importantly, new commitments and investments in not “going back” to a pre-COVID-19 world, but reimagining and creating a new reality, a different future that is more authentically inclusive, creates broader opportunities and is centered on advancing equity and justice, particularly racial equity and justice.

Addressing the trauma that immigrants have experienced is part of that new future. Imagining a different approach to “controlling our borders” is part of that future that doesn’t require billions of taxpayer dollars going every year to private, for-profit prison companies for the mass incarceration of immigrants. We could release immigrants who are in deportation proceedings on bond, or simply trust them to show up for their immigration court hearings. Meanwhile, they could be reunited with their families, working to support their families, contributing to their local economies and paying taxes.

There is a growing body of literature and evidence about the impacts—and costs in future health care services required and lost economic productivity—of ACEs and trauma. Fortunately, there is also an emerging evidence base about trauma-informed care and services, and education and training tools about trauma-informed approaches and interventions for health care and social services providers, educators, early childhood learning and childcare workers, and others who offer care and services to immigrant communities. One speaker, Dr. Altaf Saadi, recommended development and recognition of “immigration-informed care and services” as a more specific form of trauma-informed care.

While our symposium speakers shared the uncomfortable truths about the devastating and potentially lifelong and multi-generational impacts of the pervasive and persistent trauma experienced by immigrants in the U.S. these past four years, all of our speakers commended the resilience of individual immigrants and immigrant families, and the collective resilience of immigrant communities. Such examples of resilience included the experience shared by Edgar Velasquez, a DACA immigrant persisting in his dream of becoming a doctor at the University of California, Davis, School of Medicine; the deep centering of and responsiveness to community needs at Asian Health Services, a community health center that offered culturally and linguistically appropriate and accessible COVID-19 testing, contact tracing and treatment for its patients and community; and the years of work that regional immigrant rights coalitions have patiently done throughout California to successfully expand access of immigrants to health care, education and other benefits, regardless of immigration status in our Golden State. These experiences of resilience are the pathways to hope, healing and even optimism about the future, despite all the challenges and barriers that immigrants have faced.

Now that a new presidential administration is in office, hope is renewed for a new chapter in our national history, finally turning the page and undoing many of the policies that have caused so much trauma, pain and suffering among immigrant communities these past four years. Yet there will still be much work for health care providers—especially mental health providers—educators, legal service providers and others to help immigrants survive and, ultimately, thrive, despite all the trauma that they have experienced.

The nation still must find ways to control the spread of COVID-19, rebuild our economy and continue the work to honestly name, and begin to dismantle, the anti-Black racism that has prevented us from achieving our lofty ideals of freedom and equality. Immigrants, refugees and asylum seekers must be included as vital protagonists and agents of social change in addressing COVID-19, the economy and racial justice in that future.

We hope this symposium report can continue to be a resource to understand the multi-layered experiences of trauma for individual immigrants, immigrant families and all immigrant communities. While many of the specific immigration enforcement and other policies that have escalated trauma during the past four years may be ended or reversed in the coming months, the effects of the trauma that has been caused will not disappear overnight. The lessons learned about resilience and trauma-informed care and services will continue to be salient.

We dedicate this report to all the immigrants, refugees and asylum seekers that have demonstrated that resilience, and to all the health care clinicians and other providers of care and services who have used trauma-informed interventions to serve those immigrants. Together, we can have hope for a more equitable and just future for all of us.

ACKNOWLEDGEMENTS

A special thank you to the California Health Care Foundation (CHCF) for supporting this event and for their strong commitment to finding viable and effective solutions to addressing trauma in immigrant families. We are most grateful to CHCF President and CEO Dr. Sandra Hernández and Senior Vice President of Strategy and Programs Kara Carter for lending their expertise to the symposia.

In addition, this symposium would not have been possible without help and support from the UC Davis Center for Reducing Health Disparities team. Their dedication and commitment to creating and implementing a successful event is noteworthy. In particular, Andrea C. Nuñez, Shellie L. Hendricks and the Planning Committee, for all of the behind-the-scenes work and attention to one-thousand-and-then-some details. We are indebted to Vice Chancellor of Human Health Sciences and CEO of UC Davis Health David A. Lubarsky, Vice Chancellor, Diversity, Equity and Inclusion Renetta G. Tull, and Associate Vice Chancellor for Health Equity, Diversity and Inclusion Hendry Ton for their sustained support and guidance on this symposium.

We are also most grateful for the leadership and direction of Ignatius Bau, in bringing forth this symposium. His expertise and ample experience in trauma and migration, among others, proved to be essential in the planning, implementation and dissemination of the event.

We are deeply grateful to all of our presenters: Dr. Sergio Aguilar-Gaxiola, Dr. David A. Lubarsky, Dr. Sandra Hernández, Dr. Demetrios Papademetriou, Dr. Luis H. Zayas, Samantha Artiga, Mayra E. Alvarez, Dr. Nadine Burke Harris, Dr. Andrés Felipe Sciolla, Dr. Thu Quach, Dr. Altaf Saadi, Dr. Renetta G. Tull, Kara Carter, Dr. Jeffrey Hoch, Tanya Broder and Cynthia Buiza

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Another special thank you to Fostering Media Connections for their work to document the impacts

of family deportation. Without their vision, we would not have been able to highlight the experiences of immigrants that have been impacted by trauma.

Our gratitude goes out to Mark A. López and Elaina López from the Office of Vice Chancellor Renetta Tull for their support of this event.

Another special thank you to KMPH Fox 26, KFSN-TV KGO 30, and The Guardian for their work that documents the impacts of public charge, DACA and family separation

We would like to also incorporate a special note for the Avelica family who shared their story and journey of having a parent placed in deportation proceedings. We thank and admire the Avelica's courage to reveal the trauma experienced by their family.

Another special thank you to Edwin M. Garcia and Christopher R. Nelson from the UC Davis Health Public Affairs and Marketing Office for their time and creativity in creating the short videos featured in this event. Without their vision, we would not have been able to highlight the experiences of immigrants that have been impacted by trauma. We would also like to particularly thank Emily K. Lillya for her commitment to creating cohesive marking materials which contributed to the quality of the event, and Barbara Hennelly for her support with those efforts.

We would like to also incorporate a special note for Edgar Velazquez, the medical DACA student who allowed us to share his story and journey with being a DACA recipient. We thank him and admire his resilience and commitment to follow his dreams.

Additionally, we would like to thank Dan Cotton, who provided invaluable assistance on the Zoom Webinar platform. Without his support and proactiveness we would not have been able to provide the symposium in this platform, which was the best suitable for this event. We also could not have done this without the support of the UC Davis IT team: Aaron Cocker, Alexander D. Lee and Rijul Saxena. Their patience and technical support were critical in preparing this event.

And finally, thank you to all those who attended and participated in this symposium. Your interest and

engagement have elevated the event to new heights. Thank you all for your passion to improve care and services for immigrant families impacted by the traumatic experiences and multiple stressors associated with migration and now exacerbated by the COVID-19 challenges.

RESOURCES

For a list of all resources shared during the symposium events by participants and presenters, please see Appendix 5, which also includes comments and general information.

APPENDIX 1: PART 1 FLYER AND PROGRAM



Center for Reducing Health Disparities

Part I Keynote



Demetrios G. Papademetriou, PhD
Migration Policy Institute

Part I Panelists:



Luis H. Zayas, PhD
Univ. of Texas, Austin



Mayra E. Alvarez, MHA
The Children's Partnership
in Los Angeles



Samantha Artiga, MHSA
Kaiser Family Foundation

July
28

Part I
12 - 2:30 p.m.
(PDT)

Trauma-Informed Care and Services for Immigrant Families: A Three-Part Symposium

During this three-part symposium, experts will provide the context for the effects of trauma on immigrant families and:

- Report on the experiences of immigrant families regarding the chilling effects and fears created by the "Public Charge" rule, the rescission of the Deferred Action for Childhood Arrivals (DACA) and Temporary Protected Status (TPS), increased deportations, and other anti-immigrant policies as trauma and adverse childhood events (ACEs).
- Identify potential trauma-informed approaches by health care, mental health, social service providers caring for immigrant families.
- Identify the financial impact of trauma on immigrant families, and potential policy and systems changes to support trauma-informed care and services for immigrant families.



Photo: John Moore / Getty Images News via Getty Images

Part I: Trauma in Immigrant Families: Public Charge, DACA and COVID-19

The first symposium will highlight leaders' perspectives on this topic, including a panel of experts that will discuss the implications and influence of policy decisions.

Please join us for the first symposium by registering today at <https://tinyurl.com/UCDTrauma-InformedSymposium>.

Trauma-Informed Care and Services for Immigrant Families: A three-part symposium



**Part I: Trauma in Immigrant Families:
Public Charge, DACA, and COVID-19**
July 28, 2020, 12 – 2:30 p.m.

Trauma-Informed Care and Services for Immigrant Families: A three-part symposium

Agenda

PART I: JULY 28th 12 – 2:30 p.m.

Trauma in Immigrant Families: Public Charge, DACA and COVID-19

12 – 12:10 p.m.	Introduction and House Keeping	Sergio Aguilar-Gaxiola, MD, PhD <i>UC Davis Health, Center for Reducing Health Disparities</i>
12:10 – 12:25 p.m.	Opening Remarks	David Lubarsky, MD, MBA <i>UC Davis Health</i> Sandra Hernández, MD <i>California Health Care Foundation</i>
12:25 – 12:50 p.m.	Keynote Speaker	Demetrios Papademetriou, PhD <i>Migration Policy Institute</i>
12:50 – 2:00 p.m.	<p>Panel Discussion:</p> <p>Impact of Enforcement Policies and Practices on Immigrant and Refugee Children</p> <p>Health and Social Needs of Immigrant Families Amid the Shifting Policy Environment</p> <p>Healthy Mind, Healthy Future: Supporting Children in Immigrant Families</p> <p>Moderated Discussion</p>	<p>Luis H. Zayas, PhD <i>University of Texas, Austin</i></p> <p>Samantha Artiga, MHSA <i>The Henry J. Kaiser Family Foundation</i></p> <p>Mayra E. Alvarez, MHA <i>The Children’s Partnership, Los Angeles, CA</i></p> <p>Ignatius Bau <i>Consultant</i></p>



2:00 – 2:05 p.m.	Break	All Participants
2:05 – 2:20 p.m.	Discussion: Questions & Answers Recommendations from panel discussion	All Participants
2:20 – 2:30 p.m.	Closing Remarks: Upcoming sessions Wrap up discussion	Sandra Hernández, MD <i>California Health Care Foundation</i>

Introduction & Housekeeping



SERGIO AGUILAR-GAXIOLA, MD, PHD

Director, UC Davis Center for Reducing Health Disparities and Professor of Clinical Internal Medicine

BIOGRAPHY

Sergio Aguilar-Gaxiola, MD, PhD is a Professor of Clinical Internal Medicine, School of Medicine, University of California, Davis. He is the Founding Director of the Center for Reducing Health Disparities at UC Davis Health and the Director of the Community Engagement Program of the UCD Clinical Translational Science Center (CTSC). He is a past member of the National Advisory Mental Health Council (NAMHC), National Institute of Mental Health (NIMH). He is a current member of the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, National Advisory Council. He is a board member of the California Health Care Foundation, a member of the California Department of Public Health Office of Health Equity's Advisory Committee, and a member of the board of Physicians for a Health California. He is a national and international expert on health and mental health comorbidities on diverse populations. He has held several World Health Organization (WHO) and Pan American Health Organization (PAHO) advisory board and consulting appointments and is currently a member of the Executive Committee of the World Health Organization (WHO) World Mental Health Survey Consortium (WMH) and its Coordinator for Latin America and the Caribbean, overseeing population-based national/regional surveys in Argentina, Brazil, Colombia, México and Peru.

Dr. Aguilar-Gaxiola has extensive experience in population-based needs assessments and community-engaged research studies with a primary focus on identifying unmet health and mental needs and associated risk and protective factors. His work has focused on community-based approaches to addressing and reducing health/mental health disparities in underserved populations, the translation of evidence-based information and the successful implementation and dissemination of evidence-based information. He is an expert consultant and trainer of community-based organizations (CBOs), counties, and state and federal agencies on meaningful community engagement, and culturally and linguistically competency training. In the last decade, he has spearheaded California-wide efforts to (1) engage hard-to-reach communities (e.g., migrant workers, *Mixtecos*, Latino LGBTQ) that have been unserved/underserved by public mental health services and excluded in community stakeholder processes, (2) develop and implement a grassroots community engagement process to ensure their input, (3) solicit and gather their voices regarding Prevention and Early Intervention programs, strategies, and strengths, and (4) use the information gathered to transform systems of health care's service delivery. He is the recipient of multiple awards including the 2018 UC Davis Health Dean's Team Award for Inclusion Excellence, along with the Center for Reducing Health Disparities Team for outstanding multidisciplinary team contributions in the area of community engagement, the 2018 NAMI California Multicultural Outreach Excellence Award, and the 2018 Mental Health California's Research and Health Disparities Award. Dr. Aguilar-Gaxiola is currently co-chair of the National Academy of Medicine's (NAM) Committee on Assessing Meaningful Community Engagement for Health and Health Care, a work group of the NAM Leadership Consortium, Collaboration for a Value & Science-Driven Learning Health System.

Trauma-Informed Care and Services for Immigrant Families 4

Opening Remarks



David Lubarsky, MD, MBA

Vice Chancellor of Human Health Sciences and
Chief Executive Officer for UC Davis Health

BIOGRAPHY

Dr. David Lubarsky is the vice chancellor of human health sciences and chief executive officer for UC Davis Health. He oversees UC Davis Health's academic, research and clinical programs, including the School of Medicine, the Betty Irene Moore School of Nursing, the 1,000-member physician practice group, and UC Davis Medical Center, a 625-bed acute-care

hospital.

With roughly 14,000 employees, nearly 1,000 students, 1,000 faculty members, an annual operating budget of \$3 billion, and around one million outpatient visits each year, UC Davis Health is a major contributor to the health and economy of the Sacramento region and is a center of biomedical discoveries that help advance health around the world, ranked in the top 30 nationally for medical research.

Since joining UC Davis Health in July 2018, Dr. Lubarsky has re-energized the health system. He recommitted the organization to expanding care for the underserved, earning UC Davis Health public acknowledgment as a leader in caring for Medi-Cal patients, and he's established partnerships with local government agencies, entrepreneurs, technology companies, and with other health systems to further the UC Davis mission to make the world a better, healthier place. UC Davis Chancellor Gary May calls him a problem solver and change maker. And if he has any free time, you can often find him on long rides around the region on his bike.

Opening & Closing Remarks



Sandra Hernández, MD

President and CEO, California Health Care Foundation

BIOGRAPHY

Sandra R. Hernández, MD, is president and CEO of the California Health Care Foundation, which works to improve the health care system, so it works for all Californians. Prior to joining CHCF, Sandra was CEO of The San Francisco Foundation, which she led for 16 years. She previously served as director of public health for the City and County of San Francisco. She also co-chaired San Francisco's Universal Healthcare Council, which designed Healthy San Francisco. It was the first time a local government in the US attempted to provide health care for all of its constituents. In February 2018, Sandra was appointed by Governor Jerry Brown to the Covered California board of directors. She also serves on the Betty Irene Moore School of Nursing Advisory Council at UC Davis and on the UC Regents Health Services Committee. Sandra is an assistant clinical professor at the UCSF School of Medicine. She practiced at San Francisco General Hospital in the HIV/AIDS Clinic from 1984 to 2016.

Sandra is a graduate of Yale University, the Tufts School of Medicine, and the certificate program for senior executives in state and local government at Harvard University's John F. Kennedy School of Government.

Keynote Speaker



Demetrios Papademetriou, PhD

Consultant, Migration Policy Institute

BIOGRAPHY

Demetrios G. Papademetriou is Distinguished Transatlantic Fellow and Convener of the Transatlantic Council on Migration, a signature initiative of the Migration Policy Institute (MPI) that brings together senior officials and prominent experts to discuss critical migration matters. He co-founded the Washington-based MPI, where he served as President from 2002 to 2014, and founded (2011) and served as President of the Brussels-based MPI Europe until the end of 2017. He is President Emeritus of both institutions. Dr. Papademetriou has published more than 270 books, monographs, articles and research reports on migration and related issues, advises senior government officials, foundations, and civil society organizations in dozens of countries and is co-founder and Chair Emeritus of Metropolis. He also convened the Regional (North American) Migration Study Group from 2011-2014 and has chaired the World Economic Forum's Migration Council, the OECD's Migration Group, and the Open Society Foundations' International Migration Initiative.

Panelist



Luis H. Zayas, PhD

Dean and the Robert Lee Sutherland Chair in Mental Health and Social Policy at the Steve Hicks School of Social Work, and Professor of Psychiatry at the Dell Medical School of The University of Texas at Austin

BIOGRAPHY

LUIS H. ZAYAS, Ph.D., is dean and the Robert Lee Sutherland Chair in Mental Health and Social Policy at the Steve Hicks School of Social Work, and Professor of Psychiatry at the Dell Medical School of The University of Texas at Austin. Zayas is both a social worker and developmental psychologist. His clinical work and research have focused on disadvantaged families, particularly Hispanic and other ethnic/racial minorities.

Panelist



Samantha Artiga, MHA

Director, Disparities Policy Project and
Associate Director, Program on Medicaid and the Uninsured
The Henry J. Kaiser Family Foundation

BIOGRAPHY

Samantha Artiga serves as Director of the Disparities Policy Project at the Kaiser Family Foundation and Associate Director for the Foundation's Program on Medicaid and the Uninsured. Ms. Artiga develops and leads research and policy analysis to provide greater insight into health care disparities affecting underserved groups and strategies to promote equity in health care. In addition, she serves as a national expert on Medicaid and the Children's Health Insurance Program. Her work in these areas focuses on racial and ethnic disparities in health and health care and well as health coverage and access to care for vulnerable populations, including individuals experiencing homelessness, justice-involved individuals, and immigrants. Ms. Artiga holds a master's in health services administration degree with a concentration in Health Policy and a Bachelor of Arts degree in Economics from the George Washington University.

Panelist



Mayra E. Alvarez, MHA

President, The Children's Partnership,
Los Angeles, CA

BIOGRAPHY

Mayra E. Alvarez is President of The Children's Partnership, a national, nonprofit organization working to ensure all children have the resources and the opportunities they need to grow up healthy and lead productive lives. She was nominated by California Governor Gavin Newsom to serve on the First 5 California Commission and by California Attorney General Xavier Becerra to serve on the Mental Health Services Oversight and Accountability Commission (MHSOAC), which oversees the implementation of the Mental Health Services Act (MHSA).

Prior to The Children's Partnership, Ms. Alvarez completed a several-year set of assignments at the US Department of Health and Human Services (DHHS) in the administration of President Barack Obama. She served as the Director of the State Exchange Group for the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services, and led a team responsible for supporting states in the establishment of Health Insurance Marketplaces. Previously, Ms. Alvarez served as the Associate Director for the DHHS Office of Minority Health (OMH), where she led the coordination of OMH's work related to the Affordable Care Act, community health workers, and language access. Prior to this role, Ms. Alvarez served as Director of Public Health Policy in the Office of Health Reform at DHHS where she had primary oversight responsibility for coordinated and timely implementation of the public health, prevention, and health care workforce policy provisions in the Affordable Care Act.

Before joining the Obama Administration, Ms. Alvarez served as a Legislative Assistant for Senator Dick Durbin (D-IL) and for then-Congresswoman Hilda L. Solis. Ms. Alvarez began her professional career as a David A. Winston Health Policy Fellow in the office of then-Senator Barack Obama. She completed her graduate education at the School of Public Health at the University of North Carolina at Chapel Hill and her undergraduate education at the University of California at Berkeley. She is originally from outside San Diego, CA and is the proud daughter of Mexican immigrants.

Moderator



Ignatius Bau

Consultant

BIOGRAPHY

Ignatius Bau is an independent consultant, working with funders, health departments, and community-based organizations on both immigration and health policy issues. He currently is a consultant to Grantmakers Concerned with Immigrants and Refugees, Unbound Philanthropy, California Health Care Foundation, Blue Shield of California Foundation, and The California Endowment on immigration-related grantmaking. He has been a consultant to the National Immigration Law Center on the Protecting Immigrant Families campaign and to the Immigrant Legal Resource Center on the New Americans Campaign. He worked for ten years as an immigration attorney at the Lawyers' Committee for Civil Rights of the San Francisco Bay Area, for seven years as a program officer at The California Endowment, and in various positions at the Asian & Pacific Islander American Health Forum. He was the founding board chairperson of the Northern California Coalition for Immigrant and Refugee Rights, helped to draft the 1989 San Francisco City of Refuge, or "sanctuary" ordinance, and was on the statewide steering committee of Californians United Against Proposition 187



About

Center for Reducing Health Disparities

The UC Davis Center for Reducing Health Disparities (CRHD) takes a multidisciplinary, collaborative approach to the inequities in health access and quality of care. This includes a comprehensive program for research, education and teaching, and community outreach and information dissemination.

The center builds on UC Davis' long history of reaching out to the most vulnerable, underserved populations in the region. A comprehensive medical interpretive services program helps overcome limitations in access for those who don't speak English. Its regional telehealth network provides a high-tech link between UC Davis physicians and smaller clinics around the state that cannot afford to maintain medical specialists on staff.

The center represents a major commitment to addressing community needs that goes well beyond the traditional service role of an academic medical center. It is a program designed not only to raise awareness and conduct critical research, but also intended to actually assist those communities whose needs have never been addressed and met by the traditional health-care system.

The center's wide-ranging focus on health disparities includes an emphasis on improving access, detection and treatment of mental health problems within the primary care setting. It will also focus efforts on achieving better understanding into the co-morbidity of chronic illnesses such as diabetes, hypertension, pain conditions, and cancer with depression.

California Health Care Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

At the California Health Care Foundation, we know that health care is a basic necessity. We work hard to improve California's health care system, so it works for all Californians.

Because Californians with low incomes experience the biggest health burden and face the greatest barriers to care, our priority is to make sure they can get the care they need.

We are especially focused on strengthening Medi-Cal — the cornerstone of California's safety net. We are also committed to finding better ways to meet the health care needs of the millions of people who remain uninsured in our state. And we are working to better integrate care for Californians who experience mental illness, drug or alcohol addiction, or other complex health conditions.



Acknowledgement

This symposium would not have been possible without the help and support of the Center for Reducing Health Disparities staff. We are also most grateful for the leadership and direction of Ignatius Bau, in bringing forth this symposium.

Special thanks to the California Health Care Foundation that made this symposium possible as the funder and to Dr. Hernández for lending her expertise to the symposium.

We are deeply grateful to our speakers, moderator and panelists: Dr. Sergio Aguilar-Gaxiola, Dr. David Lubarsky, Dr. Sandra Hernández, Dr. Demetrios Papademetriou, Dr. Luis H. Zayas, Samantha Artiga, Mayra Alvarez, and Ignatius Bau for sharing their time and expertise. And finally, thank you to all those who attend and participate in this symposium.

APPENDIX 2: PART 2 FLYER AND PROGRAM



Center for Reducing Health Disparities

Part II Special Guest



Nadine Burke Harris, MD, MPH, FAAP
California Health & Human Services

Panelists



Altaf Saadi, MD, MSc
Massachusetts General Hospital



Thu Quach, PhD
Asian Health Services



Andrés Sciolla, MD
UC Davis Health

August
25

Part II
12 - 2:30 p.m.
(PDT)

Trauma-Informed Care and Services for Immigrant Families: A Three-Part Symposium

During this three-part symposium, experts will provide the context for the effects of trauma on immigrant families and:

- Report on the experiences of immigrant families regarding the chilling effects and fears created by the “Public Charge” rule, the rescission of the Deferred Action for Childhood Arrivals (DACA) and Temporary Protected Status (TPS), increased deportations, and other anti-immigrant policies as trauma and adverse childhood events (ACEs).
- Identify potential trauma-informed approaches by health, mental health, and social service providers caring for immigrant families.
- Identify the financial impact of trauma on immigrant families, and potential policy and systems changes to support trauma-informed care and services for immigrant families.



Photo by Olivier Douliery/AFP via Getty Images

Part II: How health systems and providers can deliver trauma-informed care to immigrant families

The second symposium will highlight leaders' perspectives on this topic, including a panel of experts that will discuss the delivery of trauma-informed care and the implications for practice and policy.

Please join us for the second symposium by registering today at <https://tinyurl.com/UCDTrauma-InformedSymposium>.

Trauma-Informed Care and Services for Immigrant Families: A three-part symposium



**Part II: How Health Systems and
Providers can Deliver Trauma-
Informed Care to Immigrant Families
August 25, 2020, 12 – 2:30 p.m. (PDT)**



Center for Reducing
Health Disparities



Trauma-Informed Care and Services for Immigrant Families: A three-part symposium

Agenda

PART II: August 25th 12 – 2:30 p.m. (PDT)

Trauma in Immigrant Families: How Health Systems and Providers can Deliver Trauma-Informed Care to Immigrant Families

12 – 12:10 p.m.	Introduction and House Keeping	Sergio Aguilar-Gaxiola, MD, PhD <i>UC Davis Health, Center for Reducing Health Disparities</i>
12:10 – 12:25 p.m.	Opening Remarks	David Lubarsky, MD, MBA <i>UC Davis Health</i> Sandra Hernández, MD <i>California Health Care Foundation</i>
12:25 – 12:50 p.m.	A Conversation with California Surgeon General	Nadine Burke Harris, MD, MPH, FAAP <i>Office of the California Surgeon General</i>
12:50 – 1:45 p.m.	<u>Panel Discussion</u>	
	Understanding Trauma-Informed Care and Building Resilience with Immigrant Families to Address Mental Health Needs	Andrés Felipe Sciolla, MD <i>UC Davis Health</i>
	Responding to the COVID Pandemic	Thu Quach, PhD <i>Asian Health Services</i>
	How health systems and providers can deliver trauma-informed care to immigrant families	Altaf Saadi, MD, MSc <i>Massachusetts General Hospital Harvard Medical School</i>

1:45 – 1:50 p.m.	Break	All Participants
1:50 – 2:20 p.m.	Moderated Discussion	Ignatius Bau <i>Consultant</i>
	Questions & Answers	All Participants
	Panelists Recommendations	Panel Members
2:20 – 2:30 p.m.	Closing Remarks	Sandra Hernández, MD <i>California Health Care Foundation</i>
	Upcoming session and wrap up	Sergio Aguilar-Gaxiola, MD, PhD <i>UC Davis Health, Center for Reducing Health Disparities</i>

Introduction & Housekeeping



Sergio Aguilar-Gaxiola, MD, PhD

Director, UC Davis Center for Reducing Health Disparities and Professor of Clinical Internal Medicine

BIOGRAPHY

Sergio Aguilar-Gaxiola, MD, PhD is a Professor of Clinical Internal Medicine, School of Medicine, University of California, Davis. He is the Founding Director of the Center for Reducing Health Disparities at UC Davis Health and the Director of the Community Engagement Program of the UCD Clinical Translational Science Center (CTSC). He is a past member of the National Advisory Mental Health Council (NAMHC), National Institute of Mental Health (NIMH). He is a current member of the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, National Advisory Council. He is a board member of the California Health Care Foundation, a member of the California Department of Public Health Office of Health Equity's Advisory Committee, and a member of the board of Physicians for a Health California. He is a national and international expert on health and mental health comorbidities on diverse populations. He has held several World Health Organization (WHO) and Pan American Health Organization (PAHO) advisory board and consulting appointments and is currently a member of the Executive Committee of the World Health Organization (WHO) World Mental Health Survey Consortium (WMH) and its Coordinator for Latin America and the Caribbean, overseeing population-based national/regional surveys in Argentina, Brazil, Colombia, México and Peru.

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Opening Remarks



David Lubarsky, MD, MBA

Vice Chancellor of Human Health Sciences and Chief Executive Officer for UC Davis Health

BIOGRAPHY

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Opening & Closing Remarks



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Sandra Hernández, MD

President and CEO, California Health Care Foundation

BIOGRAPHY

Sandra R. Hernández, MD, is president and CEO of the California Health Care Foundation, which works to improve the health care system, so it works for all Californians. Prior to joining CHCF, Sandra was CEO of The San Francisco Foundation, which she led for 16 years. She previously served as director of public health for the City and County of San Francisco. She also co-chaired San Francisco's Universal Healthcare Council, which designed Healthy San Francisco. It was the first time a local government in the US attempted to provide health care for all of its constituents. In February 2018, Sandra was appointed by Governor Jerry Brown to the Covered California board of directors. She also serves on the Betty Irene Moore School of Nursing Advisory Council at UC Davis and on the UC Regents Health Services Committee. Sandra is an assistant clinical professor at the UCSF School of Medicine. She practiced at San Francisco General Hospital in the HIV/AIDS Clinic from 1984 to 2016.

Sandra is a graduate of Yale University, the Tufts School of Medicine, and the certificate program for senior executives in state and local government at Harvard University's John F. Kennedy School of Government.

A Conversation with California Surgeon General



Nadine Burke Harris, MD, MPH, FAAP
California Surgeon General

BIOGRAPHY

Dr. Nadine Burke Harris is an award-winning physician, researcher and advocate dedicated to changing the way our society responds to one of the most serious, expensive and widespread public health crises of our time: childhood trauma. She was appointed as California's first-ever Surgeon General by Governor Gavin Newsom in January 2019.

Dr. Burke Harris' career has been dedicated to serving vulnerable communities and combating the root causes of health disparities. After completing her residency at Stanford, she founded a clinic in one of San Francisco's most underserved communities, Bayview Hunters Point. It was there that Burke Harris observed that, despite the implementation of national best-practices for immunizations, asthma, obesity treatment and other preventive health measures, her patients still faced outsized risks for poor health, development and behavioral outcomes.

Drawing in research from the CDC and Kaiser Permanente, Dr. Burke Harris identified Adverse Childhood Experiences as a major risk factor affecting the health of her patients. In 2011, she founded the Center for Youth Wellness and subsequently grew the organization to be a national leader in the effort to advance pediatric medicine, raise public awareness, and transform the way society responds to children exposed to Adverse Childhood Experiences (ACEs) and toxic stress. She also founded and led the Bay Area Research Consortium on Toxic Stress and Health, to advance scientific screening and treatment of toxic stress.

She currently serves as a government liaison for the American Academy of Pediatrics' National Advisory Board for Screening and sat on the board of the Committee on Applying Neurobiological and Socio-behavioral Sciences from Prenatal Through Early Childhood Development: A Health Equity Approach for the National Academy of Medicine.

Her work has been profiled in best-selling books including "How Children Succeed" by Paul Tough and "Hillbilly Elegy" by J.D. Vance as well as in Jamie Redford's feature film, "Resilience". It has also been featured on NPR, CNN and Fox News as well as in USA Today and the New York Times. Dr. Burke Harris' TED Talk, "How Childhood Trauma Affects Health Across the Lifetime" has been viewed more than 6 million times. Her book "The Deepest Well: Healing the Long-Term Effects of Childhood Adversity" was called "indispensable" by The New York Times.

Dr. Burke Harris is the recipient of the Arnold P. Gold Foundation Humanism in Medicine Award presented by the American Academy of Pediatrics and the Heinz Award for the Human Condition. She was named one of 2018's Most Influential Women in Business by the San Francisco Business Times.

Panelist



Andrés Felipe Sciolla, MD

Professor of Clinical Psychiatry at UC Davis, CA
Department of Psychiatry & Behavioral Sciences
Co-Director of RESTART program

BIOGRAPHY

Dr. Sciolla is a Professor of Clinical Psychiatry at the University of California, Davis. He is also Co-Director of the RESTART program (Resilience, Education and Supportive Tools for Adults Recovering from Trauma) at the UC Davis Behavioral Health Center.

Dr. Sciolla is a board-certified psychiatrist who graduated from the University of Chile School of Medicine and completed his psychiatry residency training at UC San Diego.

Dr. Sciolla's career focuses on the effects of exposure to social disadvantage and interpersonal adversities during childhood on physical and mental health. He has conducted research in this area and developed innovative educational modules for undergraduate and graduate medical trainees. This interest stems from providing comprehensive psychiatric services to ethnic and sexual minorities, including refugees and immigrants, for close to 20 years.

Panelist



Thu Quach, PhD

Chief Deputy of Administration
Asian Health Services

BIOGRAPHY

Thu Quach, PhD has been working in public health and health care for over two decades. Her research, service, and advocacy work have been grounded in her own lived experience as a refugee from Vietnam, and the struggles her family faced in the health care system. Trained as an epidemiologist, she has conducted community-based research, focusing on Asian Americans and immigrant populations, including examining occupational exposures and health impacts among Vietnamese nail salon workers. This work was inspired by her own mother, who passed from cancer at the age of 58, after working as a cosmetologist for decades. These research findings have contributed to the seminal work of the California Healthy Nail Salon Collaborative, which has shaped policy changes and worker rights and safety.

Dr. Quach currently serves as the Chief Deputy of Administration at Asian Health Services, a federally qualified health center in Oakland serving 50,000 patients in English and 14 Asian languages. She is involved in local, statewide, and national research and policy efforts to promote health equity. In 2016, she led the organization in establishing a specialty mental health department. In 2017, Dr. Quach helped form One Nation, a national coalition of over 100 organizations working to galvanize the Asian American and Pacific Islander (AAPI) community around the issue of public charge and its impacts on immigrant families for using vital services, such as health care, food and housing assistance. Currently, Dr. Quach is leading the organization in addressing racial disparities in COVID-19, including starting up a culturally and linguistically competent community testing site and contact tracing targeting AAPIs.

Dr. Quach received her Bachelors of Art at U.C. Berkely, her Master's in Public Health at U.C.L.A. and her Ph.D. in Epidemiology at U.C. Berkeley.

Panelist



Altaf Saadi, MD, MSc

Neurology, Massachusetts General Hospital
Harvard School of Medicine

BIOGRAPHY

Altaf Saadi, MD, MSc is a general academic neurologist at Massachusetts General Hospital (MGH) and instructor of neurology at Harvard Medical School. She is also associate director of the MGH Asylum Clinic. Her research is focused on health disparities and social and structural determinants of health among racial/ethnic minorities, immigrants, and refugees.

Dr. Saadi completed her neurology training at the Partners Neurology Program at MGH and Brigham and Women's Hospital in Boston, where she also served as chief resident. During her residency, Dr. Saadi's interest in health equity led her to work in resource-limited settings in the Navajo Nation, Tanzania, Zambia, with Boston Healthcare for the Homeless, and with the Doctors Without Borders telemedicine program.

Her research training includes a fellowship with the National Clinician Scholars Program at UCLA, where she conducted several health services research projects and received a master's degree in health policy and management at the UCLA Fielding School of Public Health. One of her projects focused on the understanding of how hospitals and health care facilities can ensure that all patients feel safe when accessing health care, regardless of their immigration status, exploring the concept of "sanctuary" and "safe spaces" in the clinical setting.

As an asylum evaluator for the PHR Asylum Network, Dr. Saadi has conducted evaluations for individuals in the community and in immigration detention centers. She has also assessed the medical conditions of confinement in immigration detention at facilities in California and Texas, including with Human Rights First and Disability Rights California. Her academic work has been published in the British Medical Journal, JAMA, JAMA Network Open, and Neurology, among others, and her personal writing in Boston NPR's CommonHealth Blog, the Huffington Post, the *Los Angeles Times*, *STAT News*, and *Undark Magazine*. Her work has also received media coverage in the *Christian Science Monitor*, *Reuters*, and *Salon*.

Dr. Saadi completed her undergraduate studies at Yale College and earned her medical degree from Harvard Medical School, where she graduated *cum laude* and received the Dean's Community Service Award.

Moderator



Ignatius Bau

Consultant

BIOGRAPHY

Ignatius Bau is an independent consultant, working with funders, health departments, and community-based organizations on both immigration and health policy issues. He currently is a consultant to Grantmakers Concerned with Immigrants and Refugees, Unbound Philanthropy, California Health Care Foundation, Blue Shield of California Foundation, and The California Endowment on immigration-related grantmaking. He has been a consultant to the National Immigration Law Center on the Protecting Immigrant Families campaign and to the Immigrant Legal Resource Center on the New Americans Campaign. He worked for ten years as an immigration attorney at the Lawyers' Committee for Civil Rights of the San Francisco Bay Area, for seven years as a program officer at The California Endowment, and in various positions at the Asian & Pacific Islander American Health Forum. He was the founding board chairperson of the Northern California Coalition for Immigrant and Refugee Rights, helped to draft the 1989 San Francisco City of Refuge, or "sanctuary" ordinance, and was on the statewide steering committee of Californians United Against Proposition 187



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The center represents a major commitment to addressing community needs that goes well beyond the traditional service role of an academic medical center. It is a program designed not only to raise awareness and conduct critical research, but also intended to actually assist those communities whose needs have never been addressed and met by the traditional health-care system.

The center's wide-ranging focus on health disparities includes an emphasis on improving access, detection and treatment of mental health problems within the primary care setting. It will also focus efforts on achieving better understanding into the co-morbidity of chronic illnesses such as diabetes, hypertension, pain conditions, and cancer with depression.

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The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

At the California Health Care Foundation, we know that health care is a basic necessity. We work hard to improve California's health care system, so it works for all Californians.

Because Californians with low incomes experience the biggest health burden and face the greatest barriers to care, our priority is to make sure they can get the care they need.

We are especially focused on strengthening Medi-Cal — the cornerstone of California's safety net. We are also committed to finding better ways to meet the health care needs of the millions of people who remain uninsured in our state. And we are working to better integrate care for Californians who experience mental illness, drug or alcohol addiction, or other complex health conditions.



Acknowledgements

A special thank you to the California Health Care Foundation (CHCF) for supporting this event and for their strong commitment to finding viable and effective solutions to addressing trauma in immigrant families. We are most grateful to Dr. Sandra Hernandez, CHCF's President and CEO for lending her expertise to the symposium. We also thank Amy Adams for her key collaboration in the planning and oversight of the event and to Eric Antebi, CHCF's Director of Communications and Acting Vice President for External Engagement and Lisa Alferis, CHCF's Senior Communication Officer for their key role in disseminating this important symposium.

In addition, this symposium would not have been possible without the help and support from the UC Davis Center for Reducing Health Disparities team. Their dedication and commitment to creating and implementing a successful event is noteworthy. In particular, Andrea C. Nuñez, Shellie L. Hendricks and the Planning Committee, for all of the behind-the-scenes work and attention to one thousand and then some details. We are indebted to Dr. Renetta Tull, Vice Chancellor Diversity, Equity, & Inclusion and Dr. Hendry Ton, Associate Vice Chancellor for Health Equity, Diversity and Inclusion, for their sustained support and guidance on this symposium.

We are also most grateful for the leadership and direction of Ignatius Bau, in bringing forth this symposium. His expertise and ample experience in trauma and migration, among others, proved to be essential in the planning, implementation and dissemination of the event.

We are deeply grateful to all of our presenters: Dr. David A. Lubarsky, UC Davis Health Vice Chancellor and CEO, Dr. Sergio Aguilar-Gaxiola, Dr. Sandra Hernández, Dr. Nadine Burke Harris, Dr. Andrés Felipe Sciolla, Dr. Thu Quach, and Dr. Altaf Saadi for sharing their time and expertise.


Our gratitude goes out to Janne Olson-Morgan and Cate Powers from the Office of the California Surgeon General for their support of this event. Additional thanks go to Collette Pechin, Administrative Officer to Dr. David Lubarsky, for providing continued backing for this three-part symposium.

Another special thank you to Fostering Media Connections for their work to document the impacts of family deportation. Without their vision, we would not have been able to highlight the experiences of immigrants that have been impacted by trauma.

We would like to also incorporate a special note for the Avelica family that shared their story and journey of having a parent placed in deportation proceedings. We thank and admire the Avelica's courage to reveal the trauma experienced by their family.

We would also like to thank our UC Davis Health Public Affairs and Marketing Office, for their support and creativity. In particular we thank Edwin M. Garcia for his continued support. Thank you Emily K. Lillya and Barbara Hennelly for your commitment to creating cohesive marketing materials which contributed to the quality of the symposium.

Additionally, we would like to thank Dan Cotton, who provided invaluable assistance on the Zoom Webinar platform. Without his support and proactiveness we would not have been able to



provide the event in this platform which was the best suitable for this event. We also could not have done this without the support of the UC Davis IT team: Aaron Cocker, Alexander D. Lee, and Rijul Saxena. Their patience and technical support were critical in preparing this event.

And finally, thank you to all those who attend and participate in this symposium. Your interest, engagement and thoughtful questions and comments have elevated the event to new heights. Thank you all for your passion to shed light and improve care and services for immigrant families impacted by the traumatic experiences and multiple stressors associated with migration and now exacerbated by the multiple COVID-19 challenges.

APPENDIX 3: PART 3 FLYER AND PROGRAM



Center for Reducing Health Disparities

Part III Panelists



Jeff Hoch, PhD
UC Davis



Tanya Broder, JD
National Immigration Law Center



Cynthia Buiza
California Immigrant Policy Center

Trauma-Informed Care and Services for Immigrant Families: A Three-Part Symposium

During this three-part symposium, experts will provide the context for the effects of trauma on immigrant families and:

- Report on the experiences of immigrant families regarding the chilling effects and fears created by the “Public Charge” rule, the rescission of the Deferred Action for Childhood Arrivals (DACA) and Temporary Protected Status (TPS), increased deportations, and other anti-immigrant policies as trauma and adverse childhood events (ACEs).
- Identify potential trauma-informed approaches by health, mental health, and social service providers caring for immigrant families.
- Identify the financial impact of trauma on immigrant families, and potential policy and systems changes to support trauma-informed care and services for immigrant families.



Photo by Mandel Ngan/AFP via Getty Images

Part III: Financial Impacts and Policy Solutions for Trauma in Immigrant Families

The third and final symposium will highlight leaders’ perspectives on this topic, including a panel of experts that will discuss the fiscal impact and policy solutions for providing trauma-informed care to immigrant families.

Please join us for the third symposium by registering today at <https://tinyurl.com/UCDTrauma-InformedSymposium>.

September
22

Part III
12 - 2:30 p.m.
(PDT)

Trauma-Informed Care and Services for Immigrant Families: A Three-part Symposium



Part III: Financial Impacts and Policy Solutions for Trauma in Immigrant Families

September 22, 2020, 12-2:30 p.m. (PDT)

Trauma-Informed Care and Services for Immigrant Families: A three-part symposium

Agenda

PART III: September 22nd | 12-2:30 p.m. (PDT)

Trauma in Immigrant Families: Financial Impacts and Policy Solutions for Trauma in Immigrant Families

12 – 12:15 p.m.	Introduction and House Keeping	Sergio Aguilar-Gaxiola, MD, PhD <i>UC Davis Health, Center for Reducing Health Disparities</i>
12:15 – 12:20 p.m.	Welcome Message	Renetta G. Tull, PhD <i>UC Davis, Diversity, Equity and Inclusion</i>
12:20 – 12:30 p.m.	Opening Remarks	Kara Carter, MBA, MSc <i>California Health Care Foundation</i>
12:30 – 1:40 p.m.	<u>Panel Discussion</u>	
	Financial Impacts and Policy Solutions for Trauma in Immigrant Families: Cost Matters	Jeffrey Hoch, PhD <i>UC Davis</i>
	Federal Immigration Policy Changes, and State and Local Responses	Tanya Broder, JD <i>National Immigration Law Center</i>
	Immigrant Protections in California and the Road Ahead, An Overview of Community and Policy Responses	Cynthia Buiza, MA <i>California Immigrant Policy Center</i>

Trauma-Informed Care and Services for Immigrant Families 2



1:40 – 1:45 p.m.	Break	All Participants
1:45 – 2:15 p.m.	Moderated Discussion	Ignatius Bau <i>Consultant</i>
	Questions & Answers	All Participants
	Panelists Recommendations	Panel Members
2:15 – 2:30 p.m.	Closing Remarks	Kara Carter, MBA, MSc <i>California Health Care Foundation</i>
	Wrap Up	Sergio Aguilar-Gaxiola, MD, PhD <i>UC Davis Health, Center for Reducing Health Disparities</i>

Introduction & Housekeeping



Sergio Aguilar-Gaxiola, MD, PhD

Director, UC Davis Center for Reducing Health Disparities and Professor of Clinical Internal Medicine

BIOGRAPHY

Sergio Aguilar-Gaxiola, MD, PhD is a Professor of Clinical Internal Medicine, School of Medicine, University of California, Davis. He is the Founding Director of the Center for Reducing Health Disparities at UC Davis Health and the Director of the Community Engagement Program of the UCD Clinical Translational Science Center (CTSC). He is a past member of the National Advisory Mental Health Council (NAMHC), National Institute of Mental Health (NIMH). He is a current member of the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, National Advisory Council. He is a board member of the California Health Care Foundation, a member of the California Department of Public Health Office of Health Equity's Advisory Committee, and a member of the board of Physicians for a Health California. He is a national and international expert on health and mental health comorbidities on diverse populations. He has held several World Health Organization (WHO) and Pan American Health Organization (PAHO) advisory board and consulting appointments and is currently a member of the Executive Committee of the World Health Organization (WHO) World Mental Health Survey Consortium (WMH) and its Coordinator for Latin America and the Caribbean, overseeing population-based national/regional surveys in Argentina, Brazil, Colombia, México and Peru.

Dr. Aguilar-Gaxiola has extensive experience in population-based needs assessments and community-engaged research studies with a primary focus on identifying unmet health and mental needs and associated risk and protective factors. His work has focused on community-based approaches to addressing and reducing health/mental health disparities in underserved populations, the translation of evidence-based information and the successful implementation and dissemination of evidence-based information. He is an expert consultant and trainer of community-based organizations (CBOs), counties, and state and federal agencies on meaningful community engagement, and culturally and linguistically competency training. In the last decade, he has spearheaded California-wide efforts to (1) engage hard-to-reach communities (e.g., migrant workers, *Mixtecos*, Latino LGBTQ) that have been unserved/underserved by public mental health services and excluded in community stakeholder processes, (2) develop and implement a grassroots community engagement process to ensure their input, (3) solicit and gather their voices regarding Prevention and Early Intervention programs, strategies, and strengths, and (4) use the information gathered to transform systems of health care's service delivery. He is the recipient of multiple awards including the 2018 UC Davis Health Dean's Team Award for Inclusion Excellence, along with the Center for Reducing Health Disparities Team for outstanding multidisciplinary team contributions in the area of community engagement, the 2018 NAMI California Multicultural Outreach Excellence Award, and the 2018 Mental Health California's Research and Health Disparities Award. Dr. Aguilar-Gaxiola is currently co-chair of the National Academy of Medicine's (NAM) Committee on Assessing Meaningful Community Engagement for Health and Health Care, a work group of the NAM Leadership Consortium, Collaboration for a Value & Science-Driven Learning Health System.

Welcome Message



Renetta G. Tull, PhD

Vice Chancellor of Diversity, Equity and Inclusion
UC Davis

BIOGRAPHY

Before joining UC Davis in 2019, Dr. Tull was Associate Vice Provost for Strategic Initiatives at the University of Maryland, Baltimore County (UMBC), and Professor of the Practice in UMBC's College of Engineering and IT (COEIT). Within COEIT, she served as part of the "Engagement" team, and pursues research in humanitarian engineering. Tull is Founding Director and Co-PI for the 12-institution National Science Foundation University System of Maryland's (USM) PROMISE AGEP, and Co-Director/Co-PI for the NSF USM's Louis Stokes Alliance for Minority Participation (LSAMP).

In addition to roles at UMBC and roles with grants, she also served the University System of Maryland as Special Assistant to the Senior Vice Chancellor for Academic Affairs and Student Affairs, and was the system's Director of Graduate & Professional Pipeline Development. In 2017, Dr. Tull was appointed to serve as Chair for the University System of Maryland's Health Care Workforce Diversity subgroup. Dr. Tull has engineering and science degrees from Howard University and Northwestern University.

An international speaker on global diversity in STEM, Tull has led discussions around the world on topics such as "Inclusive Engagement – Engineering for All," "Cultivating Inclusive Excellence within Science, Engineering, and Technology," work/life balance, family, and prevention of domestic and workplace abuse. She co-led Puerto Rico's ADVANCE Hispanic Women in STEM project, and continues to lead the "Women in STEM Forum" for the Latin and Caribbean Consortium of Engineering Institutions (LACCEI) and the Engineering for the Americas/Organization of American States as LACCEI's current Vice President for Initiatives.

Recognitions include: 2015 O'Reilly Media "Women in Data" cover, 2015 Global Engineering Deans Council/Airbus Diversity Award Finalist, and the 2016 ABET Claire L. Felbinger Award for Diversity. She has been an invited plenary panelist for diversity in engineering initiatives for the 2016 International Conference on Transformations in Engineering Education in India, and an invited speaker for the International Federation of Engineering Education Societies (IFEES) "Global Engagement in Diversity" webinar. She was also part of an invited United Nations Educational, Scientific and Cultural Organization (UNESCO) team for the "Engineering Report II" meeting in Beijing in September 2017, hosted by the Chinese Academy of Engineering. In 2017, she was appointed to a 2-year term for the National Academies for Science, Engineering, and Medicine's committee on The Science of Effective Mentoring in Science, Technology, Engineering, Medicine, and Mathematics (STEMM). In 2018, she was invited back to the United Nations Headquarters to talk about women in engineering as part of a UNESCO-sponsored side event during the 62nd Session on the UN's Commission on the Status of Women.

Tull has more than 50 publications, has given more than 200 presentations on various STEM topics, and is a Tau Beta Pi "Eminent Engineer." She also engages the public on topics related to STEM and society, and was a speaker for "Diversity, STEAM, and Comics," where "A" adds the "arts" to STEM, at Awesome Con in March 2018. She is a passionate advocate, global mentor, education policy strategist and champion for equity in STEM.

Trauma-Informed Care and Services for Immigrant Families 5

Opening & Closing Remarks



Kara Carter MBA, MSc

Senior Vice President, Strategy and Programs
California Health Care Foundation

BIOGRAPHY

Kara Carter is senior vice president of strategy and programs at the California Health Care Foundation, where she develops strategies, provides overall guidance, and leads the program teams in the development, execution, and assessment of CHCF's work. In this role, Kara provides thought leadership and support to CHCF's grantmaking programs and priorities, as well as CHCF's program related investments and learning and impact functions.

Prior to joining CHCF, Kara was a partner at McKinsey & Company's San Francisco and London offices. She was a leader in McKinsey's Medicaid practice in the US, and supported public and private sector health systems in the US, UK, and Europe to improve quality, access, and affordability.

Before joining McKinsey, Kara worked for UK-based philanthropic institutions on a broad range of topics related to poverty and community action. Kara received a bachelor's degree from the University of Virginia, a master's in social anthropology from the London School of Economics and Political Science, and a master's in business administration from the London Business School. She currently serves on the UC Davis Health National Advisory Board.

Moderator



Ignatius Bau

Consultant

BIOGRAPHY

Ignatius Bau is an independent consultant, working with funders, health departments, and community-based organizations on both immigration and health policy issues. He currently is a consultant to Grantmakers Concerned with Immigrants and Refugees, Unbound Philanthropy, California Health Care Foundation, Blue Shield of California Foundation, and The California Endowment on immigration-related grantmaking. He has been a consultant to the National Immigration Law Center on the Protecting Immigrant Families campaign and to the Immigrant Legal Resource Center on the New Americans Campaign. He worked for ten years as an immigration attorney at the Lawyers' Committee for Civil Rights of the San Francisco Bay Area, for seven years as a program officer at The California Endowment, and in various positions at the Asian & Pacific Islander American Health Forum. He was the founding board chairperson of the Northern California Coalition for Immigrant and Refugee Rights, helped to draft the 1989 San Francisco City of Refuge, or "sanctuary" ordinance, and was on the statewide steering committee of Californians United Against Proposition 187.

Panelist



Jeffrey Hoch, PhD

Professor and Chief of the Division of Health Policy and Management, Department of Public Health Sciences, Associate Director, Center for Healthcare Policy and Research UC Davis

BIOGRAPHY

Jeffrey Hoch received his PhD in health economics from the Johns Hopkins School of Public Health. He is a Professor and Chief of the Division of Health Policy and Management in the Department of Public Health Sciences and the Associate Director of the Center for Healthcare Policy and Research at the University of California at Davis. He has more than 200 peer-reviewed articles. As an award-winning teacher, Professor Hoch has taught classes throughout the world, giving over 250 invited presentations in 15 countries.

Panelist



Tanya Broder, JD

Senior Attorney
National Immigration Law Center

BIOGRAPHY

Ms. Broder specializes in the laws and policies affecting access to health care, public benefits, education and other services for low-income immigrants across the United States. She writes articles, offers technical assistance, participates in litigation and advocacy, and provides training to legal and social service providers, government agencies, legislative staff, educators and community-based organizations. Prior to joining National Immigration Law Center in 1996, she worked as a policy analyst for the Northern California Coalition for Immigrant Rights and as a staff attorney for the Legal Aid Society of Alameda County in Oakland. Ms. Broder holds a juris doctor from Yale Law School.

Panelist



Cynthia Buiza

Executive Director
California Immigrant Policy

BIOGRAPHY

Cynthia Buiza is the Executive Director of the California Immigrant Policy Center (CIPC) where she provides the vision for the mission of California's premiere immigrant rights organization. CIPC is thriving under her leadership, with a marked expansion in its issue area expertise and a broadening of its coalition networks working to build power for immigrants in this country. Cynthia came to this role after successfully managing a statewide capacity building project, involving nine regional coalitions in California, which strengthened their viability through a combination of highly customized training, grant-making and leadership coaching.

Cynthia brings over two decades of experience in nonprofit management and human rights advocacy to CIPC. She worked on international refugee, migration, human rights and civil rights issues in Southeast Asia before working with ACLU as Policy Director for its San Diego regional affiliate. She was also Policy and Advocacy Director at CHIRLA in Los Angeles from 2007-2010. More recently, she worked as a consultant with various immigrant rights and civil rights institutions and social justice organizations in California and the U.S., helping shape their strategic direction and plans for sustainability. Before moving to the United States, she worked in senior positions with various international organizations, including the United Nations High Commissioner for Refugees, the Open Society Institute-Burma Education Project in Thailand, and the Jesuit Refugee Service. In June 2003, she co-authored the book *Anywhere But War*, about the armed conflict and internal displacement in the Indonesian Province of Aceh.

Cynthia earned a Masters in International Affairs from the Fletcher School at Tufts University, with a concentration on human security studies. She holds a Bachelor of Science degree in Social Work from the Philippines, and a Certificate in Refugee and Migration Studies from the Oxford University Refugee Studies Centre in England. She also holds certificates from the Harvard Kennedy School of Government and the Stanford Graduate School of Business. Cynthia currently serves as a State Commissioner with the Milton Marks Little Hoover Commission for State Government Organization and the Economy. She is a member of the California Community Foundation's Immigration Advisory Council and the Southern California Policy Forum. She also serves on the Board of Directors of the Pilipino Worker's Center and Health Access California.

In her spare time Cynthia enjoys movies, visits to art museums, poetry, and decadent meals.



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Our gratitude goes out to Mark A. López and Elaina López from the Office of Vice Chancellor Renetta Tull for their support of this event.

Another special thank you to KMPH Fox 26, KFSN-TV KGO 30, and The Guardian for their work that documents the impacts of public charge, DACA and family separation

Another special thank you to Edwin M. Garcia and Christopher R. Nelson from the UC Davis Health Public Affairs and Marketing Office for their time and creativity in creating the short videos featured in this event. Without their vision, we would not have been able to highlight the experiences of immigrants that have been impacted by trauma. We would also like to particularly thank Emily K. Lillya for her commitment to creating cohesive marking materials which contributed to the quality of the event, and Barbara Hennelly for her support with those efforts.

We would like to also incorporate a special note for Edgar Velazquez, the medical DACA student who allowed us to share his story and journey with being a DACA recipient. We thank him and admire his resilience and commitment to follow his dreams.

Continued



Acknowledgements *Continued from page 133*

Additionally, we would like to thank Dan Cotton, who provided invaluable assistance on the Zoom Webinar platform. Without his support and proactiveness we would not have been able to provide the symposium in this platform, which was the best suitable for this event. We also could not have done this without the support of the UC Davis IT team: Aaron Cocker, Alexander D. Lee and Rijul Saxena. Their patience and technical support were critical in preparing this event.

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APPENDIX 4: PARTICIPANT CHARACTERISTICS

Table. Characteristics of Trauma-Informed Immigration Symposium Participants

	All Events		Symposium Part 1		Symposium Part 2		Symposium Part 3	
	n	(%)	n	(%)	n	(%)	n	(%)
Total	681	(100.0)	432	(100.0)	142	(100.0)	107	(100.0)
State of Residence								
California	547	(80.3)	337	(78.0)	115	(81.0)	95	(88.8)
Out of California	134	(19.7)	95	(22.0)	27	(19.0)	12	(11.2)
Background								
Community Member	158	(23.2)	108	(25.0)	31	(21.8)	19	(17.8)
Patient/Consumer/Family Member	36	(5.3)	26	(6.0)	5	(3.5)	5	(4.7)
Health Care Provider	77	(11.3)	46	(10.6)	20	(14.1)	11	(10.3)
Social Services Provider	165	(24.2)	103	(23.8)	35	(24.6)	27	(25.2)
Teacher/Educator	77	(11.3)	51	(11.8)	17	(12.0)	9	(8.4)
Staff of Community-Based Organization	181	(26.6)	116	(26.9)	34	(23.9)	31	(29.0)
Staff of State Government Agency	46	(6.8)	27	(6.3)	8	(5.6)	11	(10.3)
Staff of Local Government Agency	34	(5.0)	21	(4.9)	9	(6.3)	4	(3.7)
Student/Medical Student	64	(9.4)	44	(10.2)	12	(8.5)	8	(7.5)
University/Medical School Faculty/Staff	47	(6.9)	29	(6.7)	7	(4.9)	11	(10.3)
Other	116	(17.0)	60	(13.9)	28	(19.7)	28	(26.2)
Affiliated with an Organization								
Yes	534	(78.4)	327	(75.7)	117	(82.4)	90	(84.1)
No	147	(21.6)	105	(24.3)	25	(17.6)	17	(15.9)
Type of Organizational Affiliation								
Community-Based Organization	98	(14.4)	63	(14.6)	20	(14.1)	15	(14.0)
Medical Institution (Non-Academic)	24	(3.5)	10	(2.3)	10	(7.0)	4	(3.7)
Academic Institution	74	(10.9)	50	(11.6)	13	(9.2)	11	(10.3)
State/Government	75	(11.0)	41	(9.5)	21	(14.8)	13	(12.1)
Non-Profit	220	(32.3)	138	(31.9)	44	(31.0)	38	(35.5)
Other	43	(6.3)	25	(5.8)	9	(6.3)	9	(8.4)
Referral Source								
Received Invitation/Link	351	(51.5)	223	(51.6)	77	(54.2)	51	(47.7)
Social Media (e.g., Twitter or Facebook)	46	(6.8)	30	(6.9)	10	(7.0)	6	(5.6)
Word of Mouth	113	(16.6)	58	(13.4)	18	(12.7)	14	(13.1)
Saw Flyer	28	(4.1)	16	(3.7)	6	(4.2)	6	(5.6)
UC Davis CRHD Website	25	(3.7)	12	(2.8)	4	(2.8)	9	(8.4)
Other	48	(7.0)	31	(7.2)	9	(6.3)	8	(7.5)

States Represented

All Events	Symposium Part 1	Symposium Part 2	Symposium Part 3
Alabama	Alabama	California	Alabama
California	California	Maryland	California
Colorado	Colorado	Massachusetts	Illinois
Connecticut	Connecticut	Michigan	Massachusetts
District of Columbia	District of Columbia	New Mexico	Michigan
Illinois	Illinois	New York	New York
Maryland	Maryland	Ohio	Ohio
Massachusetts	Massachusetts	Oregon	Pennsylvania
Michigan	Michigan	Pennsylvania	Texas
Missouri	Missouri	Texas	Virginia
Nevada	Nevada	Virginia	
New Jersey	New Jersey	Washington	
New Mexico	New Mexico		
New York	New York		
Ohio	Ohio		
Oregon	Oregon		
Pennsylvania	Pennsylvania		
Tennessee	Tennessee		
Texas	Texas		
Virginia	Virginia		
Washington	Washington		

All Organizations Represented (Total = 171)

Organizations Represented

10,000 Degrees
AACI (Asian Americans for Community Involvement)
AltaMed Health Services
AMERICORPS LISTOS
Antelope Valley College
Antelope Valley Partners for Health
Asian Resources, Inc
Asian Youth Center
Aurrera Health Group
Bakersfield College
Barrio Action
Behavioral Health and Recovery Services
Blue Shield of CA
Blue Shield of California Foundation
BPSOS Center for Community Advancement
CA State Assembly
California Budget & Policy Center
California Department of Health Care Services
California Department of Public Health
California Department of Social Services
California Health Care Foundation
Californians Together
Canal Alliance
Catholic Charities of Boston
CCALAC
Center for Community Solutions
Center for the Pacific Asian Family
Central Valley Health Policy Institute
Central Valley Immigrant Integration Collaborative
Central Valley Opportunity Center
Centro Binacional para el Desarrollo Indigena Oaxaque
Centro La Familia Advocacy Services, Inc.
Charles R. Drew University of Medicine and Science
Children & Family Services
Children's Bureau
Children's Charter
Clinica Martin Baro
Clinica Tepati
College of Alameda
Columbia University Medical Center

Organizations Represented

Community Alliance of Tenants
Community Organizing and Family Issues
County of Marin Behavioral Health and Recovery Services
CSU San Bernardino
CSU San Bernardino Undocumented Student Success Center
CSU San Marcos
CVIIC
CVOC
Dignity Health California Hospital Medical Center
Dreamer Resource Office
Education & Leadership Foundation
El Nido Family Centers
El Paso Child Guidance Center
Empower The Community
Empower Yolo
Envision
FIRM, Inc.
Foundation for California Community Colleges
Franklin Neighborhood Development Corporation
Fresno Interdenominational Refugee Ministries (FIRM)
Fresno State University
Geisinger Commonwealth School Of Medicine
Gravenstein Health Action Coalition
Health Education Council
Health Research for Action
Healthy House Within A MATCH Coalition
Highlands Community Charter School
Hispanic Interest Coalition of Alabama
Holistic Cultural Education Wellness Center
Homeward Bound of Marin
Human Rights First
Illinois Coalition of Immigrant and Refugee Rights
ILRC
Immigrants Rising
Immigration Resource Center of San Gabriel Valley
Inform 2 Inspire
Integral Community Solutions Institute (ICSI)
Jewish Family Service of San Diego
Juntos de Lebanon
Kids in Need of Defense
LA Best Babies Network

Organizations Represented

La Clinica de la Raza
La Familia Counseling Center
LaFamilia Counseling Ctr
Latinos en Spokane
LAUSD
Legal Aid Society of Cleveland
Legal Aid Society of San Mateo County
LifeMoves
Lifemoves
Linn Co. Rapid Response Coalition
Long Beach Immigrant Rights Coalition
Los Angeles LGBT Center
Lutheran Community Services Northwest
Marin Community Foundation
Marin County Department of Children and Family Services
Maternal and Child Health Access
Maternity Care Coalition
Mental Health Association of Alameda County
Mi Familia Vota
Michigan League for Public Policy
Migration Policy Institute
Mira Costa College
Miracle Math Brain-Based Learning Center
Mission Promise Neighborhood
Montefiore Medical Center
Multicultural Center of Marin
Multi-Ethnic Collaborative of Community Agencies
National Immigration Law Center
Next Generation Scholars
NICOS Chinese Health Coalition
NorCal Resist
North County Immigration Task Force
OCA/PICA
OCA-San Francisco
OnTheGroundChi/ The Free Root Operation, Adelante
Pacoima Beautiful
Palo Alto University
Planned Parenthood
Pre-Health Dreamers
Redwood Community Health Coalition
Reedley College

Organizations Represented

Rio Vista CARE-Family Resource Center
Sacramento Food Bank & Family Services
SAJE
Samuel Dixon Family Health Center, Inc.
San Diego Mesa Community College
San Joaquin Delta College
Santa Clara Valley Medical Center Hospital & Clinics
School of Medicine UNAM
SEIU Nurse Alliance of CA
Seneca Family of Agencies
Sierra College
Siloam Health
Social Justice Learning Institute
Solano County Behavioral Health
Solano County Public Health
South Asian Network
Star View Community Services
Strategic Actions for a Just Economy
Survivors of Torture, International
Terra Firma, a program of Montefiore Medical Center and Catholic Charities
The California Wellness Foundation
The Children's Partnership
The Fresno Center
The Legal Aid Society of Cleveland
The Sharewood Project
The Spahr Center
The Welcome Project
TN Coalition to End Domestic & Sexual Violence
UC Davis
UC Davis Early Academic Outreach Program
UC Davis Global Learning Hub
UC Davis Health
UC Davis Health/CTSC
UC Davis Student Health & Counseling
UC Irvine
UC Merced
UC San Diego Extension
UCLA
UCLA Health
UCLA Labor Center

Organizations Represented

UCSF Benioff Children's Hospital
University of Colorado Denver Anschutz
VA Palo Alto Health Care System
Victim Witness Services
Vista Community Clinic
Watts Healthcare Corporation
Wellness Together
West Hills Community College Coalinga
Yakima Neighborhood Health Services

APPENDIX 5: RESOURCES/INFORMATION SHARED BY SYMPOSIUM PARTICIPANTS

PART I: Trauma in Immigrant Families: Public Charge, DACA and COVID-19

Lesson plans and resources to foster a safe and inclusive learning environment in California's PreK through 12 schools <https://www.californianstogether.org/support-immigrant-refugee-students/>

Supporting Immigrant and Refugee Students: Considerations for School Leaders in Response to the COVID-19 Pandemic <https://www.californianstogether.org/supporting-for-immigrant-and-refugee-students-considerations-for-school-leaders-in-response-to-the-covid-19-pandemic/>

English Learning Communities of Practice Zoom Call recording: Supporting Immigrant and Refugee Students through Distance Learning <https://www.youtube.com/watch?v=rRaNUtFcIIo>

The impact of COVID-19 on Pacific Islander communities, which experience high rates like Black and Latinx communities. <https://pi-copce.org/covid19response/>

PART II: How Health Systems And Providers Can Deliver Trauma-Informed Care To Immigrant Families

UCDH is planning to start a CIRCLE clinic (Comprehensive Integration of Resilience into Child Life Experiences) at the Sacramento County Clinic. Initially focused on foster care children, we hope to expand greatly. This clinic will provide comprehensive medical examination for these children and also screen them for mental health concerns. The initial plan is to have 1-2 clinics per week to evaluate and treat these children. Mental health specialists under the leadership of Susan Timmer from the CAARE (Child Adolescent Abuse Resource and Evaluation) Division of UC Davis will provide family-focused and culturally competent evidence-based interventions to these children and their parents (biological and foster). Innovative treatments such as parent-child interaction therapy (PCIT), trauma-focused cognitive behavioral therapy (TF-CBT) will also be offered to these children.

Migration Policy Institute report on changes to immigration law and policy under Trump Administration <https://www.migrationpolicy.org/research/us-immigration-system-changes-trump-presidency>

ACEs Aware is an initiative led by the Office of the California Surgeon General and the Department of Health Care Services to give Medi-Cal providers training, clinical protocols, and payment for screening children and adults for ACEs <https://www.acesaware.org/>

CA Surgeon General's Playbook: Stress Relief During COVID-19: <https://covid19.ca.gov/manage-stress-for-health/>

The US Department of Veteran Affairs created an application called COVID Coach that includes calming and coping exercises. Some can be used by parents and others could be done with children too: https://www.ptsd.va.gov/appvid/mobile/COVID_coach_app.asp

Information from the Centers for Disease Control and Prevention on ACEs: <https://www.cdc.gov/violenceprevention/acestudy/index.html>

CDC Morbidity and Mortality Weekly Report (MMWR) on ACEs in Adults: <https://www.cdc.gov/mmwr/volumes/68/wr/mm6844e1.htm>

National Education Association & ACEs <http://www.nea.org/home/75259.htm>

Healthcare facilities such as hospitals and clinics should be welcoming and safe spaces for everyone, regardless of race, ethnicity, nationality, or immigration status. Explore how healthcare facilities can play a pivotal role in ensuring the physical and psychological safety of their immigrant patients (videos and toolkits) <https://doctorsforimmigrants.com/>

Learn about the role of peer workers and access recovery-related resources about peer supports and service <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>

Pathways to Partnership: Tips for Incorporating Peer-to-Peer Support into Your Program: <https://www.nctsn.org/resources/pathways-partnership-tips-incorporating-peer-peer-support-your-program>

This brief is based on a webinar, implementing a Trauma-Informed Approach for Youth Across Service Sectors, held Tuesday, May 21, 2013, 2:00 p.m. to 3:30 p.m. EDT. The webinar was sponsored by the Interagency Working Group on Youth Programs (IWGYP), a collaboration of 18 Federal departments and agencies that support programs and services focusing on youth and promote the goal of positive, healthy outcomes for youth. The webinar was planned jointly by the IWGYP and the Substance Abuse and Mental Health Services Administration (SAMHSA). The webinar slides are housed on the IWGYP website, FindYouthInfo.gov, under the Mental Health Youth Topic https://youth.gov/docs/Trauma_Informed_Approach_508.pdf

PART III: Financial Impacts and Policy Solutions for Trauma in Immigrant Families

Research study titled, “Adult health burden and costs in California during 2013 associated with prior adverse childhood experiences”: <https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0228019&type=printable>

Survey of health funders about their support for resilience to trauma referred to by Kara Carter: <https://www.gih.org/publication/trauma-and-resilience-funding-infographic/>

Migration Policy Institute report documenting over 400 administrative changes to U.S. immigration law and policy under Trump Administration: <https://www.migrationpolicy.org/research/us-immigration-system-changes-trump-presidency>

USCIS instructions on implementing the new public charge rules: <https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge/injunction-of-the-inadmissibility-on-public-charge-grounds-final-rule>

National Foundation for American Policy Brief titled, “Immigrants and America’s Comeback from the COVID-19 Crisis”: <https://nfap.com/wp-content/uploads/2020/07/Immigrants-and-Americas-Comeback-From-The-Covid-19-Crisis.NFAP-Policy-Brief.July-2020.pdf>

State and Local Immigrants’ Rights Developments, December 2019–August 2020: <https://www.nilc.org/state-local-rights-developments-dec19-aug20/>

No Going Back: Together for an Equitable and Inclusive Los Angeles: <https://dornsife.usc.edu/eri/no-going-back>

Related LA Times Article “‘No going back’ to racist past, L.A. civic leaders say of post-COVID future”: <https://www.latimes.com/california/story/2020-09-09/philanthropic-leaders-issue-a-call-for-racial-and-economic-equity-in-the-time-of-covid>