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Training in Trauma-Responsive and Anti-racist Telehealth: A Model for Behavioral Health Clinicians and Providers

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Abstract

Telehealth's uptake in behavioral health services has been accelerated by the COVID-19 pandemic. However, many clinicians continue to lack focused training in providing trauma-informed and culturally-responsive telehealth care. This article outlines a model curriculum that was created to instruct and coach behavioral health providers in California on how to integrate anti-racist and trauma-responsive techniques into telehealth. Topics like evidence-based trauma therapies, racial/ethnic trauma, marginalized communities, digital divide, and provider selfcare were all covered in the nine-part curriculum. Every three-hour session included evidence-informed didactic content, telehealth skills practice, and concrete planning for implementation. Trauma-responsive frameworks such as the tri-phasic model of trauma recovery (Herman in *Trauma and recovery: The aftermath of violence—From domestic abuse to political terror*, Basic Books, 2015) and the neurosequential model of therapeutics (Perry in *The handbook of therapeutic care for children*, Jessica Kingsley Publishers, London, 2020) served as the foundation for the sessions. The Tools to Improve Practice (TIPs) website was created as a supplementary digital resource portal to support clinicians with continuous implementation. This model illustrates a replicable approach to strengthening workforce capacity and competence in trauma-responsive, anti-racist telehealth practices.

Keywords Telehealth · Trauma-informed care · Antiracism · Culturally-responsive · Behavioral health

Videoconferencing and other telehealth modalities have become increasingly popular in behavioral health as a result of the COVID-19 crisis (AlRasheed et al., 2022; Connolly et al., 2023). While telehealth improves access, many behavioral health providers feel inadequately prepared to deliver trauma-informed care virtually, especially to marginalized communities facing COVID-related stress and racial trauma (Ash et al., 2023; Falicov et al., 2020; Liu & Modir, 2020; Novacek et al., 2020). Trauma-informed care (TIC) is a framework that promotes the widespread impact of trauma, recognizes traumatic stress signs and symptoms, responds by integrating knowledge into practices and policies, and proactively resists re-traumatization (SAMHSA, 2023). Integrating a trauma-responsive, anti-racist lens is crucial to promote healing for BIPOC clients (Hardy, 2023; Metzger et al., 2021), but training at this intersection is very limited.

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Trauma interventions, when effectively adapted for telehealth, can have comparable outcomes to in-person services (Morland et al., 2020; Nicasio et al., 2022; Stewart et al., 2020; Villalobos et al., 2023). Key considerations include building digital therapeutic rapport, ensuring safety, flexibly implementing treatments, and addressing access barriers (Burgoyne & Cohn, 2020). For BIPOC clients more specifically, cultural humility and practices that promote racial trauma healing are essential (Ash et al., 2023; Metzger et al., 2021). However, few providers receive graduate training in cultural adaptations of trauma treatments (Ennis et al., 2020; Hall-Clark et al., 2024) or telehealth (Perle et al., 2023). Continuing education on trauma-informed, anti-racist telehealth competencies is needed to more competently translate research to practice (Dhawan & LeBlanc, 2022).

To address this gap, the author developed a nine-part trauma-responsive, anti-racist telehealth training program for behavioral health providers in California. This article aims to provide a replicable model by describing the curriculum, highlighting key frameworks, and discussing lessons learned for building trauma-informed and equity-centered telehealth capacity.

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Curriculum Development and Structure

The author developed a nine-part telehealth training series titled *Trauma-Responsive Telehealth*, guided by theoretical frameworks, literature, and community input. The 27-h curriculum aimed to train behavioral health clinicians to (a) apply TIC principles to telehealth, (b) reflect on the impacts of racial trauma and COVID-19 on BIPOC communities, (c) adapt trauma-informed and culturally responsive assessment and treatment practices to multiple telehealth modalities, and (d) develop and implement a plan to integrate new telehealth tools and skills into their clinical practice.

As shown in Table 1, a variety of topics pertinent to trauma-informed, evidence-based, and culturally responsive telehealth were covered in the curriculum. Each 3-h session followed a similar structure, balancing theoretical and didactic content with experiential skills building. Sessions began with a presentation integrating relevant research, frameworks, and clinical applications using client vignettes from the author's clinical work. This was followed by one to two breakout room activities where participants practice telehealth skills and the use of digital tools in small groups and discuss real-world implementation. The large group then reconvened to debrief key takeaways and engage in individual implementation planning. While the content was informed by theories and the literature, discussion time was integrated to create a collaborative learning environment and allow participants to share their own approaches and challenges in adapting interventions to telehealth.

Conceptual Frameworks

Two key trauma-informed frameworks were incorporated to provide some theoretical foundation for the curriculum. The first was the Neurosequential Network's (2012) three R's model of regulate, relate, and reason (Perry, 2009, 2020). This brain-based approach highlights that before expecting a client to use higher-order thinking and processing, it is essential to promote physiological and emotional stabilization. In the context of telehealth, this means that before engaging in more intensive trauma processing work, the focus should be in creating an emotionally regulated virtual environment using soothing techniques that provide a sense of safety and security. This strategy informed some breakout room activities facilitated in the series, which required participants to practice concrete regulation activities. Since physiological dysregulation can be experienced in virtual platforms that may feel less containing than in-person settings, one breakout session,

Table 1 Trauma-responsive and anti-racist telehealth training topics

Number	Title of session	Key topics for each session
1	Integrating trauma-informed care (TIC) into telehealth: an overview	Overview of TIC principles, studies on the efficacy of telehealth, and best practices on integrating TIC principles into telehealth, including guidance on implementation planning
2	Anti-racist and culturally responsive telehealth practices for racial/ethnic trauma healing	Impacts of racial/ethnic-based trauma and COVID-19 on BIPOC communities and strategies to promote racial healing in virtual spaces
3	Trauma-informed and trauma-focused interventions using telehealth	Evidence-based trauma-focused treatments and their telehealth adaptations, emphasizing the importance of regulating and stabilizing techniques
4	Telehealth and evidence-based practices part 1: video and Internet-based interventions	Telehealth adaptations of evidence-based interventions (e.g., CBT, DBT, SFBT) delivered primarily through video conference and Internet-based platforms
5	Telehealth and evidence-based practices part 2: phone and app-based interventions	Telehealth adaptations of evidence-based interventions (e.g., CBT, MI, MBSR) delivered primarily through phone/audio and app-based platforms
6	Crisis intervention using telehealth	Crisis intervention, models of crisis response, and practicing virtual safety planning and access to lethal means counseling
7	Telehealth with children and very young children	Telehealth work with children and their caregivers/parents using developmental and play therapy frameworks
8	Using telehealth to address grief and loss	Grief support techniques tailored for virtual formats, with a focus on losses related to COVID-19
9	Using telehealth to address vicarious trauma and promote self-care and self-compassion	Recognizing and preventing burnout and vicarious trauma, as well as individual and organizational best practices for self-care and self-compassion techniques to sustain trauma and clinical work

BIPOC Black, Indigenous, and people of color, *CBT* cognitive behavioral therapy, *DBT* dialectical behavior therapy, *SFBT* solution-focused brief therapy, *MI* motivational interviewing, *MBSR* mindfulness-based stress reduction

for example, focused on virtual grounding strategies that providers could teach clients to utilize during virtual sessions with their providers.

The tri-phasic model of trauma recovery developed by Herman (2015) provided the second framework. The model delineates three primary stages: (a) safety and stabilization, (b) remembrance and mourning, and (c) reconnection and integration. This serves as further evidence that establishing safety is a key foundational phase in treating trauma. Processing traumatic memories without it can be dysregulating or even re-traumatizing. Relevant to telehealth, this implies that exposure and trauma processing–based therapies should come after a focus on safety and coping skills development. As such, the activities in the breakout rooms prioritized safety-promoting telehealth behaviors over more emotionally charged ones. For instance, participants practiced recognizing subtle indicators of dissociation, teaching mindfulness and relaxation techniques virtually, and creating virtual safety plans. Later sessions built upon this foundation by discussing how to adapt trauma narrative and memory reprocessing techniques to telehealth. This phased approach was designed to mirror the sequence most therapeutic for client healing.

In addition to trauma-specific frameworks, principles of anti-racism and cultural responsiveness were central to the curriculum development. This involved highlighting the disproportionate impacts of COVID-19 on BIPOC communities, on top of preexisting racial trauma and systemic inequities (Cheng & Conca-Cheng, 2020). The series also discussed how experiences of racism, both interpersonal and structural, can greatly undermine feelings of safety and exacerbate traumatic stress. Thus, providers must actively work to mitigate these harms and create a virtual environment of cultural safety. The series also integrated strength-based, culturally affirming virtual practices including digital storytelling, somatic interventions that tap into cultural healing traditions (e.g., yoga, tai chi), and involving caregiving systems and community in treatment (e.g., Lichtenstein et al., 2017; Ogbeiwi et al., 2024). Digital access as a health equity issue was also a recurring theme across many sessions in the series, with participants discussing ways to advocate within their organizations and communities to expand telehealth devices and Internet access.

Implementation Support

The training series incorporated a number of supports to help with implementation in the real world, given that training on its own does not automatically change practices. First, the author developed a companion website called Tools to Improve Practice (TIPs, https://sites.google.com/view/cyftips), a digital hub of carefully curated clinical resources, videos, practice guidelines, manuals, and worksheets. After receiving the link, participants were encouraged to integrate the website's user-friendly tools into their telehealth sessions with clients. The resources were organized according to clinical topic areas (e.g., crisis intervention, trauma healing, CBT-informed therapy) to make them easier to utilize during telehealth sessions. Second, a structured implementation planning exercise concluded each training session. Participants were assigned homework to use a structured implementation form and implement one or two telehealth techniques or tools from the workshop into their practice over the next few weeks before the next training session. This form allowed them to document their goals and progress and also to plan ahead for potential obstacles and the help they would need. Any subsequent training session started with a review of participants' implementation experiences (i.e., celebrating successes, discussing and resolving setbacks, and sharing takeaways). The goal of this accountability framework was to augment follow-through and normalize the training-to-practice iterative process.

Discussion

This model curriculum illustrates a viable approach to building mental health workforce capacity in trauma-responsive, anti-racist telehealth practices. Its key strengths include the integration of evidence-informed didactic content, experiential skill practice, structured implementation planning, and follow-up support. Grounding the material in established trauma recovery models and anti-racism principles created a conceptual coherence and highlighted the imperative of culturally affirming and equity-centered virtual care.

Participant feedback, while preliminary, was encouraging. Anonymous post-session surveys indicated high levels of satisfaction, self-reported knowledge and skill acquisition, and strong intentions to implement trauma-responsive and anti-racist telehealth practices. Participants particularly valued the resource-rich presentations, practical tools and concrete examples, and opportunities to learn from and problem-solve with colleagues. The TIPs website was frequently highlighted as a user-friendly, accessible support for applying skills. The emphasis on cultural responsiveness, mitigating the digital divide, and flexibly adapting practices to marginalized communities was also appreciated.

However, the curriculum had several limitations. Most notably, as a quality improvement initiative focused on initial curriculum development and implementation, the author did not include a formal evaluation component assessing participant or client outcomes. Post-session surveys provided preliminary positive feedback, but without validated measures of therapist competencies, treatment fidelity, or client symptom monitoring, the training's effectiveness in

changing provider behavior and improving client outcomes remains unknown. Tracking participation, completion, and implementation metrics would also help evaluate the program's reach and uptake. Another limitation was the lack of systematic monitoring of treatment time frames. While the curriculum emphasized the importance of individualizing the pace and duration of treatment to each client's unique needs and evolving sense of safety, actual treatment time frames were not tracked.

Additionally, while the curriculum broadly covered best practices for client safety in a virtual environment, the author did not go in-depth on the unique safety aspects of virtually delivering interventions for high-risk populations, such as dialectical behavior therapy (DBT) for clients at elevated suicide risk. This is an area for further training and protocol development.

The curriculum's emphasis on virtually adapting evidence-based, culturally responsive practices aligns with recent literature demonstrating the feasibility and effectiveness of telehealth-delivered treatments during the COVID-19 pandemic. For example, a meta-analysis by Komariah and colleagues (2022) found that Internet-based CBT significantly reduced depression and anxiety symptoms in diverse global populations during the pandemic. Similarly, another study reported decreased anxiety and depression and increased coping skills among youth who participated in videoconferencing-based CBT psychoeducation programs during COVID-19 lockdowns (Uysal et al., 2022). These studies draw attention to the potential of virtual interventions to improve access and outcomes, particularly for underserved communities, while highlighting the importance of flexibility, safety considerations, and cultural responsiveness in telehealth adaptations.

Building on these findings, some key next steps for this training model include the following: (a) using validated pre-/post-therapist competency and client outcome measures to rigorously evaluate impact; (b) examining client engagement, symptom trajectories, treatment time frames, and experiences of cultural safety; (c) assessing provider and client satisfaction, therapeutic alliance, and acceptability of telehealth services; (d) tracking participation, completion, and implementation metrics to evaluate reach; (e) developing population- and treatment-specific virtual adaptation protocols, specifically for high-risk populations; and (f) culturally adapting training content and delivery for diverse provider and client groups.

Conclusion

This training model provides a preliminary blueprint that may be easily adapted by local communities. Its fundamental components, which include the integration of culturally affirming and trauma-responsive practices, the blend of knowledge building with practical skill rehearsal and application support, and the use of engaging and multimodal pedagogy, can provide best practice guidelines for broader workforce development initiatives. A behavioral health workforce prepared to enhance care and belonging for all can be strengthened by adopting telehealth training as an equity-centered strategy.

Ultimately, the rapid virtualization of care presents an opportunity to transform behavioral health services to be more accessible, trauma-responsive, and anti-racist. Realizing this potential will require collaboration across stakeholders to intentionally design a telehealth ecosystem calibrated for equity and healing. Practice-based training initiatives have a vital role to play in preparing a behavioral health workforce ready to advance culturally responsive and trauma-informed virtual care.

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Data Availability This manuscript did not generate or analyze any publicly available datasets. The data collected were limited to anonymous post-training surveys for quality improvement purposes. Summary data may be available from the corresponding author upon reasonable request.

Declarations

Ethics Approval The paper did not require Institutional Review Board approval as it describes an educational curriculum and does not report human subject research data.

Consent to Participate Informed consent was not obtained. The manuscript describes an educational curriculum and does not report human subject research data.

Consent for Publication Informed consent was not obtained. The manuscript describes an educational curriculum and does not report human subject research data.

Competing Interests The author declares no competing interests.

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