

HEALING HANDS



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Delivering Trauma-Informed Services

Although the exact prevalence is unknown, most individuals seeking homeless services are trauma survivors.¹ Trauma-inducing experiences include²

- experiencing or witnessing interpersonal violence
- physical, sexual, and institutional abuse or neglect
- intergenerational trauma (e.g., children adversely impacted by witnessing domestic violence or parents adversely impacted by traumatic events experienced by their children)
- war, terrorism, and natural disasters that induce powerlessness, fear, recurrent hopelessness, and hypervigilance

Homelessness itself is a traumatic experience, and being homeless increases the risk of further victimization and retraumatization.¹

Trauma may also be caused by stigmatization due to gender, race, poverty, incarceration, or sexual orientation.³ These traumatic experiences can be dehumanizing, shocking or terrifying, singular or multiple events over time, and frequently include betrayal by a trusted person or institution.² As a result, trauma often leads to mental health and co-occurring disorders such as chronic health conditions, substance abuse, eating disorders, and HIV/AIDS, as well as contact with the criminal justice system.⁴

Furthermore, traumatic experiences may impact one's ability to exit homelessness and remain housed. For instance, many who have experienced physical and/or sexual abuse during childhood have difficulty maintaining supportive and sustaining relationships, and the traumatic stress makes it difficult for those experiencing homelessness to cope with the countless obstacles they face in the process of exiting homelessness.⁵ The impact of trauma is broad and diverse, deep and life shaping. It affects impoverished and vulnerable people differentially.⁶

UNDERSTANDING TRAUMA

Since trauma also influences how people approach and respond to services, it is critical that organizations serving trauma survivors recognize trauma symptoms, acknowledge the role that trauma has played in their clients' lives, and better understand and address the needs of those with trauma histories.³ [Table 1] The goal of this approach—known as trauma-informed care—is to avoid retraumatization and exacerbation of trauma symptoms. It requires a paradigm shift in thinking and understanding trauma, the trauma survivor, and services as well as the service relationship.⁶ This

change in understanding can be illustrated by the difference between the questions “What’s wrong with you?” vs. “What has happened to you?”²

While the terms violence, trauma, abuse, and posttraumatic stress disorder (PTSD) are frequently used interchangeably, it is useful to think of trauma as a response to violence or other overpowering negative experience such as abuse. Trauma refers to both the event and the particular response to an event; PTSD is one type of disorder resulting from trauma.³

Becoming “traumatized” varies greatly among individuals, and not everyone exposed to a potential traumatic event will be traumatized.⁸ *Trauma* begins with an event or experience that overwhelms normal coping mechanisms. There are physical and psychological reactions—which are normal—in response. Retraumatization refers to the psychological and/or physiological experience of being “triggered,” i.e., when an environmental cue related to the trauma—such as a smell or a sound—triggers a full fight-or-flight response. Although environmental triggers cannot be completely eliminated, it is important for homeless service agencies to create an environment in which the trauma survivor feels safe.³

Table 1. Effects of trauma

- Estrangement; a sense of isolation or disconnection from others or the environment
- Feelings of powerlessness or helplessness
- Changes in one's understanding or view of oneself or of the self in relation to others; a change in world view
- Devastating fear; loss of safety or trust that may relate to interpersonal interactions, treatment practices or specific environments
- Feelings of shame, blame, guilt & stigma

Source: Adapted from Blake, M. (2010).⁶

THE TRAUMA-INFORMED FRAMEWORK

There is an important distinction between trauma-specific and trauma-informed care. *Trauma-specific* services are designed to address the impact of trauma and facilitate recovery. The goal of



trauma-informed services is to create an environment that acknowledges the impact of trauma and tries to create a sense of safety.⁹ “Trauma-informed is about being aware of and understanding trauma and its effects,” says **Karen Batia, PhD**, chief clinical officer, Heartland Alliance for Human Needs and Human Rights, and associate executive director of Heartland Health Outreach (HHO), in Chicago. “In contrast, whether an agency decides to deliver trauma-specific services will depend on organizational capacity and available resources.

“Most Health Care for the Homeless (HCH) projects provide primary medical care with limited behavioral health services, and are more likely to deliver trauma-informed services,” Batia says. “Trauma-specific care involves a formal assessment and time intensive, specialized skills, and it’s especially difficult when you see the client sporadically.”

A HOT PRIORITY

“Trauma-informed care is a hot priority for SAMHSA (Substance Abuse and Mental Health Services Administration),” says **Mary Blake**, public health advisor and program manager with SAMHSA’s National Center for Trauma-Informed Care (NCTIC). One of SAMHSA’s eight strategic initiatives is focused on trauma, and there is a new detailed plan for achieving the initiative’s goals.¹⁰ “Our

intent is to reduce the negative and costly behavioral health impact of violence and trauma by creating trauma-informed systems to implement prevention and treatment interventions,” Blake says. “We also want to better address the needs of people with substance use and mental disorders in the criminal and juvenile justice systems through trauma-informed treatment and recovery.

“Several of SAMHSA’s ground-breaking initiatives led to the creation of NCTIC in response to pervasive trauma in the lives of those seeking behavioral health services,” Blake explains. “In particular, lessons learned from the five-year Women, Co-occurring Disorders and Violence Study (WCDVS) have been influential. WCDVS evaluated new service models for women with histories of

violence, trauma, and co-occurring mental health and substance use disorders. Findings from the study showed that even effective trauma-specific interventions could be undercut if not delivered in a trauma-informed manner. The study recommended ‘trauma-integrated services counseling’ and led to the development of guiding principles for positive change. One of these principles is that clinicians be cognizant of the ways in which their own policies and practices might retraumatize.”

NCTIC shares best practices and innovative strategies for organizational change, and provides training, technical assistance (TA), consultation, and resources to facilitate implementation of trauma-informed practices. Blake adds, “Our cutting edge work involves integration of peers—clients, trauma survivors, persons in recovery—into trauma-informed systems and program change. The peer voice is unique and complements professional services. Currently, we are developing a *Trauma-Informed Peer Engagement Guide for Peers Working with Women*, which should be available in draft form in the spring of 2011. It is the first of a number of products that SAMHSA will make available.”

For information about NCTIC’s resources, training & TA, visit www.samhsa.gov/nctic or call 866/254-4819

PEER SUPPORT & SPECIALISTS

Trauma-informed care requires new thinking about the role of peers and peer support in delivering and receiving services, workforce development, program design and evaluation, policies and planning. “The survivor’s voice is important for several reasons,” says Blake. “Peer support builds on shared experiences and mutual exchange. It eliminates the power differential that is inherent in traditional behavioral health settings and clinical relationships. It provides a platform for reciprocal receiving and giving of support, and this exchange fosters relationships that bring about new ways for trauma survivors to understand and model recovery and empowerment.”

Resources to assist agencies integrate consumers, survivors of violence and those recovering from substance abuse into the design and implementation of trauma-informed services include:¹¹

- *Tips for Incorporating Peer-to-Peer Support into Your Program*⁷ at www.nctsn.org/nctsn_assets/pdfs/Pathways_PeerToPeerTipsheet.pdf
- “Defining the role of consumer-survivors in trauma-informed systems,” by Laura Prescott in *New Directions for Mental Health Services*, issue 89, pages 83–89, Spring 2001
- *Consumer/Survivor/Recovering Women: A Guide for Partnerships in Collaboration* by Laura Prescott. Download the free PDF at www.prainc.com/wcdvs/pdfs/CSR Manual Final.pdf
- *The Essence of Being Real: Relational Peer Support for Men and Women Who Have Experienced Trauma* by Jennifer L. Wilkerson. Free download at www.sidran.org/pdf/sige.pdf

BUT WE’RE THE GOOD GUYS . . .

When a homeless health care agency takes the step to become “trauma-informed,” every part of the organization is assessed and potentially modified to reflect a basic understanding of how trauma affects individuals seeking services. Trauma-informed services require an understanding of trauma survivors’ vulnerabilities or triggers that traditional service delivery approaches may worsen, so that these services can avoid retraumatization.⁴ Instead of implementing new services, for example, organizational activities, settings, relationships, and atmosphere may need to change. This fundamental shift will involve all of the organization—front desk staff, security and night staff, policies, procedures, and interactions, formal and informal.⁶ Providing training and education at an introductory level to all staff is generally more helpful than providing intensive training for a cadre of special staff; of course, the agency may do both over time.⁹

A private, nonprofit mental health agency, Community Connections in Washington, D. C., serves inner-city consumers, some of whom are homeless and many with extensive histories of homelessness. It is renowned for its innovative and compassionate services, as well as for being a leader in mental health care research and education. Two of its areas of expertise are trauma-specific services and trauma-informed systems. Community Connections’ **Maxine Harris, PhD**, and **Roger Fallot, PhD**, are credited with conceptualizing the idea of trauma-informed services for survivors of violent victimization. Their seminal work, *Using Trauma Theory to Design Service Systems*,^{12,13} remains in use today.

Table 2. Core principles of a trauma-informed culture

- **Safety:** Ensuring physical & emotional safety; “do no harm”
- **Trustworthiness:** Maximizing trustworthiness, making tasks clear, maintaining appropriate boundaries
- **Choice:** Prioritizing consumer choice & control over recovery
- **Collaboration:** Maximizing collaboration & sharing of power with consumers
- **Empowerment:** Identifying what they are able to do for themselves; prioritizing building skills that promote recovery; helping consumer find inner strengths needed to heal

Source: Adapted from Beyer, L. L. (2010).⁶

“We don’t want to admit that we could be hurting our clients, so it’s hard to examine our practice objectively; we think of ourselves as the good guys,” says **Lori L. Beyer, LICSW, MSWAC**, trauma specialist and trainer at Community Connections. “When agencies conduct a self-assessment, they may learn, for example, that clients don’t feel safe in their building or waiting room. These feelings replicate the feelings experienced when they were in abusive situations.

“There are five core principles that shape the trauma-informed organization: safety, trustworthiness, choice, collaboration, and empowerment,” Beyer continues. **[Table 2]** “Feeling safe—emotionally and physically—facilitates the trauma survivor being honest with the clinician. The agency needs to be trustworthy, which means that we do what we say we are going to do. Can the client trust our word; are tasks and responsibilities clear?

“Boundaries are very important; clear boundaries engender trust. Remember that the trauma survivor’s family situation may have been like quicksand, with rules constantly changing. When the agency establishes clear rules and the staff enforces them, clients know what to expect and that helps them feel safe.

“It’s important to present options and allow them to choose: which clinician they can see, when and where they can be seen,” Beyer continues. “Collaborate and involve the client in decisions about their care so that you are not just doing things *to* them. Finally, the client must have the right skills to be able to have a voice and feel empowered. The agency may need to help trauma survivors build communications skills so that they feel competent speaking up for themselves.”

Clients are not required to disclose trauma in order to receive trauma-informed services.¹⁴ Trauma-informed services emphasize the survivor’s strengths, and highlight adaptations and resilience over pathology. The focus is on the client—not behavior, problems, or symptoms—and reducing symptoms, not treating an illness. In practice, it means striving to be culturally competent and understanding survivors within their familial, social, and community contexts and life experiences.^{8,9} Staff must not assume that safety and trust are there from the beginning; they must be earned and proven over time.⁹

ROADMAP TO BECOMING TRAUMA-INFORMED

The Homelessness Resource Center* conducted a literature review to find out what is known about trauma-informed services; several unifying ideas run through the literature and define trauma-informed services:¹⁵

- *Training on trauma for non-trauma providers* is a vital first step to make services more trauma-informed
- *Ongoing supervision, consultation, and support* are needed to reinforce trauma-based concepts and ensure staff self-care
- *Screening for trauma is important* within homeless service settings, and findings indicate that most people benefit from this assessment
- *Comprehensive and integrated services are essential* because homeless individuals frequently have multiple needs; counseling services that are integrated and address trauma, mental health, and substance use issues obtain better results than non-integrated services
- *Specialized children's programs are important* to build coping skills, strengthen interpersonal relationships, and help develop positive self-esteem since children of parents dealing with trauma, mental illness, substance abuse, and/or homelessness are at greater risk for adverse outcomes
- *Integrating consumers into the design and evaluation* of services has a profound impact
- Because trauma may have different meanings in different cultures, and because traumatic stress may be expressed differently within different cultural frameworks, *developing cultural and linguistic competence is key*

In the case of trauma survivors who are addicted to alcohol and other drugs, they may be considered treatment failures if they relapse. Under a trauma-informed paradigm, however, they are recognized as survivors who returned to substance use in an attempt to medicate the pain of trauma or manage overwhelming feelings. Integrating trauma services with addiction treatment can reduce the risk of trauma-based relapse by understanding the context of behaviors and coping strategies. Clinicians can help by teaching healthier alternatives such as meditation, reading, journal writing, walking or listening to music instead of using drugs to alleviate stress, anxiety and depression.^{3,8}

VICARIOUS TRAUMATIZATION

Working with trauma survivors can affect staff, resulting in vicarious traumatization or "compassion fatigue." Staff will need training on how to increase awareness of their own triggers and burnout levels, and how these issues can influence their work with clients. The trauma-informed organization must encourage self-care; strategies include addressing topics related to self-care in team meetings, encouraging staff members to develop their own self-care plans, devoting supervision time to discussing the impact of working with trauma survivors; and providing opportunities for staff

* A program of SAMHSA's Center for Mental Health Services at www.nrchmi.samhsa.gov

Table 3. Principles of motivational interviewing

- **Express empathy:** really listen & use open-ended questions, affirmations, reflections & summaries
- **Develop discrepancy:** avoid hard confrontation; be respectful, observe, reflect & inquire about the clients' values, hopes & dreams as well as how certain behaviors help become the person they want to be
- **Roll with resistance:** reflect or reframe that which is inconsistent with trauma recovery; ambivalence is a normal part of the change process; remember that change involves forward & backward movement
- **Support autonomy & self-efficacy:** the clinician is a guide, not the fixer; the client is the change agent

Source: Adapted from Dempsey, K. (2010).⁸

input in programming decisions. A culture of self-care includes encouraging staff members to take breaks, eat lunch, use vacation time, and develop strategies for creating a balance between their personal and professional lives.¹¹

MOTIVATIONAL INTERVIEWING: A TRAUMA-INFORMED TREATMENT APPROACH

Motivational interviewing tools—already used widely in homeless health care settings—are relevant and useful for addressing trauma. Motivational interviewing (MI) is a collaborative, client-centered form of guiding to elicit and enhance intrinsic motivation to change by exploring and resolving ambivalence. **[Table 3]** It is a tool that allows clinicians to be advocates *with* trauma survivors instead of advocates *for* survivors. Recovery is personal and must be defined by the survivor, not the clinician. MI helps staff avoid making assumptions about what the survivor needs, while allowing clients to build motivation and skills to make the best choices for themselves.⁸

The Motivational Interviewing website,¹⁶ maintained by the Mid-Atlantic Addiction Technology Transfer Center in cooperation with the Motivational Interviewing Network of Trainers (MINT), **William Miller, PhD**, and **Stephen Rollnick, PhD**, offers resources for clinicians, researchers, and trainers on:

- the practice of motivational interviewing
- its applications to special populations such as substance abusers
- a list of upcoming training sessions nationwide as well as a list of MINT trainers
- current DVDs, CDs, trainer slides, and videotapes (some in Spanish and French)
- a considerable library of treatment manuals, PowerPoint presentations, journal articles, research findings, links to books, and more

SPECIAL POPULATIONS

Veterans. Veterans are over-represented among homeless people. According to HUD's 2009 *Annual Homeless Assessment Report to Congress*, veterans represent about 13 percent of all homeless adults counted on a single night in January 2009.¹⁷ A background paper on veterans' homelessness prepared by the U. S. Interagency

Council on Homelessness reported the following data on veterans and trauma:¹⁸

- Combat trauma appears to be an important contributing factor to high rates of PTSD among veterans returning from Iraq; PTSD rates were almost twice the PTSD rates before deployment. PTSD may also contribute to substance abuse problems and relapse.
- While the causes of homelessness among veterans are similar to causes of homelessness among non-veterans (i.e., interrelated economic and personal factors and shortage of affordable housing), traumatic pre-military service experiences have a significant effect on risk of homelessness:
 - Exposure to physical or sexual abuse prior to age 18
 - Other traumatic experiences (e.g., serious accident, natural disaster, seeing someone killed)
 - Placement in foster care prior to age 16

SAMHSA looked into the needs of veterans with service-related trauma and mental health conditions, and published a report with useful background and practice information, *Responding to the Needs of Justice-Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions*.¹⁹ In addition, the SAMHSA-funded Jail Diversion and Trauma Recovery Program – Priority to Veterans emphasizes creating trauma-informed systems and providing trauma-specific services to address veterans' combat experiences.²⁰ "It's important to note that veterans are experiencing the effects of trauma across the trauma response spectrum, and may not neatly fit the narrower diagnostic criteria of PTSD," says Blake "and female veterans are experiencing homelessness on an unprecedented scale."

Women & gender differences. There is a difference between men and women regarding their risk for physical and sexual abuse. While boys and girls may be at relatively equal risk from family members and the people they know, as boys age, they are more likely to be harmed by strangers or enemies. As teens, boys are at risk if they are gang members, gay, or young men of color; their risk is primarily from people who dislike or hate them. For adult men, the risk for violence and abuse comes from being a victim of crime or being in combat.³

In contrast, the risk for girls and women is primarily in their relationships, from those she tells "I love you." Adult women are more likely to be harmed by their lovers or partners. One hypothesis is that this conflict may account for the increase in mental health problems in women because it is more stressful and confusing to be harmed by the person who is supposed to love and care for you than it is to be harmed by a stranger or someone who dislikes you. Different women will have different responses to a traumatic experience. Some have coping skills that are effective for a specific event or the trauma may not be recognized immediately; sometimes the violent event is perceived as normal.³

These data focusing on sexual violence reported by the National Institute of Justice (NIJ) illustrate some of these gender differences:²¹

- **Sexual violence may begin early in life:** Researchers found that among female rape victims surveyed, more than half (54

percent) were younger than age 18; 32.4 percent were ages 12–17; and 21.6 percent were younger than age 12 at time of victimization.

- **Early abuse and later victimization:** Although child sexual abuse before age 13 is not by itself a risk factor for adult sexual victimization or domestic violence, girls who were victimized before turning 12 and then again as adolescents (ages 13–17) were at much greater risk of both types of victimization as adults than any other women.
- **Victims know most perpetrators of sexual assault:** Although sexual violence may occur in any type of relationship, among victims ages 18 to 29, two-thirds had a prior relationship with the offender. Six in 10 rape or sexual assault victims report that an intimate partner, relative, friend or acquaintance assaulted them. One study found that 34 percent of women surveyed were victims of sexual coercion by a husband or intimate partner in their lifetime.
- **Women are more likely to be victims of sexual violence than are men:** The National Violence Against Women Survey sampled 8,000 women and 8,000 men and found that one in six women (17 percent) and one in 33 men (3 percent) reported experiencing an attempted or completed rape at some time in their lives.
- **Women are significantly more likely than men to be injured during an assault:** In one NIJ-funded study, 31.5 percent of female rape victims—compared with 16.1 percent of male rape victims—reported being injured during their most recent rape.

"Given the difference in traumatic experiences between men and women, it's important to make gender-specific interventions available—for both men and women," notes Blake. "SAMHSA's findings are that incorporating trauma-informed principles, gender-specific services, and gender-responsive approaches into primary and behavioral health services is key to improving the program's efficacy and supporting the healing and recovery process."

CHALLENGES TO IMPLEMENTING TRAUMA-INFORMED SERVICES

Staff frustration. Trauma survivors—especially those who have experienced multiple traumas—have developed a set of survival skills to help them cope. These survival strategies—such as substance abuse, aggression, withdrawal, self-harm—may make sense given what the person has experienced, but they often get in the way of current goals and can be confusing and frustrating to others. Without an understanding of trauma, staff may view clients negatively, perhaps describing them as "manipulative," "oppositional," or "lazy."²²

Organizational change. Change, especially within larger systems, can be time-consuming and requires commitment across all levels of an organization. Challenges include philosophical differences between mental health and substance use treatment approaches, differences around issues of trauma, resistance at the service and administrative levels, limited resources, difficulties in achieving consistent participation in trauma groups, staff turnover, and the difficulty of change in general.¹⁵ Sustaining organizational change requires

creativity and thoughtfulness about how to thoroughly integrate trauma-informed principles into the organization's culture and practice.¹¹

Organizational change is a continuous process, and one-time trainings are not enough to sustain trauma-awareness, education, and growth. One way to address this is by incorporating trauma language in employee handbooks and the organization's mission statement, and including questions about trauma concepts in the interview process for potential employees. These activities help convey the message—internally and externally—that understanding trauma and providing trauma-informed care is a priority.¹¹

“Heartland Alliance created a document describing the organization's philosophy of care and outlining our core guiding principles,” says Batia. “This philosophy was articulated by working through the organization—program by program—and capturing in writing what we do. It wasn't a new thing imposed on the agency, and it's not just ‘messaging.’ It defines who we are and what makes us unique as a service provider. Over time, we've seen how the statement helped build our culture and shape how we work.” One section addresses being a trauma-informed care organization and acknowledges that many clients—or *participants*, in Heartland Alliance's words—are trauma survivors, which is the reason that the organization based its services on a trauma-informed approach.

“Ideally, we would provide trauma-specific care to all our participants,” Batia adds, “but we can't given current resources. What we can do, however, is develop systems and models of care that avoid causing additional harm to those we serve. We continually educate our staff about traumatic stress and its impact, and a tiered triage system helps get participants the help they want and need. Limited trauma-specific services are available if indicated. HHO providers will take a trauma history, ensure that the participant is not in immediate danger, prescribe any needed medications, and make referrals to specialty care.”

PRACTICAL IDEAS & HANDS-ON GUIDANCE

■ One homeless-specific resource to assist HCH grantees and others on the road to becoming trauma-informed is the *Trauma-Informed Organizational Toolkit* developed by the National Center on Family Homelessness.¹¹ The kit features an



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organizational self-assessment tool and user's guide, plus a how-to manual for creating organizational change. The toolkit is available from the Homelessness Resource Center at no charge.

- Another resource, *Developing Trauma-Informed Organizations*, is available from the Institute for Health and Recovery.²³ Produced by the WELL Project State Leadership Council, this toolkit includes principles for trauma-informed treatment of women with co-occurring disorders, plus self-assessments and instructions for using the assessments to provide trauma-informed, integrated care.
- Based on lessons learned from SAMHSA's WCDVS, *A Long Journey Home: A Guide for Creating Trauma-Informed Services for Mothers and Children Experiencing Homelessness* provides a template for operationalizing the principles for creating trauma-informed environments for homeless families.²⁴

PUTTING EVIDENCE INTO PRACTICE: TRAUMA-SPECIFIC MODELS

Homeless service providers who may wish to go deeper and learn about trauma-specific models have several to investigate [Table 4]. In the 1990s, Community Connections developed the Trauma Recovery and Empowerment Model (TREM) group intervention. Based in both clinical experience and the research literature, TREM is one of the major trauma recovery interventions—particularly for those with exposure to physical or sexual violence. This model is gender-specific: TREM for women and M-TREM for men.²⁵ “The model is designed to be inclusive,” says Beyer, “so that homeless

individuals who are still using substances and experiencing psychiatric symptoms are welcome and encouraged to attend these groups.”

TREM and M-TREM are fully manualized group interventions that address a range of trauma sequelae among people with severe mental disorders and/or substance abuse problems. Designed for 8–10 members, both use cognitive restructuring, psycho-education, and coping skills training, weaving each of these techniques throughout the intervention, which incorporates a specific recovery topic in each weekly 75-minute session.²⁵

For more information about Community Connections' training & ongoing consultation in TREM & M-TREM, go to www.ccdcl.org or contact Rebecca Wolfson Berley, MSW, at 202/608-4735 or rwolfson@ccdcl.org

RECOVERY IS POSSIBLE

One of the core values of trauma-informed care is that recovery is possible for everyone, regardless of how vulnerable they may appear. Consumer involvement, peer-to-peer support, focus on strength and resiliency, and future-oriented goals all instill hope, and healing happens in relationships when they are safe, authentic, and positive. ■

Table 4. Trauma-specific interventions

- Addiction & Trauma Recovery Integration Model (ATRIUM) | www.dustymiller.org
- Beyond Trauma: A Healing Journey for Women | www.stephaniecovington.com
- Intergenerational Trauma Treatment Model | www.theittm.com
- Risking Connection® | www.riskingconnection.com
- The Sanctuary Model® | www.sanctuaryweb.com
- Seeking Safety | www.seekingsafety.org
- Trauma, Addictions, Mental Health & Recovery (TAMAR) | www.nasmhpd.org/TAMAR.cfm
- Trauma Affect Regulation: Guide for Education & Therapy (TARGET) | www.advancedtrauma.com
- The WELL (Women Embracing Life & Living) Project | www.healthrecovery.org
- Trauma Recovery & Empowerment Model (TREM) | TREM for Male Survivors (M-TREM) | www.communityconnectionsdc.org

NATIONAL SURVEY: EXPERIENCES OF VIOLENCE WHILE HOMELESS

This past summer, the National Consumer Advisory Board (NCAB) set out to document the types of violent attacks homeless individuals have experienced and to what extent they were able to get needed assistance. CAB members from six HCH projects took to the streets and surveyed their peers. Surveying is complete, and National Health Care for the Homeless Council research staff is entering data so that analysis can begin. NCAB hopes to have its results published in a journal, and the final report will be made available to the field on the Council website at www.nhchc.org in 2011. Findings from this national survey may help communities develop policies and procedures to prevent and intervene in violent situations with victims who are homeless.

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