Homelessness and Traumatic Stress Training Package

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Acknowledgments

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Funding was provided by the Center for Mental Health Services through the Homelessness Resource Center (contract # HHSS 280200600029C).

Disclaimer

All views expressed are those of the writers and do not represent the official position of any government agency or other organization.

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This publication may be accessed electronically through the following Internet World Wide Web connection: www.homeless.samhsa.gov

Recommended Citation:

Volk, K., Guarino, K., & Konnath, K. (2007). *Homelessness and Traumatic Stress Training Package.* DHHS Publication No. (XXXXX). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Originating Office

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Table of Contents

Introduction

The *Homelessness and Traumatic Stress Training Package* is a resource for service providers to train their staff on the relationship between homelessness and traumatic stress and how to apply trauma concepts to their day-to-day work with people experiencing homelessness. This package includes a Trainer's Guide, which provides an overview and instructions for using this package.

The package also includes the training materials. The training is divided into three parts:

1. Understanding Traumatic Stress in People Experiencing Homelessness;
2. Creating Trauma-Informed Services and Settings for People Experiencing Homelessness; and
3. Incorporating Trauma-Informed Concepts into Daily Practice in Settings for People Experiencing Homelessness.

Each part includes a complete trainer's script, PowerPoint slides, handouts, and evaluation materials. In the handouts materials for Part I, you will find a list of trauma related resources that may be helpful as you prepare for the training. We hope that this package will inform your practice and assist your program as you work with people experiencing the trauma of homelessness.

Trainer's Guide

Why Learn About Traumatic Stress?

Homelessness is a traumatic experience. The loss of home, community, stability, safety, friends, and routines is outside the realm of everyday experience and is highly stressful. Sleeping on the street, in an abandoned building or car, or in a shelter, leaves one feeling vulnerable, out of control, and hopeless. Many are often sleep deprived, hungry, and anxious about their ability to bathe and use the bathroom when needed and in privacy. Not surprisingly, people experiencing homelessness may feel frantic and overwhelmed. For most, the stress of being homeless is compounded by past traumatic experiences, such as catastrophic illness, violence, combat, abrupt separations, and physical or sexual abuse.

Traumatic stress impacts every aspect of a person's life, including their responses to danger, ability to form and sustain relationships, self-concept, decision-making, physical and mental health, and ability to maintain housing and employment. Using a "trauma-lens" provides a way to understand clients' behaviors, responses, attitudes, and emotions as a collection of survival skills developed in response to traumatic experiences. Given the extensive trauma in the lives of people experiencing homelessness, it is essential that providers, and the service systems in which they work, adopt this "trauma-lens" in order to make services and programs effective, facilitate recovery, and promote housing stability.

The *Homelessness and Traumatic Stress Training Package* offers a good first step in developing such an understanding. The goals of this training include learning about:

"Traumatic" stress refers to a level of stress that is so intense that it can be overwhelming for our bodies to mange. A traumatic experience usually includes the following components:

- Overwhelming experience.
- Involves a threat to our physical and/or mental well-being.
- Results in vulnerability or a loss of control.
- Leaves people feeling helpless and fearful.
- Interferes with relationships and beliefs.

- The relationship between homelessness and trauma.
- The nature of traumatic stress and the human stress response.
- Responses to traumatic stress
- The effects of trauma on people's lives and functioning.
- The meaning of trauma-informed services.
- Developing trauma-informed responses across multiple domains of an organization.

Training Content

We have designed this training package as an easy way for community-based organizations to provide their staff with basic training on traumatic stress and homelessness. The content is designed for those working with people who have experienced homelessness including those working with single adults, children and families, and unaccompanied youth.

This package contains the following components:

- Trainer's Guide
- 3 sets of PowerPoint slides
- 3 scripts to accompany PowerPoint slides
- Handouts and Sample Evaluation Forms

The training content is divided into three sections, outlined below.

Part I: Understanding Traumatic Stress in People Experiencing Homelessness

(Length: 3 hours)

- Overview of the US homeless population and their experiences of traumatic stress
- Definition and examples of traumatic stress
- Impact of traumatic stress across various areas of people's lives (e.g., cognitive, emotional)
- Relationship between homelessness and chronic trauma
- Pathways to healing

Part II: Creating Trauma-Informed Services and Settings for People Experiencing Homelessness

(Length: 3 hours)

- Understand what it means to be "trauma-informed."
- Understand the principles of trauma-informed care.
- Begin to develop strategies for creating trauma-informed services and programs.

Part III: Incorporating Trauma-Informed Concepts into Daily Practice in Settings for People Experiencing Homelessness

(Length: 3 hours)

- Continue to develop strategies for creating trauma-informed services and programs.
- Discuss practical "next steps" for participants to take to implement trauma-informed practices in their own work and in their organization.

This training is meant to be presented in sequence. The concepts build on one another, and Part I is necessary in order to in order to fully comprehend those discussed in Parts II and III.

Training Logistics

To assist you in hosting a successful training, we have highlighted several important logistical considerations below.

1. Trainer Qualifications

We strongly recommend that the person(s) presenting this training have the following qualifications:

- Knowledge of homelessness and/or experience working with people experiencing homelessness.
- Basic knowledge of traumatic stress and mental health issues common among people experiencing homelessness.
- Basic understanding of trauma-informed care.
- Experience conducting trainings or workshops that include both didactic and interactive group facilitation.
- Basic knowledge of PowerPoint.

Trainers without the qualifications outlined above are discouraged from serving as the primary trainer of the material presented in this training package.

2. Training Audience

This training is appropriate for anyone who works with, advocates for, or is interested in people experiencing homelessness. It is also useful for people working with those who are formerly homeless or marginally housed.

3. Training Space

When choosing a training space, consider the following:

- Is the room an appropriate size for the number of participants attending? For example, squeezing 25 people into a small conference room makes for an uncomfortable and distracting environment. By contrast, 25 people in a large auditorium can feel impersonal and overwhelming.
- Does it have adequate seating for the number of participants anticipated? Is the seating comfortable? Ideally, participants will be seated at tables or desks.
- Do participants have an unobstructed view of the PowerPoint slides and presenter?
- Is the room a comfortable temperature (not too hot, not too cold)? Are there windows to open?
- Are restrooms easily accessible?
- Are there electrical outlets to plug in the laptop and projector?
- Will participants and trainers be able to hear one another? Consider using microphones if the space is large.

4. Training Materials

In addition to this packet, other materials required or strongly recommended to conduct this training include:

- Laptop and projector (for PowerPoint slides)
- Screen or blank wall
- Flipchart, dry-erase board, or chalkboard
- Markers and/or chalk
- Handouts for participants, including copies of PowerPoint slides and other handouts specified in the training script.

- Evaluation forms
- Extra pens/pencils and paper, for participants to take notes.
- List of local mental health organizations and other participant supports (see page ## of this document for more detail).

5. Using the Script

In this package, we have included three scripts – one for each part of the training series. For each slide, the script includes:

- Suggested talking points (in a shaded box)
- A thumbnail of the slide itself
- Recommended questions to encourage audience participation
- Directions on the flow of the training, including when to pass out handouts, how to engage the audience at various points, and more.
- Directions for using the slides' animation (described in more detail below)

Use the script as your guide, and feel free to modify it to be in your own voice. Additionally, we encourage you to have as much interaction with the training participants as time will allow, as this makes for a more interesting and fruitful training experience. **It is important that you review the slides and are very familiar with the script prior to the training.** As you prepare for the training, you should try to identify examples you might give from your own experience, make note of points you want to emphasize, and ensure that you are comfortable explaining the concepts "in your own words."

6. Using the PowerPoint Slides

The PowerPoint slides are meant to compliment the training. They provide printed information that can be especially helpful for visual learners, reinforce key concepts throughout the training, and aid you in your presentation.

Many of the slides are animated, as noted in the script. For some slides, this means that the bullet points appear one by one each time you click the space bar or arrow key. For slides with graphics, it means that clicking the space bar or arrow key will show the next part of the graphic, ideally in synch with your explanation. We have noted in the script when to cue the animation. We strongly recommend that you familiarize yourself with the slide animation before conducting each part of the training. We have included animation to visually demonstrate concepts for participants, and so that you can have a discussion with participants and add points to the screen as the discussion progresses. If you are familiar with the animation, it will enhance your presentation. If you are not, it will be confusing to you and participants.

Participant Support

As the training makes clear, we all experience traumatic events over the course of our lives. During the training, participants may be reminded of their own past difficult experiences. To be attentive to this, we strongly encourage you to offer all participants some support. We recommend that you make an announcement at the beginning of the training to this effect, and have a list of local resources available to all participants (e.g., in their packets) that includes the names of local mental health organizations and peer support groups.

Modifications to the training format

This training package is meant to be implemented over the course of three sessions that are approximately three hours each. However, you may want to modify the content based on your training needs, time constraints, and training goals.

If this training package is presented in its entirety, it will require a one to two day training commitment. We recommend that you consider other alternatives to the full day(s) format because there is a great deal of information provided in this training that can be broken down into multi-day formats. Other formats include:

- Mini trainings (half day trainings) – Present one session a week for three weeks, or one session a month for three months, etc.
- Staff training meetings (1 to 2 hours in length) – These can occur once or twice a month over a six to nine month period.

No matter how you decide to present the content of the training package to your audience, it is essential that all of the sessions are presented and that they are presented in sequence. The material is cumulative. For example, understanding the material from session three is contingent on understanding what was presented in the previous two sessions.

Tips for Facilitating Different Types of Groups

In Parts II and III of the training, there are various opportunities for small and large group discussions. Although we cannot anticipate every combination of group dynamics that may arise, we anticipate that those using this guide may run trainings with group members from:

- One program within a large organization OR one organization that runs one program (e.g., a small shelter).
- Group members from one organization with many programs (e.g., a large multi-service agency that offers shelter, substance abuse counseling, mental health treatment, family programs, etc.).
- Group members from many different organizations and programs throughout the community.

As you prepare for the training, think about the training content and your goals as a trainer. Do you want to encourage individuals to reflect on their own practice? Would you like participants from each department in the organization to work together, or would you like cross-department discussions, or a combination? Perhaps you would like all the case managers from each department to work together or all the administrators from across the organization to get to know one another. Also think about what discussion style will best encourage participation given the size and personality of your group. No matter what you decide, remember that using a variety of methods is often the best way to keep participants engaged.

Here are some common group discussion methods to consider:

- **Large group discussion** – a question or topic is discussed among group members – amount of structure provided by facilitator will vary.
- **Brainstorming** – participants are encouraged to bring up a wide-range of ideas or suggestions without being self-censoring – no discussion is permitted until all ideas have been expressed.
- **Go-rounds** – everyone in the group is given an opportunity to comment briefly on the topic of discussion – can go around the room sequentially or use a random "popcorn" approach – individuals can "pass" if they do not wish to comment.
- **Small group discussion /pairs** – the facilitator invites small groups to self-select or assigns participants to particular groups – a representative often summarizes the discussion and reports back to the large group.
- **Fishbowl** – several participants representing differing views meet in an inner circle to discuss a topic while the outer circle listens – outer circle members can periodically exchange places with those in the fishbowl.
- **Human continuum** – members physically place themselves in the room on a continuum representing a spectrum of viewpoints – time should be permitted for members to discuss relative to each other their place on the continuum.
- **Caucusing** – a caucus is composed of members with similar viewpoints who are convened to help bring greater clarity to a confusing or multi-faceted issue to better inform the larger group in its decision-making.

Adapted from Kraybill, K. (2003). *Creating and Maintaining a Healthy Work Environment: A Resource Guide for Staff Retreats.*National Health Care for the Homeless Council. Nashville, TN.

Evaluating the Trainings

We strongly encourage you to evaluate your trainings. It can help you improve them over time, provide insight into staff development opportunities and challenges, and help inform your organization's efforts to become more trauma-informed. It can also provide valuable concrete information to share with potential funders.

For each of the trainings in this package, we have included sample evaluation forms. Distribute one at the end of each training session. They should take about five minutes to complete. You can use these documents as they currently exist, or you can modify them into your own evaluation document.

We have also included a sample pre- and post-test. By using both the pre and post-tests, you will learn what new information participants have gained and/or new perspectives they have developed over the course of the training. Distribute the pre-test before Part I of the training begins and ask participants to complete it. This should take five to 10 minutes. At the end of Part III of the training, distribute the post-training form and ask participants to complete it *before they leave*. By doing so, you have a good chance to collect evaluation data from most training participants. The sample post-training form we have included in this package should not take more than 10 minutes to complete.

Training Follow-Up

Making services, programs, and systems of care responsive to the needs of people who are homeless and have experienced traumatic stress is an on-going process. This training serves as a starting point from which staff can examine their personal and organizational practices in an on-going, interactive process. We encourage you to revisit the concepts discussed throughout the training in follow-up meetings with staff, after they have had an opportunity to apply trauma concepts to their daily work. We have also provided a resource list in this training package so that you and your colleagues can further educate yourself about the nature of traumatic stress and its implications for program design and service delivery.

Training Materials

Specific Instructions for Part I:

Understanding Traumatic Stress in People Experiencing Homelessness

In Part I, training material includes:

- Overview of the US homeless population and their experiences of traumatic stress
- Definition and examples of traumatic stress
- Impact of traumatic stress across various areas of people's lives (e.g., cognitive, social, etc.)
- Relationship between homelessness and chronic trauma
- Pathways to healing

The training lasts approximately three hours, depending on the length of group discussion, group size, break time, etc. Below is a sample agenda for Part I.

Sample Agenda – Part I:
Understanding Traumatic Stress in People Experiencing Homelessness

(8:30-12:30)

8:30 Welcome and Introductions (Slides 1-5)

9:00 Understanding Traumatic Stress in People Experiencing Homelessness (Part I) (Slides 6 -23)

- What is Trauma?
- Homelessness and Trauma
- The Human Stress Response

10:15 Break

10:30 Understanding Traumatic Stress in People Experiencing Homelessness (Part II) (Slides 24-51)

- What Determines How People React to Trauma
- The Human Stress Response and Complex Trauma
- Pathways to Healing

12:15 Evaluation and wrap up

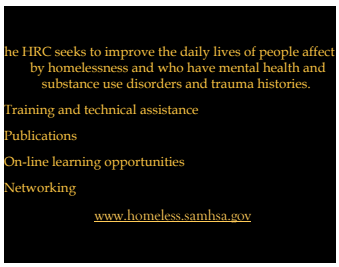
***Note**: If your budget permits, you may want to offer beverages (e.g., coffee, tea, water) and light refreshments (e.g., fruit, crackers and cheese) during the break.*

Slide 1

Introduction

- Welcome participants to the training.
- Introduce yourself (and other presenters if applicable).
- Have training participants introduce themselves if time permits.

Slide 2



This training curriculum was created by SAMHSA's Homelessness Resource Center, which provides:

- Training and technical assistance.
- Publications.
- Online Learning Opportunities.
- Networking.

Handout

SELECTED RESOURCES ON HOMELESSNESS AND TRAUMA

General Trauma Information

Printed Material

Bassuk, E.L., Dawson, R., Perloff, J., & Weinreb, L. (2001). Post-traumatic Stress Disorder in Extremely Poor Women: Implications for Health Care Clinicians. *Journal of the American Medical Women's Association*, 56, 79-85.

Herman, J. (1992). *Trauma and Recovery*. Basic Books.

American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members (2007) *The Psychological Needs of U.S. Military Members and Their Families: A Preliminary Report*. Available at www.apa.org/releases/MilitaryDeploymentTaskForceReport.pdf

Van der Kolk B.A., McFarlane, A.C., & Weisaeth L. (Eds.). (1996). *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*. New York: Guilford Press, 214-241.

Websites

Community Connections – www.communityconnectionsnh.org
National Center for Post Traumatic Stress Disorder (PTSD) - www.ncptsd.org
National Child Traumatic Stress Network – www.nctsnet.org

Homelessness and Trauma

Printed Material

Bassuk, E.L., & Friedman, S.M. (2005). Facts on Trauma and Homeless Children. From the National Child Traumatic Stress Network, Homelessness and Extreme Poverty Working Group. *Available at* www.nctsnet.org.

Bassuk, E.L., Melnick, S. & Browne, S. (1998). Responding to the Needs of Low-Income and Homeless Women Who Are Survivors of Trauma. *Journal of the American Medical Women's Association*. 53(2): 57-64.

Bassuk, E.L., Weinreb, L., Buckner, J., Browne, A., Solomon, A., & Bassuk, S.S. (1996). The Characteristics and Needs of Sheltered Homeless and Low-Income Housed Mothers. *Journal of the American Medical Association*. 276(8): 640-646.

Buckner, J., Bassuk E.L., Weinreb L., & Brooks M. (1999). *Homelessness and Its Relation to the Mental Health and Behavior of Low-Income School-Age Children: Developmental Psychology*. 35(1): 246-257.

Fairweather, A. (2006). *Risk and Protective Factors for Homelessness among OIF/OEF Veterans*. San Francisco: Swords to Plowshares.

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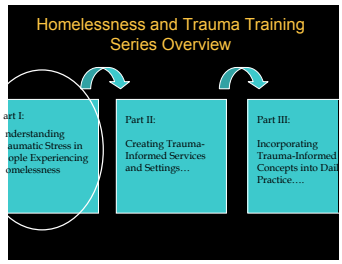
Slide 3

This is the first of a three-part series on traumatic stress and homelessness.

Slide 4

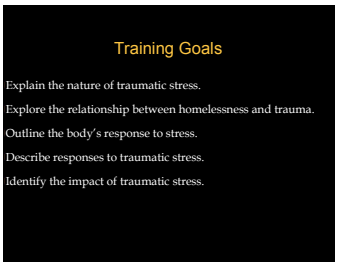


Slide is animated

This slide serves as a road map for the training ("You are here"). Give participants an overview of the three sessions.

> We will begin by exploring the relationship between homelessness and trauma and how they impact people's lives.
>
> In the second session, we will talk about how we – as providers and organizations - can better respond to the needs of our clients in light of the traumas they have experienced.
>
> We will continue this discussion in the third session, making concrete many of the concepts we have discussed in parts I and II of the training series.

Slide 5



The goals of today's training are:

- Explain the nature of traumatic stress.
- Explore the relationship between homelessness and trauma.
- Outline the body's response to stress.
- Describe responses to traumatic stress.
- Identify the impact of traumatic stress.

Review the agenda for today's training:

- We will begin by defining traumatic stress and discussing the prevalence of traumatic experiences that people who are homeless often face.
- We will then talk about the impact of stress on the body, the range of responses to trauma, the different factors that determine how someone may respond to trauma, and the ways that experiences of trauma can impact interactions and relationships with providers.

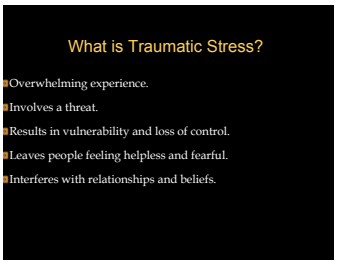
Acknowledge that participants may find material overwhelming and that support is available.

- As the training makes clear, we all experience traumatic events over the course of our lives, and the subject matter of this training may be difficult in light of those experiences.
- We encourage you to take a break at any point during the session if you begin to feel overwhelmed.
- I will be available during the breaks if anyone needs to talk.
- There is a list of local resources in your packet that can also offer you support.

Announce any logistical details (e.g., location of bathrooms, break times, handouts, etc.).

We suggest that you remind people to turn off their cell phones.

Slide 6



Slide is animated

Introduce traumatic stress.

- We all experience some stress on a daily basis. It might include conflict at work or home, problems with a child, or being sick. This stress is more or less intense depending on the situation.
- *Traumatic* stress goes beyond these types of day to day stressors.

Ask the audience:

What is traumatic stress? What comes to mind when you hear the word trauma?

Write responses on a flip chart. Participants may answer these questions by giving specific examples. (If this happens, encourage them to be more general by asking "What is it about X that makes it traumatic?")

Wrap up the discussion with a summary of audience responses based on the list of ideas that they create and have been recorded on the flip chart.

Summarize the discussion. Cue the animation to bring the slide's bullet points onto the screen.

- As we have just discussed, trauma involves some sort of **overwhelming experience** that goes beyond usual day to day stressors.
- It typically **involves some sort of threat** either to ourselves or to a loved one. This threat can be physical or emotional.
- The experience overwhelms our usual systems of coping and results in a **sense of vulnerability and a loss of control**.
- This **leaves people** feeling helpless and fearful, and over time, may **adversely affect people's relationships and ways of thinking about the world.**

Slide 7

Discuss sources of traumatic stress:

- Various life events can be experienced as traumatic.
- Most of us have experienced some type of traumatic stress in our lives, perhaps the sudden loss of someone we love or the experience of violence in our neighborhoods.
- Remember that trauma is "in the eyes of the beholder;" what one person may consider traumatic may not be traumatic to another person. Whether an event is identified as "traumatic" has to do with how it is perceived by the individual involved.

Acknowledge that the list on the slide is not comprehensive.

A traumatic experience can result from a single incident or from multiple exposures.

- Single incident traumas (or acute traumas) occur as a one-time event such as an earthquake, bombing, assault, or car accident.
- Multiple traumas refer to the layers of on-going trauma that people sometimes experience over their lifetime. Multiple traumatic experiences can occur as a result of a single event such as a natural disaster that leads to loss of loved ones, loss of home, or separation from family, or from a lifetime of traumatic experiences that may include childhood abuse and adult experiences of domestic violence.

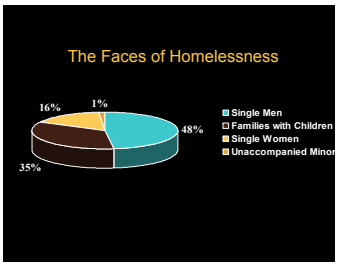
Until recently, traumatic experiences were considered to be limited to those people who were exposed to combat, disasters, and rape.

- In the last fifteen years, there has been a greater appreciation of the high prevalence of trauma in the general population and in the lives of individuals treated in the mental health system.
- In a study by Kessler, 56% of a general adult sample reported having at least one experience of trauma.[1]

Slide 8

Transition slide as you move to describe homeless subpopulations and their experiences of trauma.

Slide 9



Before we describe the high rates of traumatic stress that our clients experience, let's talk briefly about the faces of homelessness.

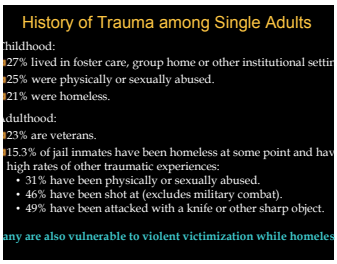
- This pie graph describes national data from the first Annual Homelessness Assessment Report to Congress, published in Fall 2007. It is based on HMIS data of "sheltered homeless persons" – those in emergency shelter or transitional housing. As you can see, single men and families with children are the two largest groups, followed by single women and unaccompanied minors.

The next set of slides describes three major subpopulations of people experiencing homelessness and the traumas they have experienced:

- Single adults
- Parents with children in tow
- Youth

These subgroups correspond to how people are sheltered. In reality, the groups overlap. For example, more than 60% of single adult women have children who are not with them.

Slide 10



Slide is animated

Single adults experiencing homelessness have significant histories of trauma.

Cue animation to show childhood statistics.

For many, these stresses began in childhood:

- Over a quarter of single adults lived outside of their homes as children.
- A quarter report childhood physical or sexual abuse.
- More than one-fifth report experiencing homelessness as children.

Cue the slide animation to show the adulthood statistics on the screen.

Almost a quarter of homeless clients are veterans; 1% of homeless women are veterans compared to 33% of homeless men.

A recent study by Greenberg and Rosenheck examined rates of homelessness and mental illness among adult jail inmates. Of the 6,953 jail inmates they surveyed:

- 15.3% had been homeless at some point
- 12.4% had been homeless in the previous year

They also learned that homeless inmates were significantly more likely to have experienced all categories of trauma, particularly sexual or physical abuse. Of those who had been homeless in the year before incarceration:

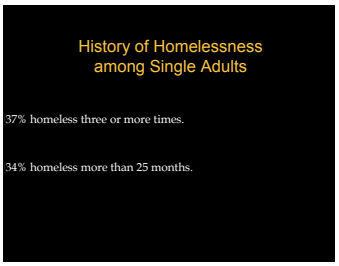
- 31% have been physically or sexually abused.
- 46% have been shot at (excludes military combat).
- 49% have been attacked with a knife or other sharp object.

Cue animation to show final line on slide.

People are also vulnerable to violent victimization while homeless:[2]

- 22% report being physically assaulted or beaten up while homelesss.
- The total number of attacks on people who are homeless rose 13% from 2006 to 2007, and the number of attacks resulting in death rose by 40% over the same time period.

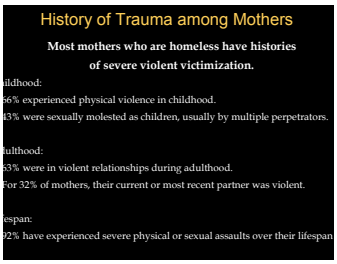
Slide 11



Single adults experiencing homelessness also have a history of multiple episodes of homelessness:

- Almost 40% of homeless single adults have been homeless 3 or more times and 1/3 have been homeless for 2 years or more.
- Those who have been homeless multiple times, for long periods at a time and have a disability, such as severe mental illness, are often referred to as the "chronic" homeless population.

Slide 12



Slide is animated

84.5% of homeless families are female-headed, and many have significant histories of violent victimization:

Cue animation.

66% experienced physical violence in childhood.

43% were sexually molested as children, usually by multiple perpetrators.

Cue animation.

63% were in violent relationships during adulthood.

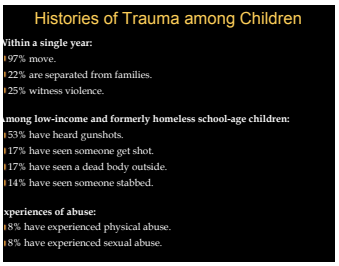
For 32% of mothers, their current or most recent partner was violent.

Cue animation.

92% have experienced severe physical or sexual assaults over their lifespan.

These numbers are staggering, especially when you consider that the average age of the women in this study is 27 years.

Slide 13



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Sadly, approximately 1.3 million children experience homelessness each year.

Cue animation.

Within a single year, these children experience multiple moves, separation from their families, and witness violence between adults in their lives.

- 97% move.
- 22% are separated from families.
- 25% witness violence.

Cue animation.

Among low-income and formerly homeless school-age children (8 to 17 years old):

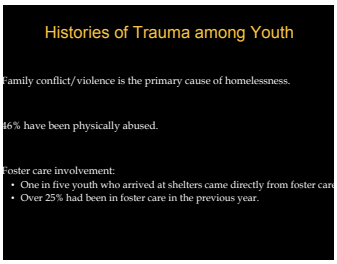
- 53% have heard gunshots.
- 17% have seen someone get shot.
- 17% have seen a dead body outside.
- 14% have seen someone stabbed.

Cue animation.

Experiences of abuse:

- 8% have experienced physical abuse (twice rate of other children).
- 8% have experienced sexual abuse (three times rate of other children).

Slide 14



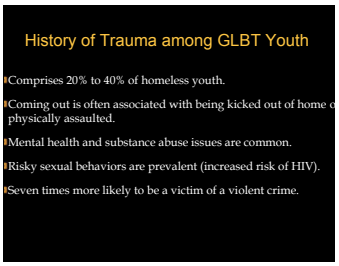
In addition to single adults and families, another subgroup of the homeless population includes unaccompanied youth.

- Many have run away from homes where there is considerable conflict and violence.
- At least half a million unaccompanied minors are on the streets each year. Services for these children are limited.

Many have histories of foster care involvement, and although it is difficult to find updated data, one study conducted by the National Association of Social Workers found that:

- One in five youth who arrived at shelters came directly from foster care.
- Over 25% had been in foster care in the previous year.

Slide 15

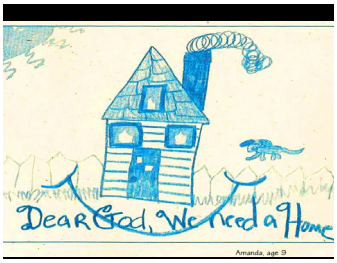


Since they comprise such a high proportion of homeless youth and their trauma histories are severe, let's talk about the experiences of Gay, Lesbian, Bisexual, or Transgendered (GLBT) homeless youth in particular:

- For this population, openness about sexuality often leads to severe consequences, whether in the form of physical violence and aggression or being thrown out of one's home. GLBT youth struggle with mental health and substance abuse issues, as well as unsafe activities such as risky sexual behaviors that lead to health crises such as increased risk of HIV.
- This population is very vulnerable to continued victimization on the streets. They are seven times more likely to be the victim of a violent crime.

Note: Participants may ask what the age range is for these statistics. The Task Force report cited does not give a specific age range for these statistics cited. It does, however, include detailed analysis and a review of the literature on GLBT youth and homelessness, and many of the sub-studies to which they refer include specific age ranges. Refer participants to this report if they would like more information, which can be found at http://www.thetaskforce.org/downloads/HomelessYouth.pdf.

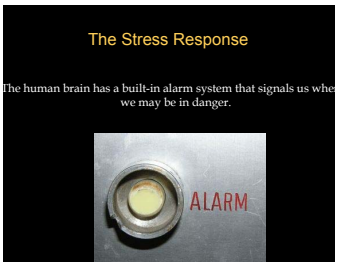
Slide 16



In addition to all of the experiences we have just detailed, it is essential to recognize that homelessness itself is traumatic.

A home is more than bricks and mortar. It represents a safe haven – a place of privacy, familiarity, and comfort. Home provides connection to family, friends, neighborhood, and community. People who are homeless have lost the fundamental sense of safety and stability associated with having a place to call their own.

Slide 17



Now that we've discussed what traumatic stress is and how prevalent it is in those experiencing homelessness, let's talk about trauma and the body.

To begin, it is helpful to understand the "normal" stress response that we all experience when we encounter a stressful experience.

The first place that stress is felt is in our bodies. We all have a built-in alarm system that is designed to detect danger and respond to keep us safe.

Ask the audience to take a moment to imagine the following scenario:

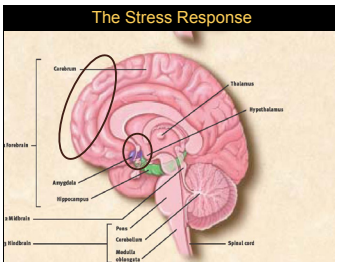
Imagine you are driving to the store and you get distracted by your cell phone ringing on the seat next to you. When you look up, the car in front of you has come to an abrupt stop. What do you do? How do you feel? What happens in your body?

Participants will likely describe responses that range from feeling frozen and numb to feeling hyper aroused, frightened, and agitated. You may want to write down their responses on a flip chart.

At the end of the discussion, emphasize the following:

- All of the things that you are describing are exactly what is supposed to happen when faced with a threat or danger.
- Our brains are designed to respond quickly and effectively to a threatening situation.
- There are two important parts of our brain that are involved when responding to danger: the **doing brain** and the **thinking brain**.

Slide 18



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Describe how the brain responds to stress:

For the purpose of understanding how the brain responds to stress, we will divide its functions into the doing and thinking parts of the brain.

- The doing part of our brain, referred to as the amygdala, is housed in the limbic system where response to threat, danger, and intense emotion occurs.

Cue animation to indicate where the amygdala is located in the picture.

- The doing brain acts like the "smoke alarm" that is designed to go off when we might be in danger.
- The thinking part of our brain, referred to as the pre-frontal cortex or cerebrum, is used for planning, problem-solving, and organizing.

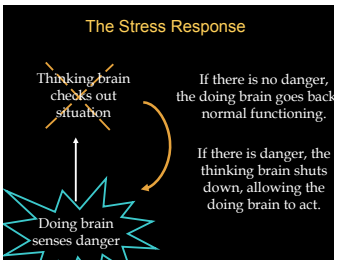
Cue animation to indicate where the cerebrum is located in the picture.

The thinking brain is designed to check things out when the doing brain sounds the alarm, to see if there is actual danger.

If the doing brain signals possible danger (e.g., you hear a loud noise) and the thinking brain checks it out and sends a message back that there is no actual danger (e.g. the wind just blew a door closed), the alarm system is shut off and we can go back to what we were doing.

However, going back to the car example, once the doing brain sounds the alarm and the thinking brain confirms that we are in danger and about to get in an accident, the thinking brain shuts down to allow the doing brain to take over and keep us safe. When this happens, the doing part of our brain signals the body to release chemicals, like fuel for a car, to provide us with the energy to respond (e.g. put our foot on the break, swerve, do what we need to do to stay safe).

Slide 19



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We can think of this system as being similar to the smoke alarm systems in homes or offices.

- The smoke detector (similar to the doing brain) goes off to signal that there may be danger (in the case of a smoke detector, a potential fire).

Cue animation to show "doing brain senses danger."

When the alarm goes off, do you immediately run out of your house? Usually we begin by asking "Is this real, or is this just a false alarm?" Similar to what the thinking brain does, we check things out to see if there is an actual fire or if the alarm is faulty (e.g. if the alarm is going off in response to someone burning food or steam from a shower).

Cue animation to show "thinking brain checks out situation."

If there is no danger, then we turn the alarm off and return to what we were doing before. The thinking brain signals back to the doing brain that "everything is fine."

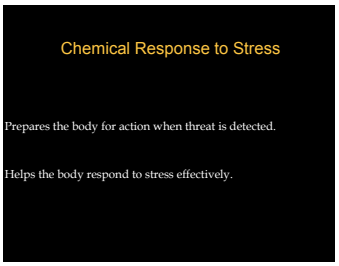
Cue animation to show "if there is no danger…" and curved arrow.

If there is danger (e.g. a "real" fire), we don't need to continue to stand there checking things out, we need to act!

Cue animation to show "If there is danger…"

- At this point, we stop thinking and start responding in ways that will keep us safe (e.g. getting out of the building or house, throwing water on the fire, etc.).
- The thinking brain shuts down and the doing brain acts.

Slide 20



When the doing brain detects threat, chemicals are released in the brain to prepare the body for action. These chemicals, referred to as neurotransmitters and neurohormones, are designed to work together:

- One set of chemicals called the catecholamines ("ka-ta-'kO-la-"mEns") helps to increase arousal in your body. These chemicals bring the energy in the body up, like when you get a rush of adrenalin.
- Other chemicals called the glucocorticoids ("glü-kO-'kor-ti-"koids") help manage the arousal in your body. These chemicals bring you back down, calming the body.
- A final chemical called serotonin ("ser-a-'tO-nan,") regulates the other chemicals in the bloodstream. The serotonin helps to make sure that you have just the right amount to give you energy but also to bring you back to a state of calm.

In other words, we have one set of chemicals that revs us up, another that calms us down, and a third set that helps regulate the other two.

Slide 21

The chemicals released in times of stress lead to varied responses that fall into three primary categories: **fight**, **flight** and **freeze**. You have already described some of these responses when we discussed how you might respond to an impending car accident.

FIGHT RESPONSE:

- The fight response is often referred to as hyperarousal. Your engine is revved up and you are doing something in response to the danger.

Ask the audience:

What might be a "fight" response in the car example we just talked about?

Audience will give varying answers, which may include: slamming foot on the break, yelling/swearing, etc.

FLIGHT RESPONSE:

- Includes withdrawing, getting away from or avoiding the threat.

Ask the audience:

What might be a "flight" response in the car example we just talked about?

Audience will give varying answers, which may include swerving, pulling over to the side of the road, etc.

FREEZE RESPONSE:

- The freeze response often looks like constriction or shutting down.
- This response is often the one that the brain chooses when the fight and flight responses are not an option or have not worked in times of danger.
- This may look like "playing dead", becoming unresponsive or appearing "spaced out" or just not with you in the moment. It's a feeling of numbness or disconnection.

Continued on next page...

Slide 21, continued

Ask the audience:

> What might be a "freeze" response in the car example we just talked about?

Audience will give varying answers, which may include feeling numb, unable to move, seeming lack of reaction/feeling "flat," etc.

You may want to give additional examples of fight-flight-freeze responses. Here are some ideas:

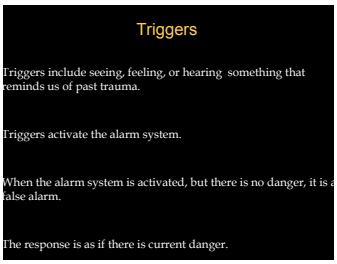
> **Fight:** Swatting at a bug, screaming when you are startled.
> **Flight:** Getting out of the way of a moving car, running away from wasp.
> **Freeze:** If a large dog is coming after you, you may freeze instead of running away.

(Note: Try to keep the discussion focused on the typical stress response. Later in the training, participants will have an opportunity to discuss the responses they see in their clients in depth.)

Summarize the discussion:

- People often experience intense emotional responses to threatening events.
- Most of us have been faced with threatening or stressful events and have experienced the feelings and shown the behaviors that we have just discussed.
- While these responses to danger may be intense in the moment, once the danger has passed, most people are able to return to their usual level of functioning and move on.

Slide 22



Our body is designed to keep us out of danger. It remembers past signs of danger so that it can respond efficiently the next time something dangerous happens. If we're in constant danger, this efficient system is protective. However, sometimes something will remind us of a past danger even when we're not in actual danger:

- Reminders of past dangerous experiences are called **triggers**.
- Triggers activate the alarm system.
- When someone is triggered they may feel and act as though they are back in the time of danger, even though they are not.

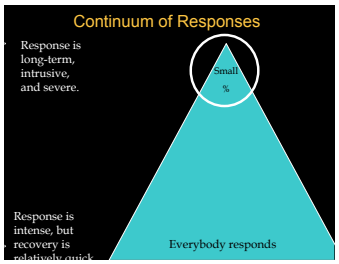
Ask the audience:

What might be some potential triggers from the car example we used earlier?

(Answers will most likely include: smell of burning rubber, particular song on radio, sirens, screeching of tires, type of weather, time of day, location of incident, etc.)

When we are triggered, our brain responds without first having the thinking brain check things out. This leads to an intense response to situations that may actually be safe. When this happens it is called a **false alarm**. False alarms happen when we see, hear, or feel something that reminds us of dangerous things that happened in the past, and we respond as if we are in danger when we are not.

Slide 23



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People's responses to trauma fall on a continuum:

Cue animation to bring up "everybody responds" text.

Although the type of response varies, **everyone has a response when they experience trauma.**

Cue animation to bring up "response is intense…" text.

For most, the response is intense but recovery is relatively quick and doesn't lead to long-term difficulties.

Cue animation to bring up "small percentage" text.

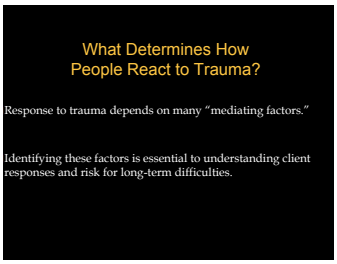
For a smaller percentage, recovery is less immediate, and symptoms can become more intrusive and impact more aspects of daily life. Some people may show signs of more severe distress and develop long-term mental health issues.

- For this group, recovery may take longer and people may need more supports during the recovery process.

Cue animation to bring up "response is long term" text.

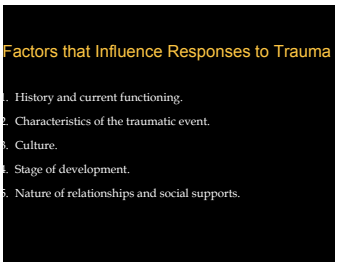
Everyone's recovery path is different and depends on a number of different factors.

Slide 24



- As we have discussed, most people who experience trauma **do not** go on to develop more severe mental health issues.
- However, for some, recovery is much more difficult.
- Many factors determine how people respond to traumatic stress and their level of risk for developing significant, long-term difficulties.

Slide 25



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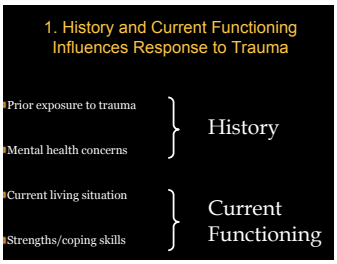
> We are going to focus on five major factors that influence how people respond to traumatic experiences.

Cue animation.

> It is important to consider all of these factors and how they interact with each other when thinking about how people respond to traumatic stress.

The next set of slides discusses each of these factors in more detail.

Slide 26



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The **first factor** that impacts a person's response to trauma is their **past history and current functioning**.

Cue animation.

HISTORY

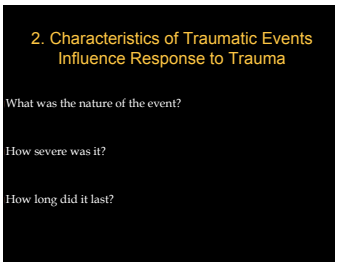
- Prior exposure to trauma will impact how a person responds to trauma. The more traumatic experiences a person has, the more intense future traumatic experiences may be and the more difficult it may be to come back to balance and move on.
- It is important to consider the presence of mental health issues such as depression and anxiety, both in the past and at present. Some mental health issues may be a response to past trauma. Mental health issues increase a person's vulnerability to future difficulties and impair their ability to manage traumatic stress.
    - Patterns of behavior and mental health functioning have implications for people's coping and problem-solving skills and how they have learned to manage stress.

Cue animation.

CURRENT FUNCTIONING

- A person's current living situation is important. Where are they living? In a shelter, tent, trailer, hotel, on the street, with other families? How might that be impacting sleep, mood, stress level, etc.? Current living situation can have a significant impact on a person's ability to manage traumatic stress. Lack of a stable living situation itself can be a traumatic stress.
- Many trauma survivors are incredibly resilient. Their strengths can help them on their path to recovery.
    - How have they managed so far? What are they good at?
    - By considering a person's strengths, we can understand and acknowledge that regardless of what has happened, this person is here and has survived. This fact alone deserves recognition and respect.

Slide 27



The **second factor** that influences how a person will respond to trauma involves the nature and extent of the traumatic event (or events) itself.

NATURE OF EVENT:

- The nature of the event influences how we respond to trauma. What kind of traumatic event occurred? Was it a natural disaster, physical abuse, community violence, etc.? Who was the perpetrator?
- Remember that trauma is in the eye of the beholder. The part of an event that I consider to be traumatic may not have been the part that someone else experiences as traumatic.

SEVERITY:

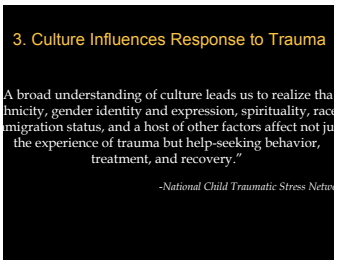
- The more severe the trauma, the more likely we are to be impacted (e.g., a minor car crash versus a severe one).
- In general, the closer we are to a traumatic event, the more severe the impact.
    - "Proximity" can mean physical closeness to the event or emotional closeness.
    - Typically, for example, interpersonal violence is typically more devastating than random violence.
    - The more personal the trauma, the closer a person was to actual death, the greater the impact on the family, the more severe the response may be.

LENGTH:

- Finally, the duration of the traumatic experience will impact our response.
    - How long did the trauma last? Minutes, hours, days, weeks, months, years?
    - Even though the traumatic event may have ended, did the trauma result in other kinds of significant stressors? (as in the case of Hurricane Katrina, for example, where many people lost homes, schools, communities, loved ones, etc.).

When thinking about these three components together, it is important to keep in mind the chronic nature of the traumatic event. Was this a one-time event or has it happened multiple times? Did this traumatic event occur in a long line of other traumatic events? Traumas can build on each other and become multi-layered, affecting people's responses to each subsequent trauma.

Slide 28



The **third** factor to consider is **culture**.

Culture is the filter through which we experience everything.

- It determines how assign meaning to different events, and how our communities respond to us.
- Traumatic events happen to people from all racial, ethnic, and religious backgrounds.
- While the brain's response to trauma is consistent for all trauma survivors, cultural context plays a significant role in the types of trauma that may be experienced, the risk for continued trauma, how survivors manage and express their experiences, and which supports and interventions are most effective.
- Violence and trauma have different meanings across cultures, and healing can only take place within one's cultural and "meaning-making" context.

Ask the audience:

Can anyone think of an example of how culture might influence people's response to trauma?

You may want to give an example of your own or use some of the ones below:

- In some cultures, if a woman is raped, she has brought dishonor to her family and is ostracized.
- Individual families have cultures/mores around help-seeking behavior, secret-keeping, etc. (e.g., "Don't air your dirty laundry outside the family.")
- Practices of grieving vary from culture to culture, and can have an impact on how trauma survivors are able to process the loss they may feel.
- Recall the statistics we talked about earlier related to GLBT youth, many of whom become homeless because their family/community culture does not accept their sexual orientation.
- Religious views have implications for how people make meaning of their experiences (e.g., God's will, God's punishment, etc.) and trauma can significantly impact how one views the world (recall earlier definition of trauma – that it interferes with one's belief system).

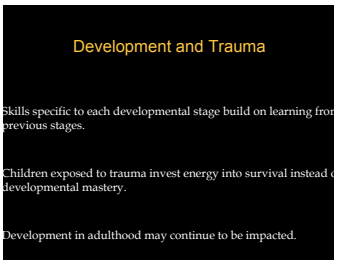
Slide 29

The **fourth factor** that influences how people respond to trauma is the **stage of development** at which the trauma first occurred.

- We all pass through various stages of development across the lifespan.
- Where we are in our development when we experience trauma can have a significant impact on how we respond and how severe an impact a traumatic experience may have.
    - Illustrating this concept is the fact that children who experience traumatic events before the age of 11 are three times more likely to develop psychological symptoms.
    - Children have not yet developed the skills necessary to manage traumatic stress and cope with the associated feelings that may lead to intense psychological symptoms.

You may want to remind participants of the statistics of childhood experiences of violent victimization among those who are homeless. It may also be useful to note that 42% of homeless children are under the age of six.[4]

Slide 30



Childhood experiences can have a major impact on adulthood. Adults are expected to have mastered certain skills based on their chronological age, but adults who have experienced trauma throughout their lifespan may not have had the opportunity to master certain skills in childhood and adolescence. These adults may struggle to hold jobs, raise children, and manage day to day stressors.

Consider the experience of trauma during childhood:

- Throughout childhood and adolescence, our energy is supposed to be focused on growth and learning. This is what children are supposed to do; this is their job.
- When children experience a traumatic stress, this may impede their ability to master developmental tasks because they must put more energy towards self-protection.
- If a child is able to recover and heal from traumatic events, and is no longer being exposed to trauma, there may be little or no impact on development.
- If a child has difficulty healing or continues to be exposed to trauma, energy will continue to be focused on self-protection and there may be little energy left to put into achieving developmental tasks, which will impede development over time.

Exercise: Ask the audience to discuss different developmental tasks throughout the lifespan. Write audience responses for each stage on flip chart. (Depending on your audience you may choose to focus on only particular stages of development.)

What are some of the tasks that we accomplish in the following stages of development?

- Early childhood (birth to age 5) (crawl, walk, talk, potty train, attach to caregivers)
- School Age (6-12) (begin to learn to read, write, count, get along with other children)
- Adolescence (12-18) (begin to form identity, become more independent, learn to think in more abstract ways)
- Young Adulthood (18-25) (continue to form identity, develop career identity, gain independence, form romantic attachments)
- Adulthood (25-65)(solidify career, continue to develop relationships, childrearing, caring for older parents)
- Elder Adulthood (65+)(mentor others, retirement, manage health)

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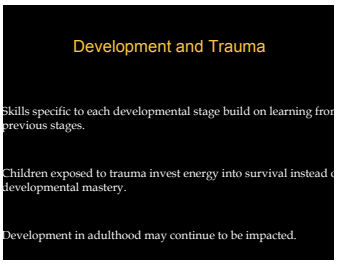
Slide 30, continued



Give an example of your own or use the one below (read aloud to audience):

The following is an example of the impact of early childhood trauma on development and the achievement of adult tasks:

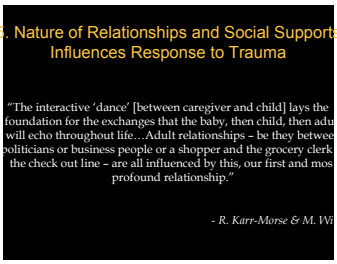
> "James is 42 years old and has difficulty organizing his time and planning ahead. He gets easily overwhelmed while trying to maintain housing and employment. He needs extra support to figure out how to solve even smaller issues, such as which bus he will take to get to work on time. James was severely neglected by his caregivers beginning in early childhood. He was also physically abused by his parents throughout his first 10 years, before being removed and placed in several foster care settings. James focused on survival throughout his childhood, adolescence and early adulthood when skills such as problem-solving and planning would have developed. Though 42 years old, James still needs to master tasks from a much earlier stage of development. This is embarrassing to James, and he finds it difficult to ask for help with things that others feel he should already be able to do."

Ask the audience:

Looking at our list of developmental tasks across the lifespan (refer to flip chart), what do you notice about the impact on the achievement of these expected tasks for the people who you work with? Do any of your clients struggle with some of the things we just named?

If a client spent his/her childhood staying safe from trauma, he/she may not have put energy into achieving normative developmental milestones (e.g., if someone experiences abuse/neglect during middle school years, when children are learning to negotiate conflict and peer relationships, he/s she may struggle with those things later in life.)

Slide 31

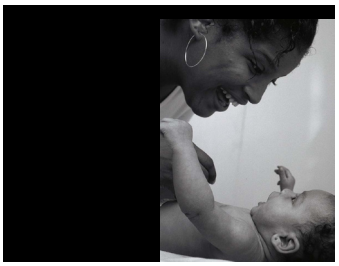


The **fifth factor** that influences how a person will respond to trauma involves the **nature of their relationships and social supports.**

Read the quote on the slide to the audience.

- Human beings are hard-wired to be in relationship with one another.
- Relationships and social supports are key to our well-being and, in fact, our survival.
- Our ability to form nurturing relationships during childhood will also affect how we relate to providers and access care later in life.

Slide 32



Ask the audience:

> What do you notice about this picture? What do you think of?

Participant responses may include bonding, love, happiness, etc. If it is not mentioned, point out how the baby and mother are in synch with one another (smiling, mouths open, eye contact, arms outstretched to one another, etc.)

Slide 33

Slide is animated

Ask the audience:

> What is attachment?

Write responses on the flip chart.

> When thinking about the nature of social supports and relationships, we begin with attachment because our attachment relationship is our first and primary one, and it is pivotal to all future relationships.

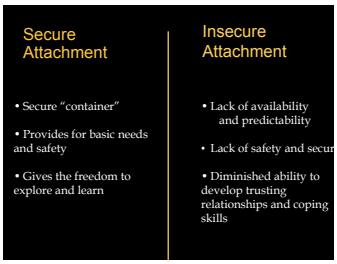
Cue animation.

> Attachment is an enduring emotional bond that is biologically driven and provides the building blocks for future relationships and self-regulation.
>
> What does attachment do?
> - Early attachments provide a template for future relationships. Early attachment to caregivers provides us with a model for how to be in relationships with others. This relationship helps us to understand who we are, who others are, how we work out problems in relationships, and how we learn to trust others.
> - Early attachments build internal self-regulation by providing a model for self-soothing and coping. The caregiver holds, rocks, coos and soothes the child in order to help her to calm down. As the child grows, she learns how to manage her feelings and behaviors and soothe herself based on these early experiences of comfort and support. Over time, she can rely more on herself and less on her caregivers to manage her feelings and needs.

Attachment and Stress/Trauma:

> Because children are not born with all the skills they need to handle trauma they require the external support of caregivers to buffer the effects of trauma. Beginning in early development this support happens in the context of the attachment relationship.

Slide 34



In broad terms, attachment is either secure or insecure. The nature of attachment will influence the child's ability to achieve various developmental tasks such as developing language, modulating feelings and having the ability to soothe him or herself.

Describe secure attachment:

- Most children have a secure attachment with their caregiver.
- This occurs when parents provide "good enough" parenting, which is done by attuning to and meeting their child's basic needs.

Describe what secure attachment teaches us:

- When children have secure early attachments they can explore the world and learn the skills that help them to cope with stress.
  - These children, as adults, are more likely to have both the internal resources to cope with stress as well as the ability to connect with others, develop healthy relationships, and utilize outside supports.
- Gives us a template for future relationships and teaches us how to develop mutual, sustaining relationships:
  - Connect with others
  - Ask for and accept help and support, and offer it when needed
  - Maintain healthy boundaries
  - Trust and communicate with others
  - Sustain relationships over the long term

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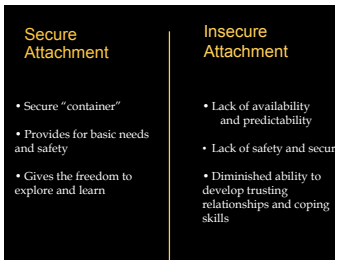
Slide 34, continued



Describe secure attachment and trauma:

- The importance of secure attachments in supporting children through adulthood cannot be understated. The presence of secure attachments enable children who have experienced trauma to move on into adolescence and adulthood and remain relatively unaffected.
- If children are faced with traumatic experiences during their childhood, their caregivers provide a safe space where they can hold them, talk to them, soothe them and reassure them that they are still safe. With this as a model, as children grow older, they are able to do these things for themselves in order to calm down and manage their responses to threat or danger.

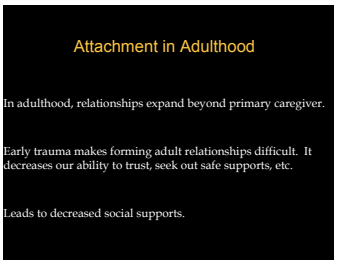
Describe insecure attachment:

- Attachments can become disrupted when the caregiver becomes physically or emotionally unavailable (due to traumatic event(s), mental health issues, stress, separation, illness, death).
- This may lead to the caregiver becoming or being unpredictable or unable to consistently respond to the child and meet the child's needs.
- This leads to a lack of stability and sense of safety for the child.
- At times caregivers, who are a child's source of trust and security, can also become a source of the child's pain and fear (e.g., child abuse, maternal substance abuse, etc.)

Describe what insecure attachments lead to:

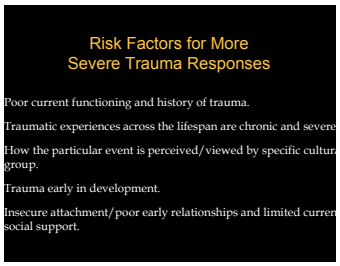
- Without a secure attachment base, children are unable to explore the world and learn.
- As children grow into adolescents and adults this can have an impact on relationships, coping skills, and self-identity.
- For example, an adult who is not able to ask for help from providers may become defensive or withdrawn when offered help or become overwhelmed by small tasks such as planning and organizing their day. This lack of skill can lead to increased difficulties managing future traumas if they arise.
- For children, an insecure attachment *is* a trauma.

Slide 35



- As we get older, our attachment relationships expand. We form romantic relationships, strong friendships, professional and community connections, etc.
- If we did not have the necessary support, attention, and care in childhood, it will be more difficult to build these skills and form sustaining relationships in adulthood.
- Early trauma makes forming adult relationships difficult. It decreases our ability to trust, seek out safe supports, etc. As a result, we are likely to have decreased social support and therefore the impact of another trauma on our lives can be disabling.

Slide 36



Now that you have discussed all five factors, summarize them by describing the risk factors for more severe trauma responses. This slide begins the transition towards discussing complex trauma.

The risk for developing more severe and long-term difficulties associated with trauma are associated with the following:

- Multiple traumatic experiences.
- Cultural view of a traumatic event
- Traumatic experiences that occur early in development and span multiple stages.
- Insecure attachment with primary caregivers.
- Poor social support in adulthood.

Thinking back to our initial discussion about the various subgroups of the homeless population, multiple traumas that occur across the lifespan are prevalent for most people we serve.

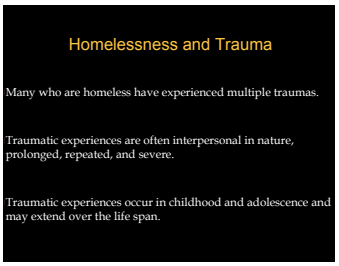
Ask the audience:

How many of you look at this list and think of your clients?

Slide 37

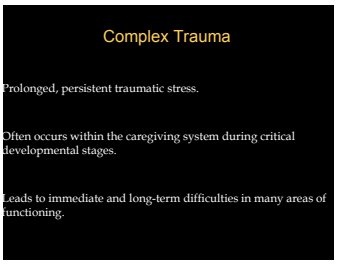
Use this slide to transition from the discussion about clients' experiences with the risk factors on the previous slide to the next part of the training, which is about homelessness and trauma.

Slide 38



- As we discussed at the beginning of the training, people experiencing homelessness have often experienced trauma that is interpersonal in nature and at times intentional and severe.
- These events have often been repeated and prolonged, beginning in early childhood and/or adolescence, with patterns of abuse often extending into adulthood.

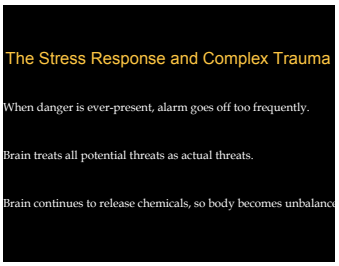
Slide 39



Introduce complex trauma:

- We began by talking about how we all respond to stress and how we commonly respond to traumatic stress.
- But what happens when trauma is interpersonal in nature and at times intentional and severe? What happens when it is repeated and prolonged, beginning in early childhood and/or adolescence, with patterns of abuse often extending into adulthood?
- These experiences move beyond the one-time dangers/stressors that we talked about earlier.
- We have a name for this type of chronic, interpersonal trauma: **complex trauma.**
- Complex trauma is prolonged and persistent. It often occurs within the caregiving system during critical developmental stages. It leads to immediate and long-term difficulties across many areas of people's lives.
- It also most often the kind of trauma that our clients have experienced or are still experiencing.

Slide 40



We initially began by talking about how we all respond to stress, the alarm system in our brains, and how we commonly respond to traumatic stress. Now let's talk about how chronic stress impacts these systems.

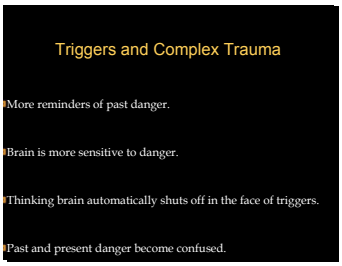
When dangerous things happen often (e.g., chronic stress), and the alarm goes off too frequently, the brain adapts in order to help us survive.

- It does this by becoming better at recognizing signals that are reminders of past situations that have been dangerous or threatening.
- The **doing brain** starts to become more alert to danger and more sensitive to even the most subtle reminders of past dangerous experiences. Eventually, the brain becomes so sensitive that any time the alarm goes off to signal potential danger, the brain assumes there is actual danger.
- The **thinking part of the brain** is shut down before it can check things out, and the doing brain takes over, starting the fight-flight-freeze response. This is helpful when you're in danger on a regular basis, because you learn to react even more quickly in order to stay safe.

For those who experience chronic trauma from an early age, the thinking brain is constantly being by-passed, which results in a less developed thinking brain and more difficulties with the planning, reasoning, organizing and evaluating skills that are so necessary to succeed in adulthood.

Under conditions of chronic stress and/or threat, the neurotransmitters and neurohormones that facilitate the fight, flight, freeze responses become dysregulated or out of balance. The body is trying to manage being in constant danger.

Slide 41



Describe the way the brain changes when a person has experienced complex trauma:

Chronic, complex trauma actually changes the way the brain functions. As we described earlier, our brains are highly calibrated to keep us safe. If the world we live in is consistently dangerous, the brain decides that it can more efficiently protect us by assuming that everything is dangerous.

In other words, rather than the thinking brain checking things out, as we talked about earlier, the doing brain always assumes that the body is in danger and responds accordingly.

To compound this experience, people who have experienced complex trauma have significant lists of triggers, making the whole world a dangerous and scary place for them.

- Because chronic trauma survivors have learned to pay close attention to signals for danger, these triggers are often subtle and can be difficult to detect.

Ordinary things become triggers, which can lead to intense fight, flight or freeze responses that may appear confusing and out of place to others. (e.g., smells, colors, etc.)

Remember the smoke alarm analogy:

- Imagine if every time the smoke alarm went off in your house, there was a fire. Eventually, when the smoke alarm went off, you would automatically assume that there was a real fire, and you would run out of the house without checking things out first. Now, imagine that you have moved to a new place and you hear a smoke alarm go off. You have learned to react immediately, and so that's what you do – however, you haven't checked things out and may just be reacting to a false alarm.

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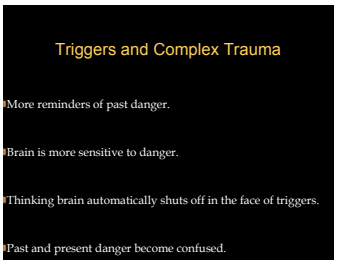
Slide 41, continued



Example:

Here is an example of a common situation where triggers play a role in a person's response:

> Amy is living in an emergency shelter. A staff member reminds her that she needs to clean her apartment. When Amy does not respond, the staff member taps her on the shoulder, and says again, in a louder voice, that Amy needs to clean her room. Amy reacts by jumping up off the chair, screaming at the staff member and throwing her bag across the room.
>
> For Amy, being touched and feeling as though she is being yelled at are two very triggering experiences that remind her of past violent relationships in childhood and adulthood. When the staff member raises his voice and touches Amy, her alarm goes off which leads to an automatic emergency response (in this case the "fight" response). Amy's body is reacting to a current experience as though she is back in past dangerous situations. Amy may be so sensitive to people's responses that a tap on the shoulder may feel very aggressive or threatening, and a raised voice or an angry look may be read as violent. This intense response can be very confusing to the staff member who has a different perception of the situation and feels that he was not being aggressive or particularly loud in the moment.

Slide 42

Slide is animated

Ask the audience:

> What do you think might be some common triggers for people who have experienced traumatic stress?

or

> What are some common triggers for your clients?

Cue animation.

> Common triggers may include:
>
> - Reminders of past events.
> - Lack of power/control.
> - Conflict in relationships.
> - Separation or loss.
> - Transitions and routine/schedule disruption.
> - Feelings of vulnerability or rejection.
> - Feeling threatened or attacked.
> - Loneliness.
> - Sensory overload (too much stimulation).

Slide 43

Triggers can lead to fight-flight-freeze responses, and we see them often in people who have experienced complex trauma.

Ask the audience:

What are some of the fight, flight, freeze responses that you notice when the people you work with are triggered?

Examples:

Fight:

- Extreme anger and/or aggression (seemingly disproportionate to the situation)

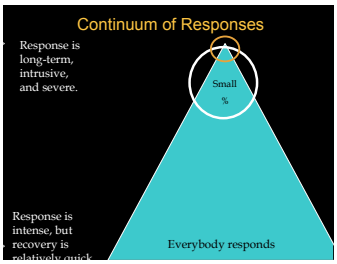
Flight:

- Avoidant behavior
- Withdrawal

Freeze:

- One response to overwhelming feelings and/or physical sensations associated with traumatic experiences is dissociation – a freeze response.
- We all dissociate from time to time to cope with stress. For example, many of us have missed our exit on the highway because we were preoccupied and driving automatically.
- A person with a history of complex trauma may experience more persistent dissociation. Some trauma survivors have learned to disconnect from overwhelming experiences when things become too intense for them to handle. Feelings, physical sensations, and thoughts associated with traumatic events may be fragmented and walled off from other memories. When these unwanted memories or sensations come up, people may attempt to disconnect from these sensations.
- This can look like someone is "spaced out" or "in a daze" or just does not feel connected to you in the moment.
- This behavior can be particularly confusing for others to understand, as it is sometimes difficult to recognize or may be misinterpreted.

Slide 44



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> Now that we've talked about traumatic stress, the factors that influence our response, and complex trauma, let's take another look at our continuum of responses.

Cue animation.

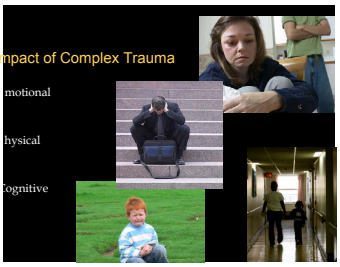
> - Remember that everyone responds to a traumatic event, and for most the response is intense but recovery is quick.
> - We've discussed the risk factors for a more severe response, which are especially applicable to those who have experienced complex trauma

Cue animation to show white circle.

> For many of our clients, their trauma histories are so severe and so long-term that they are extremely vulnerable to having a response that is severe, significant, and long-term. They fall at the very top of the triangle.

Cue animation to show orange circle.

Slide 45

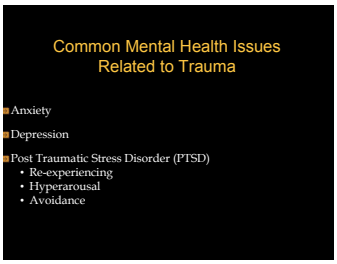


Discuss the impact of complex trauma on various areas of a person's life.

Chronic traumatic experiences, like those often found in the lives of people who are homeless, can have an **impact on the physical, emotional, relational and cognitive aspects of people's lives**. Complex trauma impacts the brain's alarm system, development, competency, attachment/relationship-building, and view of self and other.

Let's review the impact of complex trauma on the above areas of daily functioning and talk about the struggles that face people who are homeless and have experienced traumatic stress.

Slide 46



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Ask the audience:

> What are some of the emotional effects of trauma that you see in the people who you serve?
>
> - Feelings of fear, anxiety, panic, irritability, anger, withdrawal, numbness, depression, confusion, hopelessness and helplessness
> - People often have major difficulties managing, understanding, and regulating feelings as a result of chronic traumatic stress.
> - Major mental health issues such as Depression, Bi-Polar Disorder, Anxiety Disorders, Borderline Personality Disorder, PTSD, etc.

You may want to share the following statistic:[5]

> Approximately 20 - 25% of the single adult homeless population suffers from some form of severe and persistent mental illness.

Use the slide's animation to highlight common mental health issues related to trauma:

> **Anxiety**
>
> "Feelings of unease and fear of impending danger characterized by physical symptoms such as rapid heart rate, sweating, trembling and feeling of stress. I contrast to fear, the danger of threat in anxiety is imagined, not real."[6]

Cue animation.

> **Depression**
>
> "A mood disturbance characterized by feelings of saddness, lonliness, despair, low self-esteem, worthlessness, withdrawal from social interaction, and sleep and eating disturbances." [7]
>
> - About 50% of mothers have experienced a major depressive episode since becoming homeless.[8]

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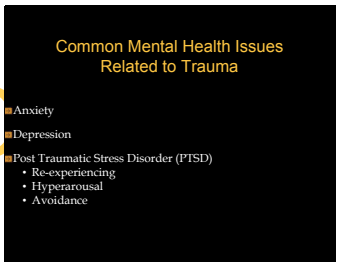
Slide 46, continued



You may want to share the following statistic:

47% of school-age children have problems with anxiety, depression, or withdrawal.[9]

Cue animation.

Post Traumatic Stress Disorder (PTSD)

The hallmark symptoms of PTSD are ones that we have already described:

- Re-experiencing of the traumatic event (often in the form of nightmares or flashbacks).
- Hyperarousal (e.g., difficulty falling or staying asleep, angry outbursts, hypervigiliance, difficulty concentrating). This happens when the chemicals in our bodies continue to "rev" us up, though we no longer need the energy to escape danger.
- Avoiding reminders of the event, characterized by constricted behavior and numbing (e.g., diminished interest or participation in significant activities, feeling detached or estranged from others).

PTSD may develop months or even years after experiencing or witnessing a traumatic event.

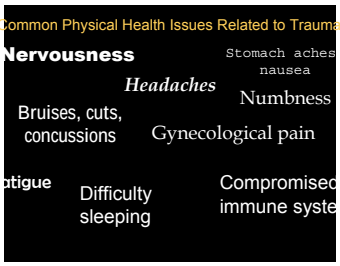
Recall our continuum. Everyone responds to trauma, but only a small percentage of people who experience a traumatic event develop PTSD.[10]

- Research suggests that only 9% of men and 20% of women who are exposed to traumatic experiences develop PTSD.
- Overall, 7% to 10% of the general population experience PTSD at some point in their lives.

You may want to share the following statistic:

Mothers experiencing homelessness have three times the rate of PTSD (36%) compared to rates of PTSD in the general population.[11]

Slide 47



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In an article entitled "The Body Keeps the Score: Approaches to the Psychobiology of PTSD," noted trauma researcher Bessel van der Kolk writes that "Brain, body, and mind are inextricably linked…Alterations in any one of these three will intimately affect the other two."[12]

Our bodies express what cannot be verbalized, and so traumatic memories are often transformed into physical outcomes.

Ask the audience:

What are some of the common physical issues that you see with the people you serve? How might these relate to their experiences of trauma?

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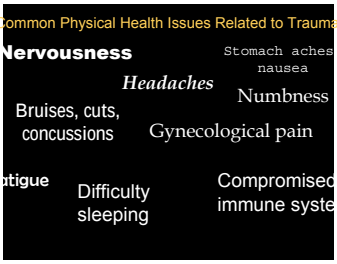
Slide 47, continued



Cue animation.

There are so many physical symptoms associated with trauma that the animation is designed for many to show on the screen at once. Most likely, participants will have named many of them already. Use the talking points below to highlight the physical impact of trauma:

Many of the emotional health issues we just mentioned can have physical health implications. For example:

- Anxiety often comes hand in hand with headaches or stomach aches, nervousness, etc.
- Depressed people often experience fatigue, difficulty sleeping, etc.

Clients may have physical difficulties related to the actual traumatic incident:

- Gynecological pain.
- Risk of pregnancy, HIV, and other sexually transmitted diseases
- Bruises, cuts, concussions, broken bones, etc.

The neurobiology of trauma that we discussed earlier also has physical health implications.

- Remember that when someone is triggered, their brains react as though they're in danger, which means that there are chemicals being released to rev the body up, calm the body down, and regulate the two. Since the person is not actually in danger (and therefore does not need the added energy that the chemicals are providing), he/she may experience various physical symptoms such as:
    - Headaches.
    - Stomach aches.
    - Nausea.
    - Nervousness.
    - Fatigue.
    - Palpitations.
    - Generalized pain.
    - Difficulty sleeping.
    - Nightmares.

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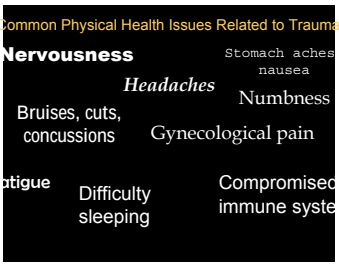
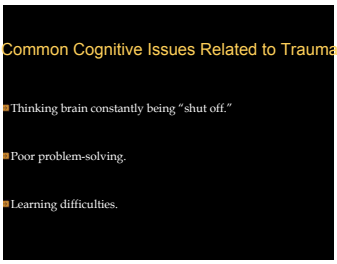
Slide 47, continued



Other physical problems might include:

- More difficulty with existing medical problems (e.g., asthma, heart disease, blood pressure).
- Compromised immune system: chronic danger and anticipation of violence stresses the immune and other bodily symptoms.
- Sleeping/Eating difficulties.
- Tearfulness.
- Fearfulness.
- Feeling jumpy.
- Having flashbacks of what happened (one of the hallmarks of PTSD).
- Feeling numb (freeze response).

Slide 48



Ask the audience:

> How do you see the impact of chronic trauma on cognitive skills play out with your clients?

(Participants will likely volunteer many examples, but if you need to prompt them, you can remind them of the functions of the "thinking brain," which is shut down when people are experiencing trauma and when they are triggered. These functions include planning, organizing, reasoning, etc. – many of the skills that are required for day-to-day life.)

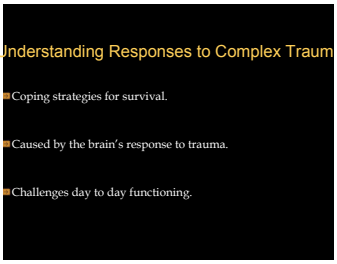
Cue animation.

- Some effects of chronic trauma on cognitive functioning include difficulty focusing, concentrating, thinking, planning, problem-solving.
- The thinking part of the brain is constantly being shut off in the face of actual on-going danger or triggers that sound the alarm system.
- This can lead to academic and work-related difficulties for children and adults.

You may want to share the following statistics:[13]

- Children experiencing homelessness are four times more likely to show delayed development.
- They also have twice the rate of learning disabilities as non-homeless children.

Slide 49



The ways that people cope with the impact of trauma on the whole self – physical, emotional, cognitive, relational – may seem inappropriate or destructive. We may rush to label them as pathological or dysfunctional, and the people as "ill" or "sick". We now understand that many behaviors arise as adaptations to extreme stress and experiences of chronic trauma.

These behaviors grow out of attempts to cope with traumatic events in the past, but continue in the present even in the absence of the original source of the trauma. These were effective responses at the time and were necessary for survival in the face of danger. These behaviors made sense and were useful at the time of the trauma, but are no longer effective in the present and often interfere with daily functioning.

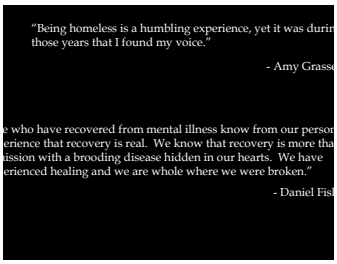
Example:

Here is an example of adaptive behaviors resulting from past trauma that are no longer effective in the present: "Sally" learned from a young age to shut down or "space out" in the face of overwhelming family violence (mom and dad were always yelling and sometimes dad pushed or hit mom). Sally still shuts down in response to overwhelming situations such as applying for housing and jobs and managing childcare. While withdrawing kept Sally safe within her early caregiving system, in the present, this behavior prevents her from adequately providing for herself and her children and often leaves her case worker with the impression that she is lazy and just doesn't care enough to pay attention.

Ask the audience:

What are some coping strategies that you see clients use that might have been helpful while in danger in the past but are getting in the way of success in the present?

Slide 50



No matter how impaired or troubled clients may seem, the reality is that they have survived devastating traumas and that with support, they can recover.

We must be sensitive to the impact that trauma has had on people's lives, but also recognize that no matter how devastating the impact, there is always strength and resiliency to be found.

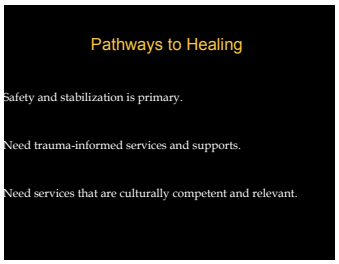
While our clients may sometimes be all-consumed by their trauma, we know – and so do they – that they are more than just their trauma.

Cue the animation to show the quotes one at a time. Use the information below to describe the speakers:

Amy Grassette is a mother of two and is formerly homeless. She describes her experiences in *Every Success Story is a Great Story*, published by the National Health Care for the Homeless Council. Amy is currently the co-chair of the National Consumer Advisory Board to the National Health Care for the Homeless Council.

Daniel Fisher, MD, PhD, is the Executive Director of the National Empowerment Center. His quote is taken from an article entitled "Healing and Recovery Are Real."

Slide 51



Today we have focused on the nature of traumatic stress, how it impacts people, and the brain/body adaptation to trauma, specifically chronic experiences of trauma. We encourage you to use this information as a foundation for the work that you do. By understanding behaviors as adaptations to past danger and threat, we can begin to think about new adaptations that might lead to healthier futures. This approach gives both the provider and client hope that recovery is possible.

Education about the brain's adaptation to trauma and people's sensitivity to danger and reminders/triggers, highlights the importance of creating a sense of safety and stabilization in all work that we do with trauma survivors. All services and supports need to be "trauma-informed," meaning that the work done by providers is informed by an understanding of trauma and the impact of complex trauma on physical and emotional health, cognitive skills and relationship building.

Summarize this part of the training for the audience:

In the first part of this training, we have provided an overview of

- the relationship between homelessness and trauma
- the nature of traumatic stress
- our responses to daily stress and traumatic stress
- the factors that impact people's responses to trauma
- and the impact of complex trauma on people's lives and functioning.

The second part of this training will focus on applying what we have learned about homelessness and traumatic stress to our work as service providers. This will include defining what it means to be "trauma-informed" and beginning to discuss the various aspects of service delivery that need to be examined in light of an understanding of the impact of trauma. Areas of service delivery to be examined will include the following: staff support, training and education, developing welcoming and safe environments, assessments and service planning, and policies and procedures. Using the information gained in part one of this training, providers will evaluate their own services, programs, and service systems and develop ideas about how to incorporate trauma-sensitive practices into their work.

Part I Endnotes

Slide 7:

[1]Kessler, RC, Sonnega, A., Bromet, E., Hughes, M. & Nelson, CB. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry.* 52: 1948-2060.

Slide 10:

[2]National Coalition for the Homeless. (2007). *Hate, Violence, and Death on Main Street USA: A Report on Hate Crimes and Violence against People Experiencing Homelessness 2007*. Available at www.nationalhomeless.org.

Slide 29:

[3]Disaster Training International (2001). Seattle. Learn more at www.disastertraining.org.

[5]Burt et al. (1999). *Homelessness: Programs and the People They Serve.* Washington, DC: The Urban Institute. Available at www.urbaninstitute.org.

Slide 46:

[6]National Resource and Training Center on Homelessness and Mental Illness. (2003). *Get the Facts.*

[7]Kraybill, K. & Olivet, J. (2006). *Shelter Health: Essentials of Care for People Living in Shelter*. Nashville: National Health Care for the Homeless Council, p. 109, 111.

[8]Weinreb, L. et al. (2006). A comparison of the health and mental health status of homeless mothers in Worcester, Massachusetts: 1993 and 2003. *American Journal of Public Health*. 96(8): 1444-1448.

[9]The National Center on Family Homelessness. *Homeless Children: America's New Outcasts.* Newton, MA: author.

[10]Yehuda, R. (2002). Posttrauamtic stress disorder. *New England Journal of Medicine.* 346(2).

[11]Yehuda, R. (2003). Changes in the concept of PTSD and trauma. *Psychiatric Times.* 20(4).

[12]American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.* Washington, DC: author.

[13]Bassuk, EL et al. (1996). The characteristics and needs of sheltered homeless and low-income housed mothers. *Journal of the American Medical Association*. 276(8): 640-646.

[14]Van der Kolk, B. (1996). *The body keeps the score: Approaches to the psychobiology of PTSD*. In *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society.* B. van der Kolk, AC McFarlane, and L. Weisaeth, Eds. New York City: Guilford Press.

Slide 48:

[15]The National Center on Family Homelessness. *Homeless Children: America's New Outcasts.* Newton, MA: author.

Part I Handouts

HRC
HOMELESSNESS RESOURCE CENTER

THE NATIONAL CENTER ON
Family Homelessness
for every child, a chance

Handouts and Evaluation Materials

Part I:

- Selected Resources
- Sample Training Pre-Test

We also recommend that you provide participants with the PowerPoint slides and an agenda.

Selected Resources on Homelessness and Trauma

General Trauma Information

Printed Material

Bassuk, E.L., Dawson, R., Perloff, J., & Weinreb, L. (2001). Post-traumatic Stress Disorder in Extremely Poor Women: Implications for Health Care Clinicians. *Journal of the American Medical Women's Association,* 56, 79-85.

Herman, J. (1992). *Trauma and Recovery*. Basic Books.

American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members (2007) *The Psychological Needs of U.S. Military Members and Their Families: A Preliminary Report*. Available at www.apa.org/releases/MilitaryDeploymentTaskForceReport.pdf.

Van der Kolk B.A., McFarlane, A.C., & Weisaeth L. (Eds.). (1996). *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society.* New York: Guilford Press, 214-241.

Websites

Community Connections - www.communityconnectionsdc.org
National Center for Post Traumatic Stress Disorder (PTSD) - www.ncptsd.org
National Child Traumatic Stress Network - www.nctsnet.org

Homelessness and Trauma

Printed Material

Bassuk, E.L., & Friedman, S.M. (2005). Facts on Trauma and Homeless Children. From the National Child Traumatic Stress Network, Homelessness and Extreme Poverty Working Group. *Available at* www.nctsnet.org.

Bassuk, E.L., Melnick, S. & Browne, S. (1998). Responding to the Needs of Low-Income and Homeless Women Who Are Survivors of Trauma. *Journal of the American Medical Women's Association.* 53(2): 57-64.

Bassuk, E.L., Weinreb, L., Buckner, J., Browne, A., Solomon, A., & Bassuk, S.S. (1996). The Characteristics and Needs of Sheltered Homeless and Low-Income Housed Mothers. *Journal of the American Medical Association*. 276(8): 640-646.

Buckner, J., Bassuk E.L., Weinreb L., & Brooks M. (1999). *Homelessness and Its Relation to the Mental Health and Behavior of Low-Income School-Age Children*: *Developmental Psychology*. 35(1): 246-257.

Fairweather, A. (2006). *Risk and Protective Factors for Homelessness among OIF/OEF Veterans*. San Francisco: Swords to Plowshares.

Goodman, L., Saxe, L., and Harvey, M. (1991). Homelessness as Psychological Trauma: Broadening Perspectives. *American Psychologist.* 46 (11): 1219-25.
The National Center on Family Homelessness. (1999). *Homeless Children: America's New Outcasts*. Newton, MA: author.
Kim, Mimi M. & Ford, Julian D. (2006). Trauma and Post-Traumatic Stress Among Homeless Men: A Review of Current Research. *Journal of Aggression, Maltreatment & Trauma*. 13(2): 1-22.
Melnick, S., & Bassuk, E.L. (1999). *Identifying and Responding to Violence among Poor and Homeless Women: A Health Provider's Guide*. The National Center on Family Homelessness. Newton, MA.
Nyamathi, A., Wenzel S., Lesser J., Flaskerud J., & Leake B. (2001). Comparison of psychosocial and behavioral profiles of victimized and non-victimized homeless women and their intimate partners. *Researching in Nursing and Health*. 24(4): 324-335.
Vostanis, P., Tischler, V., Cumella, S., & Bellerby, T. (2001). Mental Health Problems and Social Supports among Homeless Mothers and Children Victims of Domestic and Community Violence. *International Journal of Social Psychiatry*. 47(4): 30-40.
Wenzel, S., Leake, B., & Gelberg, L. (2001). Risk Factors for Major Violence Among Homeless Women. *Journal of Interpersonal Violence*. 16(8): 739-752.
Zlotnick, C., Tam, T., & Bradley, K. (2006). Impact of Adulthood Trauma on Homeless Mothers. *Community Mental Health Journal.* 43(1): 13-32.

Websites

The Homelessness Resource Center ~ www.homeless.samhsa.gov
The National Center on Family Homelessness ~ www.familyhomelessness.org
National Coalition for Homeless Veterans ~ www.nchv.org
SAMHSA's Resources for Returning Veterans and Their Families ~ http://www.samhsa.gov/vets
U.S. Department of Veterans Affairs Homeless Veterans Page ~ www.va.gov/homeless

Culture and Trauma

Printed Material

Bronheim, Suzanne. (2006). *Cultural Competence: It All Starts at the Front Desk*. Washington, DC: National Center on Cultural Competence, Georgetown Center for Child and Human Development.
Good, T.D. & Jones, W. (2000, Revised 2006). *A Guide to Advancing Family Centered and Culturally and Linguistically Competent Care.* Washington, DC: National Center on Cultural Competence, Georgetown Center for Child and Human Development.
The National Child Traumatic Stress Network. (2006). *Culture and Trauma Brief*. Available at www.nctsn.org.
The National Child Traumatic Stress Network. (2006). *Promoting Culturally Competent Trauma-Informed Practices*. Available at www.nctsnet.org/nccts/asset.do?id=817.
The National Child Traumatic Stress Network. (2006). *Trauma among Lesbian, Gay, Bisexual, Transgender, and/or Questioning Youth*. Washington, DC. Available at www.nctsnet.org/nccts/asset.do?id=885.

Websites

National Child Traumatic Stress Network ~ www.nctsn.org
National Center on Cultural Competence ~ www11.georgetown.edu/research/gucchd/nccc

Trauma-Informed Services

Printed Material

Harris, M. and Fallot, R. (Eds). (2001). *Using Trauma Theory to Design Service Systems.* San Francisco: Jossey-Bass.

Jahn Moses D., Reed B.G., Mazelis R., & D'Ambrosio, B. (2003). *Creating Trauma Services for Women with Co-occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse, and Mental Health Disorders Who Have Histories of Violence Study*. The Coordinating Center of the SAMHSA Women, Co-Occurring Disorders, and Violence Study. Available at www.mentalhealth.samhsa.gov/cmhs/womenandtrauma.

Jahn Moses, D., Huntington, N., & D'Ambrosio, B. (2004). *Developing Integrated Services for Women with Co-occurring Disorders and Trauma Histories: Lessons from the SAMHSA Women with Alcohol, Drug Abuse and Mental Health Disorders Who Have Histories of Violence Study*. The Coordinating Center of the SAMHSA Women, Co-Occurring Disorders, and Violence Study. Available at www.mentalhealth.samhsa.gov/cmhs/womenandtrauma.

National Center on Family Homelessness. (Forthcoming). *Trauma-Informed Organizational Self-Assessment for Programs Serving Homeless Families*. Newton, MA: author.

Prescott, L., Soares, P., Konnath, K. & Bassuk, E. (Forthcoming). *The Long Journey Home: A Guide for Creating Trauma-Informed Services for Mothers and Children Experiencing Homelessness.* Newton, MA: The National Center on Family Homelessness.

Websites

National Center for Trauma-Informed Care ~ www.mentalhealth.samhsa.gov/nctic
The Trauma Center, Brookline, MA ~ http://www.traumacenter.org/training/training_landing.php

Consumer Involvement

Printed Material

Prescott, L. (2001). *Defining the Role of Consumer-Survivors in Trauma-Informed Systems.* In M. Harris & R. Fallot (Eds.). *Using Trauma Theory to Design Service Systems*. San Francisco: Jossey-Bass.

Prescott, L. (2001). *Consumer/Survivor/Recovering Women: A Guide for Partnerships in Collaboration*. Delmar, NY: Policy Research Associates. Available at www.mentalhealth.samhsa.gov/cmhs/womenandtrauma.

Websites

National Consumer Advisory Board to the National Health Care for the Homeless Council ~ http://www.nhchc.org/advisory.html
National Empowerment Center ~ www.power2u.org

Self-Care for Service Providers

Printed Material

Arledge, E. & Wolfson R. (2001). *Care of the Clinician*. In M. Harris & R. Fallot (Eds.). *Using Trauma Theory to Design Service Systems*. San Francisco: Jossey-Bass.

Saakvitne, K., Gamble, S., Pearlman, L., & Lev, B. (2001). *Module 5: Vicarious Traumatization and Integration: Putting It All Together* in *Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse*. New York: Sidran Traumatic Stress Foundation. Available at www.sidran.org.

Stamm, B.H., Varra, E.M., Pearlman, L.A., and Giller, E. (2002). *The Helper's Power to Heal and To Be Hurt – or Helped – By Trying.* Register Report: A Publication of the National Register of Health Services Providers in Psychology.

Stamm, B.H. (2005). *The ProQOL Manual: The Professional Quality of Life Scale: Compassion Satisfaction, Burnout and Compassion Fatigue/Secondary Traumatic Stress Scales*. Baltimore: Sidran Press.

Websites

National Health Care for the Homeless Council ~ http://www.nhchc.org/healthyenviron.html.

Interventions

Printed Material

Clark, C., & Fearday, F. (Eds.). (2003). *Triad Women's Project: Group Facilitator's Manual.* Tampa, FL: Louis de la Parte Florida Mental Health Institute, University of Southern Florida. For more information, visit www.usfweb2.usf.edu/sowc/resources/mental.html.

D'Ambrosio, B. & Jahn Moses, D. (2002). *Nurturing Families Affected By Substance Abuse, Mental Illness, and Trauma: A Parenting Curriculum for Women and Children*. The Coordinating Center of the SAMHSA Women, Co-Occurring Disorders, and Violence Study. Available at www.mentalhealth.samhsa.gov/cmhs/womenandtrauma.

Developing Trauma-Informed Organizations: A Tool Kit. (2002). The Women Embracing Life and Living (WELL) Project and the WELL Project State Leadership Council of the Institute for Health and Recovery. Available from www.healthrecovery.org.

Foa, E.B., Keane T.M., & Friedman M.J. *Effective Treatments for PTSD*. (2000). New York City: Guilford Press.

Ford, J.D., Courtois, C., Steele, K., Van der Hart, O. & Nijenhuis, E. (in press).Treatment of the complex sequelae of psychological trauma. *Journal of Traumatic Stress.*

Harris, M., & Anglin, J. (1998). *Trauma Recovery and Empowerment: A Clinician's Guide for Working with Women in Groups*. New York, NY: Free Press. This and other resources about TREM are available at www.communityconnectionsdc.org.

Kinniburgh, K. and Blaustein, M. (2005). *Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth.* Brookline, MA: The Trauma Center.

Najavits, L. (2001). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press.

Saakvitne, K., Gamble, S., Pearlman, L., & Lev, B. (2001). *Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse*. New York: Sidran Traumatic Stress Foundation. Available at www.sidran.org.

SAMHSA Homeless Families Coordinating Center. (2005). *Trauma Interventions for Homeless Families: Innovative Features and Common Themes.* Washington, DC: Vanderbilt University Center for Evaluation and Program Improvement.

Wilson, J.P. & Keane T. (Eds.). (2004). *Assessing Psychological Trauma and PTSD*. New York, NY: Guilford Press.

Substance Abuse and Trauma

Printed Material

Brenda, Brent B. (2006). Survival analyses of social support and trauma among homeless male and female veterans who abuse substances. *American Journal of Orthopsychiatry.* 76(1): 70-79.

Miller, D. & Guidry L. (2001). *Addictions and Trauma Recovery: Healing the Body, Mind, and Spirit*. New York: NP Psychotherapy Books.

Moore, J., Buchan, B., Finkelstein, N. et al. (2001). *Nurturing Families Affected by Substance Abuse, Mental Illness, and Trauma*. Cambridge, MA: Institute for Health and Recovery. Available at www.healthrecovery.org.

Najavits, L.M., Weiss, R.D., & Shaw, S.R. (1997). The link between substance abuse and posttraumatic stress disorder in women: A research review. *American Journal on Addictions.* 6(4): 273-283.

North, C.S., Thompson, S.J., & Smith, E.M. et al. (1996). Violence in the lives of homeless mothers in a substance abuse treatment program: A descriptive study. *Journal of Interpersonal Violence*. 11(2): 234-249.

The Coordinating Center of the SAMHSA Women, Co-Occurring Disorders, and Violence Study *Parenting Issues for Women with Co-Occurring Mental Health and Substance Abuse Disorders who Have Histories of Trauma*. (2000).. For more information, visit ***www.mentalhealth.samhsa.gov/cmhs/womenandtrauma***.

Children and Trauma

Printed Material

Bassuk, E., Konnath, K., Volk, K. (2007). *Understanding Traumatic Stress in Children.* Newton, MA: National Center on Family Homelessness.

Buckner, J., Beardslee, W., & Bassuk, E.L. (2004). Exposure to violence and low-income children's mental health: Direct, moderated, and mediated relations. *American Journal of Orthopsychiatry*. 74(4): 413-423.

Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. (Eds.). (2003). *Complex Trauma in Children and Adolescents: A White Paper from the National Child Traumatic Stress Network Complex Trauma Task Force*. From the National Child Traumatic Stress Network. For more information, visit www.nctsn.org.

Cook, A., Spinazzola, J., Ford, J.,et al. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*. 35(5): 390-398.

Gil, E. (1983). *Outgrowing the Pain: A Book for and About Adults Abused as Children*. New York: Dell Publishing.

Greenwald, R. (2005). *Child Trauma Handbook*. Binghamton, NY: Haworth Press.

Karr-Morse, R. & Wiley, M. (1998). *Ghosts from the Nursery*. New York: Atlantic Monthly Press.

Shonkoff, J.P. & Phillips, D.A. (Eds.). (2000). *National Research Council and Institute of Medicine. Committee on Integrating the Science of Early Childhood Development: Board on Children, Youth and Families, Commission on Behavioral and Social Sciences and Education. From Neurons to Neighborhoods: The Science of Early Childhood Development.* Washington, DC: National Academy Press.

Websites

Child Trauma Academy ~ www.childtrauma.org
Child Trauma Institute ~ www.childtrauma.com
National Association of School Psychologists ~ www.nasponline.org/NEAT/ptsd.html
National Child Traumatic Stress Network ~ www.nctsn.org

Books for Children about Homelessness

Young Children (3-7)

Asch, F. (1986). *Goodbye House*. New York: Aladdin Paperbacks/Simon and Schuster.

Bunting, E. (1991). *Fly Away Home*. New York: Clarion Books/Houghton Mifflin.

DiSalvo, D. (2001). *A Castle on Viola Street*. New York: Harper Collins.

Groth, B.L. (1995). *Home is Where We Live: Life at a Shelter through a Young Girl's Eyes*. Chicago: Cornerstone Press.

Hammond, A., & Matunis, J.(1993). *This Home We Have Made/Esta Casa Que Hemos Hecho.* New York: Crown.

Polacco, P. (1999). *I Can Hear the Sun.* New York: Putnam.

Testa, M. (1996). *Someplace to Go*. Morton Grove, IL: Albert Whitman and Company.

Weitzman, E. (1996). *Let's Talk About Staying in a Shelter*. New York: Powerkids Press.

Elementary School (5-10)

Gunning, M. (2004). *A Shelter in Our Car.* San Francisco, CA: Children's Book Press.
Kroll, V. (1995). *Shelter Folks*. Grand Rapids, MI: William B. Eerdmans Publishing Company.
Powell, E. Sandy. (1992). *A Chance to Grow*. Minneapolis: Carolrhoda Books.

Middle School (8-12)

Berck, J. (1992). *No Place to Be: Voices of Homeless Children.* New York: Houghton Mifflin.
Carey, J.L. (2004). *The Double Life of Zoe Flynn*. New York: Atheneum Books for Young Readers/Simon and Schuster.
Chalofsky, M., Finland, G., & Wallace, J. (1992). *Changing Places: A Kid's View of Shelter Living.* Beltsville, MD: Gryphon House, Inc.
Greenberg, K.E. (1992). *Erik is Homeless.* Minneapolis: Lerner.
Hubbard, J. (1991). *Shooting Back: A Photographic View of Life by Homeless Children*. San Francisco: Chronicle Books.
Hubbard, J. (1996). *Lives Turned Upside Down: Homeless Children in Their Own Words and Photographs.* New York: Simon and Schuster.

Books for Young Children Healing from Trauma

Young Children (3-7)

Bang, M. (1999). *When Sophie Gets Angry – Really, Really Angry*. New York: Scholastic.
Cain, J. (2000). *The Way I Feel*. Seattle: Parenting Press.
Davis, D. (1984). *Something is Wrong at My House*. Seattle: Parenting Press.
Holmes, M., & Mudlaff, S. (2000). *A Terrible Thing Happened*. Washington, DC: Magination Press.
Jackson, E., & Rotner, S. (2002). *Sometimes Bad Things Happen*. Brookfield, CT: Millbrook Press.
Shuman, C. (2003). *Jenny is Scared—When Sad Things Happen in the World*. Washington, DC: Magination Press.
Vail, R. (2002). *Sometimes I'm Bombaloo*. New York: Scholastic.

Sample Pre-Test

Homelessness and Trauma: A Three Part Training Series

Please complete the following questions by checking the appropriate box(es).

Background

1. **Which of the following best describes your organization? (Check all that apply.)**

- ☐ Homeless shelter
- ☐ Health Care for the Homeless grantee
- ☐ Domestic violence shelter
- ☐ Faith-based organization
- ☐ Supportive housing program
- ☐ Mental health service provider
- ☐ Child care/early education
- ☐ Other:

2. **What best describes your role in the organization? (Check all that apply.)**

- ☐ Social Worker
- ☐ Case Manager
- ☐ Outreach worker
- ☐ Nurse
- ☐ Doctor
- ☐ Administrator
- ☐ Therapist
- ☐ Psychiatrist
- ☐ Teacher
- ☐ Clergy
- ☐ Shelter staff
- ☐ Other

3. **What is your gender?**

- ☐ Female
- ☐ Male

4. **Which of the following best describes your race/ethnicity? You may select more than one category.**

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Hispanic/Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Other:_____

5. **How many years have you worked with people who are homeless or at risk of homelessness?**

- ☐ I do not work with people who are homeless or at risk of homelessness
- ☐ Less than 1 year
- ☐ 1 to 5 years
- ☐ 6 to 10 years
- ☐ 11 to 15 years
- ☐ 16 to 20 years
- ☐ More than 20 years

Training Content

1. The human stress response is the body's way of protecting itself against danger. ☐ True ☐ False

2. The fight-flight-freeze response is something we can control. ☐ True ☐ False

3. Which of the following factors influence a person's response to trauma?

- ☐ Current living situation
- ☐ Duration of the traumatic experience
- ☐ Stage of development
- ☐ Social relationships
- ☐ All of the above
- ☐ None of the above

4. Someone who has experienced traumatic stress will most likely develop Post-Traumatic Stress Disorder. ☐ True ☐ False

5. Your shelter is required to have resident curfews. You work to implement this rule in a trauma-informed way by (Check all that apply.):

- ☐ Setting up a system of penalties for clients who miss curfew.
- ☐ Helping your clients plan their time so that they can arrive at the shelter on time.
- ☐ Working with the shelter director to establish a procedure that avoids penalizing clients who have jobs that make it difficult for them to arrive on time.
- ☐ Reminding your clients to stay at the shelter in the afternoons so that they don't risk missing curfew.

6. Which of the following are possible definitions of trauma-informed services?

- ☐ Services that strive to "do no harm" – to avoid re-traumatizing clients or blaming them for their efforts to manage their traumatic reactions – are considered trauma-informed services.
- ☐ All services provided to clients who have experienced trauma are considered "trauma-informed" services.
- ☐ Both of the above
- ☐ None of the above

7. Many who are homeless have experienced multiple traumas, which are often interpersonal in nature, prolonged, repeated, and severe. This is an example of:

- ☐ Complex trauma
- ☐ Typical trauma
- ☐ Acute trauma
- ☐ Post Traumatic Stress Disorder

8. Which of the following is <u>not</u> a principle of trauma-informed services?

- ☐ Understanding trauma
- ☐ Promoting safety
- ☐ Establishing clear staff authority
- ☐ Integrating care

9. A safety plan… (Check all that apply.)

- ☐ Is reactive
- ☐ Is made in partnership with the client
- ☐ Promotes staff safety
- ☐ None of the above

10. Asking a question such as "I don't know how this is interpreted in your community, can you help me understand it?":

- ☐ Fosters cultural competence
- ☐ Invades the client's privacy
- ☐ Undermines professional credibility
- ☐ None of the above

11. Client goals should be: (Check all that apply.)

- ☐ Made collaboratively
- ☐ Determined by service providers
- ☐ Best kept long-term
- ☐ Dictated by funders
- ☐ None of the above

12. Complex trauma alters the way the brain responds to danger. ❑ True ☐ False

13. Which of the following promotes a client's sense of safety? (Check all that apply.)

- ☐ Good lighting
- ☐ Random room checks
- ☐ Predictable routines
- ☐ None of the above

14. Which of the following is the definition for "Vicarious Traumatization"?

- ☐ Trauma that occurs when a by-stander witnesses a traumatic event happening to someone else
- ☐ When work with clients results in providers experiencing post-traumatic stress responses that can eventually impact their view of themselves and others
- ☐ When children are traumatized by their parents' experiences

15. Building trusting relationships with clients: (Check all that apply.)

- ☐ Involves providing clients with choice and control
- ☐ Includes setting realistic expectations
- ☐ Includes giving clients a set number of chances to achieve their goals
- ☐ Involves many setbacks and challenges

Thank you!

Sample Pre-Test - ANSWER KEY

Homelessness and Trauma: A Three Part Training Series

Please complete the following questions by checking the appropriate box(es).

Training Content

1. **The human stress response is the body's way of protecting itself against danger.** ☒ True ☐ False
2. **The fight-flight-freeze response is something we can control.** ☐ True ☒ False
3. **Which of the following factors influence a person's response to trauma?**

   ☐ Current living situation

   ☐ Duration of the trauma experience

   ☐ Stage of development

   ☐ Social relationships

   ☒ All of the above

   ☐ None of the above

4. **Someone who has experienced traumatic stress will most likely develop Post-Traumatic Stress Disorder.** ☐ True ☒ False
5. **Your shelter is required to have resident curfews. You work to implement this rule in a trauma-informed way by: (Check all that apply)**

   ☐ Setting up a system of penalties for clients who miss curfew.

   ☒ Helping your clients plan their time so that they can arrive at the shelter on time.

   ☒ Working with the shelter director to establish a procedure that avoids penalizing clients who have jobs that make it difficult for them to arrive on time.

   ☐ Reminding your clients to stay at the shelter in the afternoons so that they don't risk missing curfew.

6. **Which of the following are possible definitions of trauma-informed services?**

   ☒ Services that strive to "do no harm" – to avoid re-traumatizing clients or blaming them for their efforts to manage their traumatic reactions – are considered trauma-informed services.

   ☐ All services provided to clients who have experienced trauma are considered "trauma-informed" services.

   ☐ Both of the above

   ☐ None of the above

7. Many who are homeless have experienced multiple traumas, which are often interpersonal in nature, prolonged, repeated, and severe. This is an example of:

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- ☐ Typical trauma
- ☐ Acute trauma
- ☐ Post Traumatic Stress Disorder

8. Which of the following is <u>not</u> a principle of trauma-informed services?

- ☐ Understanding trauma
- ☐ Promoting safety
- ☒ Establishing clear staff authority
- ☐ Integrating care

9. A safety plan… (Check all that apply.)

- ☐ Is reactive
- ☒ Is made in partnership with the client
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10. Asking a question such as "I don't know how this is interpreted in your community, can you help me understand it?":

- ☒ Fosters cultural competence
- ☐ Invades the client's privacy
- ☐ Undermines professional credibility
- ☐ None of the above

11. Client goals should be: (Check all that apply.)

- ☒ Made collaboratively
- ☐ Determined by service providers
- ☐ Best kept long-term
- ☐ Dictated by funders
- ☐ None of the above

12. Complex trauma alters the way the brain responds to danger. ☒ True ☐ False

13. Which of the following promotes a client's sense of safety? (check all that apply)

- ☒ Good lighting
- ☐ Random room checks
- ☒ Predictable routines
- ☐ None of the above

14. Which of the following is the definition for "Vicarious Traumatization"?

- ☐ Trauma that occurs when a by-stander witnesses a traumatic event happening to someone else
- ☒ When work with clients results in providers experiencing post-traumatic stress responses that can eventually impact their view of themselves and others
- ☐ When children are traumatized by their parents' experiences

15. Building trusting relationships with clients: (Check all that apply.)

- ☒ Involves providing clients with choice and control
- ☒ Includes setting realistic expectations
- ☐ Includes giving clients a set number of chances to achieve their goals
- ☒ Involves many setbacks and challenges

Thank you!

Specific Instructions for Parts II:

Creating Trauma-Informed Services and Settings for People Experiencing Homelessness

In Part II, we encourage participants to begin thinking practically and critically about their programs, practices, and organizational culture using a trauma-lens. The first section of Part II is intended to be foundational and theoretical in nature to help establish an understanding of the practices that are introduced in the second section. The second section is designed to be more practical and activity-based. Specific skills are introduced and practiced by participants. We encourage trainers to make this section of the training as interactive as possible and to use your creative energy to develop additional exercises and examples if you desire.

The training lasts approximately three hours, depending on the length of group discussion, group size, break time, etc. Below is a sample agenda for Part II.

Sample Agenda – Part II:
Creating Trauma-Informed Services and Settings for People Experiencing Homelessness

(8:30-12:30)

8:30 Welcome, Introductions, and Review (Slides 1-6)

9:00 What Does It Mean to Be "Trauma-Informed?" (Slides 7-17)

- Defining trauma-informed services
- Comparing and contrasting trauma-informed and traditional service provision

9:40 Principles of Trauma-Informed Care (Slides 18-28)

10:10 Break

10:25 Operationalizing Trauma-Informed Principles:
An Introduction the Organizational Domains (Slides 29-30)

10:35 Supporting Staff Development (Slides 31-38)

11:20 Creating a Welcoming and Safe Environment (Slides 39-51)

12:20 Evaluation and wrap up

***Note**: If your budget permits, you may want to offer beverages (e.g., coffee, tea, water) and light refreshments (e.g., fruit, crackers and cheese) during the break.*

Slide 1

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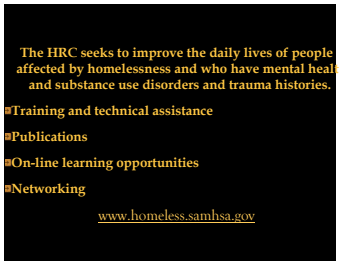
Introduction

- Welcome participants to the training.
- Introduce yourself (and other presenters if applicable).
- Have training participants introduce themselves if time permits.

Slide 2



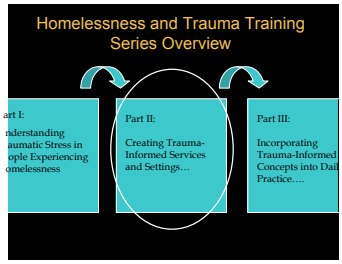
This training curriculum was created by SAMHSA's Homelessness Resource Center, which provides:

- Training and technical assistance.
- Publications.
- Online Learning Opportunities.
- Networking.

Slide 3

Today's training is entitled, "Creating Trauma-Informed Services and Settings for People Experiencing Homelessness."

Slide 4



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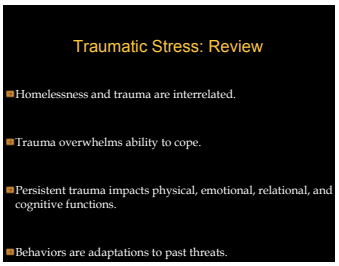
Slide 5



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To set the stage for today's training, briefly review key concepts with participants.

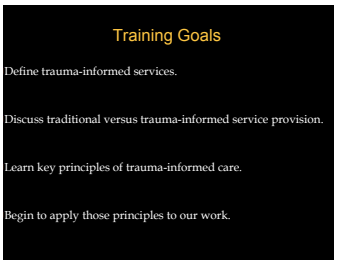
Ask the audience:

> What key points stand out for you from the first part of the training?

Facilitate a brief, large group discussion. After the discussion, cue the animation and review the concepts listed on the slide.

> We learned that:
>
> - People experiencing homelessness often have a long history of interpersonal trauma.
> - A traumatic event overwhelms a person's usual ability to cope and leads to intense responses that may last for varying time periods, depending on how a person perceives the situation and their prior experiences.
> - Repeated and continuing traumatic experiences, like those in the lives of people who are homeless, can have an impact on the physical, emotional, relational and cognitive aspects of people's lives. Complex trauma impacts the brain's alarm system, development, competency, attachment/relationship-building, and view of self and other.
> - Knowledge of the brain's adaptation to trauma, people's sensitivity to danger, and reminders of past trauma (or triggers) highlights the importance of helping clients develop a sense of safety in their environment, within themselves and in relationships with others.
> - By understanding behaviors of traumatized individuals as adaptations to past threat, we can begin to think about ways of developing new adaptations that might lead to more productive outcomes. This approach gives both the provider and client hope that recovery is possible.
> - Because most of our clients have been exposed to high levels of traumatic stress, all services and supports must be provided and developed with an understanding of the impact of trauma.

Slide 6

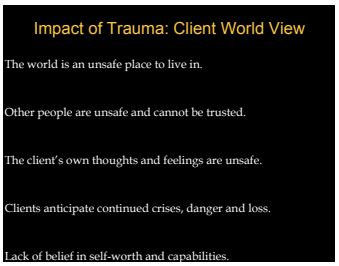


Today, we are going to focus on what it means to be "trauma-informed" in the context of our work with people experiencing homelessness.

We will:

- Define trauma-informed services.
- Compare and contrast traditional approaches to service provision with trauma-informed approaches.
- Discuss key principles of trauma-informed care.
- Begin to apply those principles to our work.

Slide 7



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The experience of trauma is life-altering. It changes one's outlook on the world, especially when the trauma happens in the context of interpersonal relationships. Let's examine this more closely:

Cue animation to show the first two bullet points on screen.

The world is an unsafe place to live in and other people are unsafe and cannot be trusted.

- Those with secure attachments have a view of themselves as "good, wanted, worthwhile, lovable and competent." They view others as being safe and responsive to their needs and they see the world as safe.
- Children and adults with disrupted attachments see themselves as "bad, worthless, helpless and unlovable." They view others as insensitive, untrustworthy and unsafe, and they view the world as an unsafe place.
- Especially for people who have experienced trauma at the hands of those who were supposed to protect and love them, the world becomes an unsafe place in which it is dangerous to trust others.

Cue animation to show bullet point on screen.

The client's own thoughts and feelings are unsafe.

Ask the audience what this means.

- As we discussed in the first session, trauma has significant impact on emotional wellbeing (nightmares, flashbacks, anxiety, depression, etc.)
- These feelings can sometimes become so overwhelming that a person feels unsafe and out of control.
- Clients want feelings to stop because they are too overwhelming.
- May lead to self-medication, self-harm, etc.
- Many single adults who are homeless report problems with alcohol, drugs, or mental health issues in the past 30 days. 66% have used alcohol and/or drugs, or have had mental health problems in past 30 days. [1]

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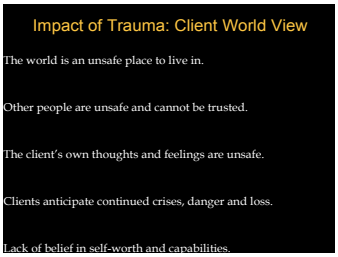
Slide 7, continued



Clients anticipate continued crises, danger and loss.

Cue animation to show bullet point on screen.

Chronic trauma leads people to think 'This is what has always happened to me, so this is what will always continue to happen.'

Remember the reaction of the brain to trauma, which we discussed in the first session. People who have experienced complex trauma are being triggered all the time, so their brains are constantly on alert and sending signals of danger.

Cue animation to show bullet point on screen.

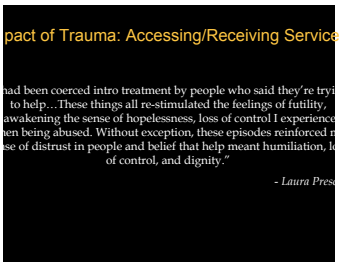
Lack of belief in self-worth and capabilities.

- Trauma takes away people's beliefs that they matter in the world.
- These feelings are so strong that they often inhibit people's ability to see their strengths and capabilities.

Ask the audience some questions to see how this fits with their experience.

- Is what I just described consistent with what you see in your clients?
- Can you give examples of what these things look like? (e.g. inappropriate responses, fewer coping/problem solving skills, difficulty asking for/accepting help).
- Where are your struggles with clients? What behaviors or responses are most difficult to handle or understand?

Slide 8



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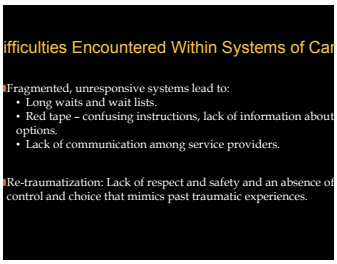
> Trauma survivors' world view also impacts how they access and receive services.

The quote on this slide describes an experience of a woman named Laura who became homeless after running away from a psychiatric institution. Laura has been an advocate for trauma-informed, recovery-oriented service systems for many years. The slide is animated so that you can show the quote to the audience and then have it disappear as you have a discussion on the impact of trauma on service delivery.

Ask the audience:

> What is the impact of trauma on service delivery?
>
> - Lack of trust in providers.
> - Inappropriate responses.
> - Difficulty asking for and accepting help.
> - Difficulty sustaining long-term relationships.
> - Few coping and problem-solving skills.

Slide 9



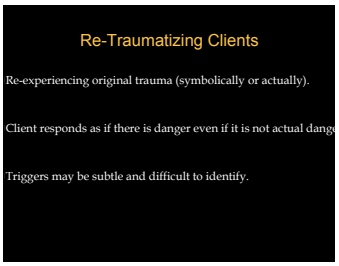
Difficulties within the system compound the difficulties that adults are already experiencing and support views of self as incompetent and the world as dangerous and people as out to get them.

Fragmented, unresponsive systems lead to:

- Long waits and wait lists.
- Red tape – confusing instructions, lack of information about options.
- Lack of communication among service providers.

Clients may experience the system as re-traumatizing due to the lack of respect and safety, and an absence of control and choice, which mimics past traumatic experiences.

Slide 10



Clients can be re-traumatized when past experiences of traumatic stress are re-experienced (symbolically or actually). Here are some examples:

- A woman who has a history of sexual assault is re-traumatized when her doctor insists on conducting a pelvic exam.
- A mother is re-traumatized when a male staff person becomes irritable and impatient with her after she returns to the shelter after curfew.
- A combat veteran is re-traumatized when he walks down a dark street and hears firecrackers being set off on the next block.

In each of these examples the re-traumatization occurred as a result of a reminder, or a trigger, of a previous traumatic event. Triggers can have a significant impact on a person's daily functioning because, when triggered, a person may feel as though she is back in the time of danger, even though she is not, activating the fight, flight, freeze response.

When someone is triggered, they may begin to "space out" (or dissociate), become angry, irritable, distracted, cry uncontrollably, etc. This response occurs because the brain has adapted to be able to detect danger more easily, leading to an individual being more likely to detect danger with even very subtle reminders of the past (e.g., smell, time of day, feelings of loneliness, having little control). As a result, many things in the environment may appear to be threatening and triggers may be subtle and difficult to identify.

We can never create an environment that is completely "trigger-free," but we can create trauma-informed programs that minimize triggers as much as possible. This begins by recognizing that services, programs, and systems can often be both overtly and covertly re-traumatizing.

Ask the audience:

Describe some ways that programs and systems may be overtly or covertly re-traumatizing.

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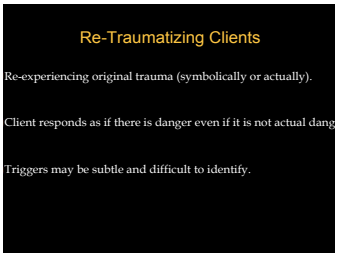
Slide 10, continued



Faciliate a brief, large group discussion. You may want to use the examples below to help the audience get started.

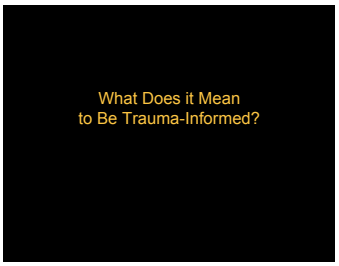
Overt Examples:

- A shelter does not have locks on the bathroom doors, leading to a lack of privacy that makes clients wary of showering/using the restrooms.
- The property around the shelter is not well-lit.

Covert Examples:

- Staff are often put in positions as "rule enforcers" rather than collaborators with clients, leading to power struggles and staff-client conflicts.
- The system/program often determines what the goals should be for the client, rather than having the client identify her own goals/needs.

Slide 11



Given the intense impact and high prevalence of trauma in the lives of our clients, we must ask ourselves how we can use this information to transform our services. In other words, we must become more trauma-informed.

Let's start by defining what it means to be trauma-informed.

Ask the audience:

What do you think it means to be trauma-informed?

Facilitate a brief, large group discussion. You may want to write audience responses on a flip chart.

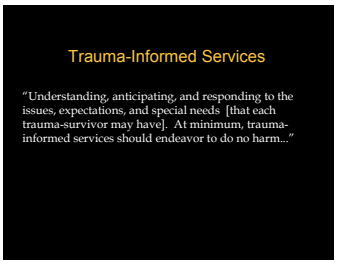
- Potential responses may include understanding that trauma impacts the lives of clients at multiple levels, importance of providing trauma-related services such as counseling, staff training, etc., implications for rules/policies of the program.
- If the audience is having trouble coming up with ideas you may want to ask them some follow-up questions. (e.g., "Now that you know about traumatic stress and its impact, how will your work change?")
- You may also use the example below or one of your own to further illustrate this concept.

Example:

Consider a client who uses drugs to manage anxiety and flashbacks. If these behaviors are only understood as a relapse or lack of commitment to sobriety, neither staff nor the client will make the connections necessary to understand that substance abuse may serve as a way of coping with the impact of trauma and will miss the opportunity to help the client identify triggers to using drugs and alcohol and support to develop healthier coping skills.

The audience's responses will serve as an indication to you about how much knowledge the group has about trauma, trauma-informed systems, etc. You may decide to review additional basic information about traumatic stress if needed (see Homelessness and Trauma Part I: Understanding Traumatic Stress in People Experiencing Homelessness). Wrap up the discussion with a summary of audience responses. If you've used a flip chart to document audience responses, use those as your guide.

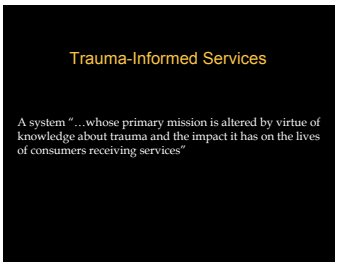
Slide 12



- There is no single definition of what it means to be trauma-informed.
- We offer two definitions today. The first is taken from SAMHSA's Women and Violence study.

Read the definition on the slide slowly and to allow the audience to understand what you are conveying.

Slide 13



The second definition is from Maxine Harris, an expert in the field of homelessness and trauma.

Read the definition on the slide slowly aloud to allow the audience to understand what you are conveying.

In other words, the work done by providers is informed by an understanding of trauma and its impact on the physical and emotional health, cognitive skills and relationships of trauma survivors.

Both of these descriptions have in common the idea that our programs and services should reflect an understanding of the impact of trauma at every level – individual, programmatic, broader systems.

Slide 14

Slide is animated

- Given the pervasiveness of trauma among the people we serve, we can assume that almost everyone who walks through our doors has been exposed to — or is still being exposed to — traumatic experiences.
- When programs provide services without knowledge of, or respect for, clients' traumatic histories, clients can be unintentionally re-traumatized, may not benefit from the services we provide, and may receive inappropriate services.
- Thus, it is important to take a "universal precautions" approach, interacting with everyone we meet in our programs in a trauma-informed way.

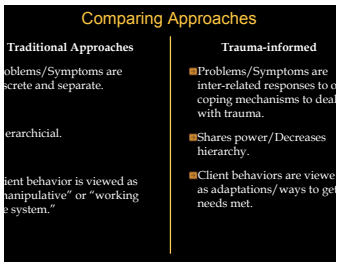
No matter what our role within our organization, we can work to become more trauma-informed. Trauma-informed care must happen at every level of our work.

Cue animation to show each level as you talk about it.

During this session and session three, we're going to discuss in detail different strategies that you, your organization, and the system can implement to create trauma-informed services. Each level has an important role to play and transformation can begin with any of these levels.

- You
- Your Organization
- System

Slide 15



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How do trauma-informed services differ from traditional approaches?

Using the bullet points on the slide and the talking points below, facilitate a discussion about traditional versus trauma-informed discussions. Note that the intention of this discussion is not to blame providers or systems, but to illuminate key themes in service provision through a trauma-informed lens. Cue animation to make each bullet appear as you discuss it.

Traditional: "Problems/Symptoms are discrete and separate."
Trauma-Informed: "Problems/Symptoms are inter-related responses to or coping mechanisms to deal with trauma."

- Our systems and programs are often set up to treat problems/symptoms as distinct from one another (e.g., clients may be told to go to one place for mental health services, another for substance abuse counseling, and a third place for homelessness services).
- In a trauma-informed system, we know that people's problems/symptoms are interrelated (e.g., clients use substances to numb themselves to overwhelming feelings and/or mental health issues, which stem from the chronic trauma they have experienced).

Traditional: "Hierarchial."
Trauma-informed: "Shares power/decreases hierarchy."

- Programs are typically set up with a distinct hierarchy, which can – unintentionally – be frustrating and even re-traumatizing to clients.
- Recall our definition of trauma from the first session: One of the hallmarks of traumatic stress is that it leaves people feeling out of control, helpless, and fearful. Power differentials between staff and clients can often re-create that sense of powerlessness.
- In a trauma-informed system, we try to minimize hierarchy and share power whenever possible.

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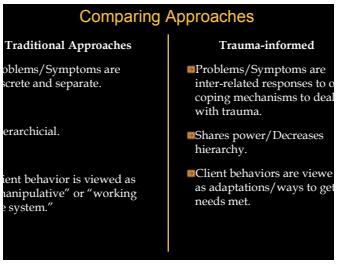


Traditional: Client behavior is viewed as 'manipulative' or 'working the system.'
Trauma-informed: Client behaviors are viewed as adaptations/ways to get needs met.

It is common to hear (or say ourselves) that "she is working the system," or "he's just doing X to manipulate you."

To survive trauma, our clients have learned how to adapt their behaviors in order to meet their basic needs for support, protection, food, shelter, etc. When we look at client behaviors through a trauma lens, we acknowledge that these behaviors are often adaptations and that clients are doing their best to get their needs met, even if their methods are frustrating and/or maladaptive to us.

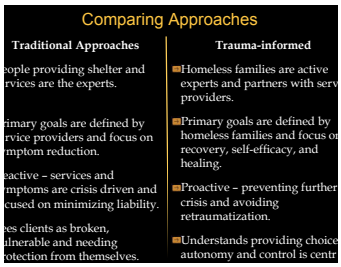
Example:

Consider a client who uses drugs to manage flashbacks and anxiety. These symptoms – and the client's adaptation to them – may be a result of the client's unaddressed trauma history. If we understand his/her behaviors only as a relapse and lack of commitment to sobriety, neither the staff nor the client will make the connections necessary to figure out other ways of coping and decrease the reliance on substances.

Be sure to engage participants in a discussion (if you haven't done so already) before moving to the next slide. Below are some questions that may help you.

- How do these perspectives play out in your daily work?
- Is their tension between these two perspectives? Explain or give examples.
- What are the benefits of taking a trauma-informed approach? What are the challenges?
- Which of these themes or approaches seem the most challenging to you? Which is the most straightforward?

Slide 16



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Cue animation to make each bullet appear as you discuss it.

Traditional: People providing shelter and services are the experts.
Trauma-informed: Homeless families are active experts and partners with service providers.

Ask the audience:

> Why is it important that, if we are using a trauma-informed approach, that our clients are the experts?

- Clients are experts on their own lives. They know what helps and what hurts, what has worked in the past, what their goals are, etc.
- If we are to truly be in partnership with clients, then our jobs become more of "facilitator" rather than "expert."
- This concept also relates back to the idea of minimizing hierarchies.
- Using a "client as expert" approach is strengths-based.

Traditional: Primary goals are defined by service providers and focus on symptom reduction.
Trauma-informed: Primary goals are defined by the client and focus on recovery, self-efficacy, and healing.

- By focusing on symptom reduction, we miss the bigger picture. We must ask 'What led to the symptoms?' 'What is at the root of the problem?'
- Again, clients are experts on their own lives.
- Their goals might not be the goals that we would choose for them, but their life should be within their control.
- Trauma takes away power. When survivors of trauma set goals for their own lives, they are taking an active part in their recovery by taking back the power that was once removed from them.

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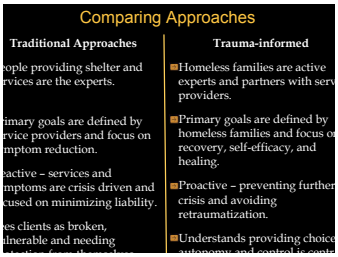


Traditional: "Reactive – services and symptoms are crisis driven and focused on minimizing liability."
Trauma-informed: "Proactive – preventing further crisis and avoiding retraumatization."

Ask the audience:

- Why would a trauma-informed approach strive to be proactive?
- A proactive approach can acknowledges and minimizes triggers.
- When we're proactive, we're in control, so working with clients in a proactive way rather than a reactive way gives them more control over their lives.
- Being proactive means having a "future" orientation, which gives us and clients hope that recovery is possible. Many survivors of trauma lose their "future" orientation because they are just trying to survive day-to-day.

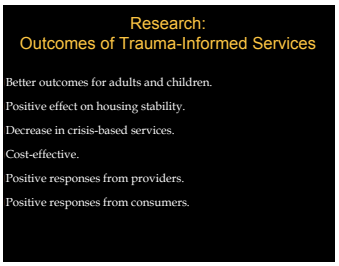
Traditional: "Sees clients as broken, vulnerable and needing protection from themselves."
Trauma-informed: "Understands providing choice, autonomy and control is central to healing."

- Our clients certainly have many challenges, but the fact that they have survived and have come through our doors should remind us just how strong and resilient they are.
- By providing choice, autonomy, and control at every juncture, we can help clients reclaim their lives and heal.

Be sure to engage participants in a discussion (if you haven't done so already) before moving to the next slide. Below are some questions that may help you.

- How do these perspectives play out in your daily work?
- Is their tension between these two perspectives? Explain or give examples.
- What are the benefits of taking a trauma-informed approach? What are the challenges?
- Which of the dynamics seems the most challenging to you? Which is the most straightforward?

Slide 17



A trauma-informed approach is not just the right thing to do, but the smart one as well. Consider the research:

In 2007, Hopper, Bassuk and Olivet conducted a systematic review of qualitative and quantitative research evidence regarding trauma-informed systems. They also interviewed experts working in programs that use trauma-informed interventions. Here is what they learned:

1. Trauma-informed service settings, with trauma-specific services available, have **better outcomes** than "treatment as usual" for many symptoms.

   In adults:

   - Improvement in consumer's daily functioning
   - Decrease in trauma symptoms, substance abuse, and mental health symptoms.

   In children:

   - Better self-esteem
   - Improved relationships
   - Increased safety

2. Early indications suggest that trauma-informed services may have **a positive effect on housing stability.**
   - A multi-site study of trauma-informed services for homeless families found that, at 18 months, 88% of participants had either remained in Section 8 housing or moved to permanent housing
3. A **decrease in the use of crises-based services** such as hospitalization and crisis intervention following the implementation of trauma-informed services[2]

4. When services are trauma-informed and integrated, **they are cost effective**:
   - Because trauma-informed integrated services have improved outcomes but do not cost more than standard programming, they are judged to be cost-effective[3].

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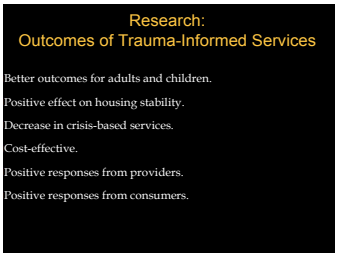
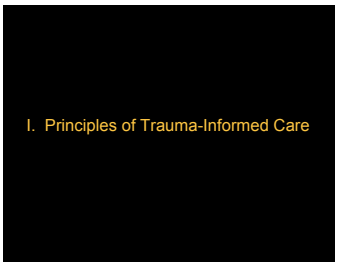


5. Qualitative results find that **providers report positive outcomes** in their organizations from implementing trauma-informed services.
   - Greater collaboration with consumers, enhanced skills, improved staff morale, fewer negative events, and more effective services[4].
6. Qualitative results indicate that **consumers respond well** to trauma-informed services.
   - Increased sense of safety, better collaboration with staff, and a more significant "voice."
   - Within the DC Trauma Collaboration study, 84% of consumers rated their overall experience with these trauma-informed services using the highest rating available [5].

Slide 18



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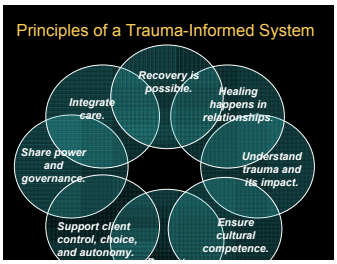
Slide 19



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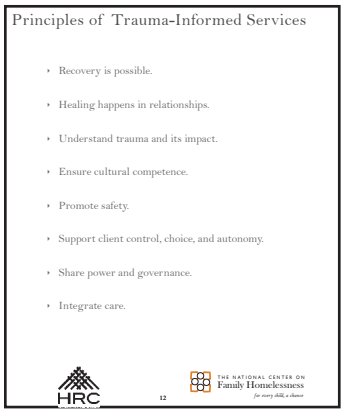
Handout: Principles of Trauma-Informed Services

Introduce the principle.

Handout


Principles of Trauma-Informed Services

- Recovery is possible.
- Healing happens in relationships.
- Understand trauma and its impact.
- Ensure cultural competence.
- Promote safety.
- Support client control, choice, and autonomy.
- Share power and governance.
- Integrate care.

HRC

12

THE NATIONAL CENTER ON Family Homelessness

Over the next few slides, we're going to discuss eight principles of trauma-informed services. These principles make up the core values of a trauma-informed system.

- The principles were developed by the National Center on Family Homelessness through a multi-year process that involved consumers and direct care staff and is based on many years of research and evaluation on homelessness and traumatic stress.
- As you continue thinking about ways to become more trauma-informed, you may want to expand or even add to these principles.

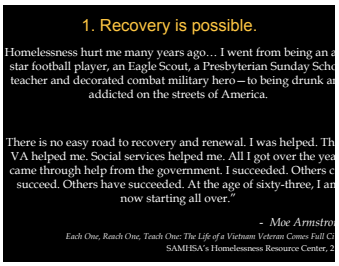
Cue animation as you name each principle.

The principles are:

1. Recovery is possible.
2. Healing happens in relationships.
3. Understand trauma and its impact.
4. Ensure cultural competence.
5. Promote safety.
6. Support client control, choice, and autonomy.
7. Share power and governance.
8. Integrate care.

- The principles are represented by circles because they are interrelated and overlap.
- Over the next few slides, we'll discuss these principles individually. We'll then move into a discussion of how you can apply these principles to your daily work, your program, and your system.

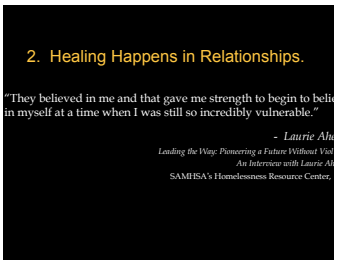
Slide 20



The first principle of a trauma-informed system involves instilling hope that **recovery is possible**.

- It can be a struggle for trauma survivors to take control of their lives and make choices when opportunities are presented.
- Because survivors' brains and bodies continue to be on alert for and react intensely to any possible danger, they have less energy for fulfilling daily responsibilities such as taking care of children, going to work, keeping appointments and communicating clearly with others.
- Continuing to feel incompetent and unable to manage daily tasks only contributes to a lessening self-worth and self-esteem. Trauma survivors require support and practice to build competencies in areas such as vocation, education, parenting, and daily living skills, in order to take more control for themselves and their families.
- We must recognize that trauma impacts all aspects of our clients' lives, and work to instill hope whenever possible. This includes:
  - Using a strengths-based approach. By focusing on client strengths, we work with them to build skills, set and meet goals, and ultimately, help them heal.
  - Recognizing that healing begins with the person who has experienced the trauma, no matter how vulnerable he/she appears to be.

Slide 21



We suggest that you begin this slide by reading the following quote:

> When asked what helped her heal from trauma, consumer-survivor Laurie Ahern remarked that it was "the support of other women who had been impacted by trauma and homelessness as well. I was invited to participate in a women's group by a psychologist who had been diagnosed with manic depression and hospitalized herself. She reached out to me and it really turned my life around. The group bonded with each other." A couple of the women from the group invited Laurie to stay with them until she found a job. "They believed in me and that gave me strength to begin to believe in myself at a time when I was still so incredibly vulnerable."
>
> This leads to our second principle: **Healing happens in relationships**.
>
> - Trauma survivors have often experienced severe interpersonal conflict and violence. These experiences can diminish their ability to form healthy and secure relationships with others in their lives.
> - Experiencing safe, authentic, positive relationships can be tremendously restorative to survivors of trauma.

Ask the audience:

> Why might it be difficult for a trauma survivor to maintain healthy connections/ relationships?

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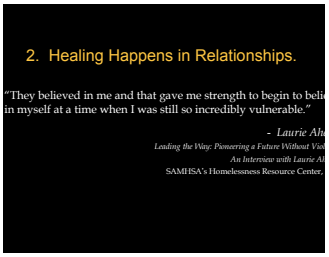
Slide 21, continued



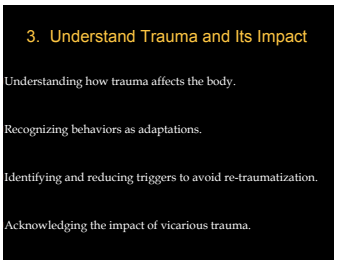
Facilitate a brief, large group discussion using the key points below:

- They frequently anticipate being taken advantage of or abused.
- Relationships may feel triggering to clients.
- At times, a trauma survivor's uncertainty about forming relationships may play itself out in the form of attempts to develop intensely close, intimate connections to others, followed by equally intense withdrawal and rejection.

Conclude the discussion by noting that for many clients, there are challenges associated with relationships.

Trauma survivors have been violated within relationships and frequently struggle to identify both people's intentions towards them and what they are being asked to do within a relationship.

Slide 22



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- Of course, **understanding trauma and its impact** is an essential principle to any trauma-informed system.
- This understanding must come at all levels – providers, programs, and service systems (as discussed earlier).

Ask the audience:

To be trauma-informed, what are key pieces of information we must understand about trauma and its impact?

Facilitate a brief discussion, being to sure to highlight the points below. Cue the slide animation when you think it is appropriate.

Understanding how trauma affects the brain and the body.

- Trauma survivors have different reactions in the present due to their past experiences.
- As you know from the first training in this series, for people who are exposed to chronic danger, the brain's alarm system is continuously activated and the body is constantly taking action to protect itself from dangerous situations.

Recognizing that clients' **behaviors are adaptations** that have been helpful to their survival, even if these responses seem ineffective in the present.

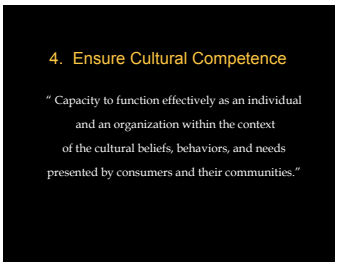
- On-going training and trauma education for providers will help them understand why survivors may be responding in seemingly "maladaptive" ways.

By **identifying and understanding common triggers** of those who have been impacted by trauma, providers can identify and alter daily practices, policies or ways of responding to clients that might result in a client experiencing loss of control or power and being re-traumatized.

Acknowledging the impact of vicarious trauma on providers working with trauma survivors.

- Part of understanding trauma is understanding the impact that it has on us as providers, and taking steps to mitigate that impact by paying attention to our own self-care, working in a team, receiving regular supervision, etc.

Slide 23



Providing **culturally competent services** is also an important principle of being trauma-informed. Our culture is the lens through which all of our experiences and actions are filtered. It is how we make meaning of the world.

Begin by defining terms, highlighting that culture is more than race/ethnicity and religious preference.

- Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.
- Cultural Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by clients and their communities.

The National Center for Cultural Competence describes cultural competence as a "developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum."

Ask the audience:

What do you think being culturally competent has to do with providing trauma-informed services?

Facilitate a brief, large group discussion. Consider the following points as you facilitate the discussion.

- Traumatic events happen to people from all racial, ethnic, religious, and social backgrounds, and the brain's response to trauma is consistent for all trauma survivors. However, cultural context plays a significant role in the types of trauma that may be experienced, the risk for continued trauma, how survivors manage and express their experiences, and which supports and interventions are most effective.
- Violence and trauma have different meanings across cultures, and healing can only take place within one's cultural and "meaning-making" context.

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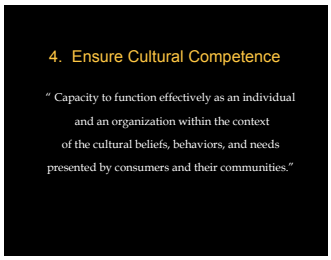
Slide 23, continued

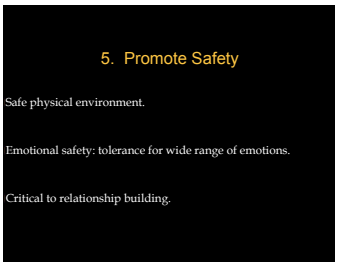


Use the example below or one of your own. You may want to ask the audience for examples of how cultural differences impact their work.

> A Haitian woman and her two children come to your shelter. The children are five and ten years old. The shelter's rules state that each person has and sleeps in his/her own bed. Several staff members notice that this family sleeps in one bed every night, and they are worried that there may be a potential for sexual abuse. However, understanding the cultural context, you recognize that co-sleeping is a cultural norm for this family and is unrelated to trauma.

Providers should understand the diversity of cultures within the population they serve and find ways to respect the values and rituals of those cultures. This may include offering people opportunities to engage in various cultural rituals or religious services, cook specific foods, and speak in their language of origin. A culturally competent approach helps to create a safe and respectful environment in which survivors can begin to rebuild a sense of self and a connection to their communities.

Slide 24



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- The experience of trauma violates one's fundamental sense of safety and security, and so an essential principle of trauma-informed care is that we must **promote safety**.
- Many trauma survivors have lived in chaotic, unpredictable, and violent environments. As a result of their traumatic experiences, clients often live in a perpetual state of fear and distress, and frequently feel overwhelmed and unsafe.

Ask the audience:

What comes to mind when you think of safety?

It is likely that participants' responses will fall into two categories, physical and emotional safety. Cue animation as it is appropriate to your discussions.

Creating a **safe physical space** for clients requires meeting basic needs and creating a safe environment. It includes:

- The environment itself (e.g., good lighting, doors that lock, etc.).
- Meeting a person's basic needs (e.g. warmth, rest, food, safe place to be).
- Consistent and predictable routines/responses.

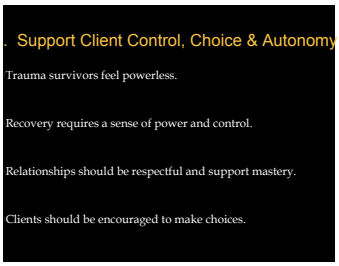
Along with the creation of a safe external environment is the need to create an environment that enhances the client's sense of emotional safety. Helping people establish **emotional safety** can be done in many ways. Emotional safety includes:

- Feeling protected, comforted, in control, heard, and reassured.
- Tolerance of a range of emotions that may be expressed by the client. Tolerance for arange of emotional expressions which enhance the survivor's internal sense of security, and therefore, their ability to regain self-control.

In order to help clients heal, we must form authentic relationships with them. The more safety clients feel – emotionally and physically, the more open they will be to forming relationships.

Note: The theme of staff safety may come up in discussions. While this is important, it is not the focus of this part of the training. If staff safety is mentioned, assure participants that it will be addressed during another portion of the training (see slide 35 of Part II).

Slide 25



The next principle of trauma-informed programs are strategies that **foster client control, choice, and autonomy**. Traditionally, clients have been treated as passive recipients of services. They enter our doors, we tell them what we have to offer, and what they need to do, and they either take it or leave it.

Give an example, using the one below or one from your own experience.

Example

Residents at a shelter may be required to attend a particular group session. They resent being forced to attend and are unclear how it is helpful to them. As a staff member, you become the "enforcer," rounding people up at group time and making sure residents comply with attendance requirements.

Ask the audience:

Keeping that example in mind, why do you think client control, choice, and autonomy is an important principle of a trauma-informed approach?

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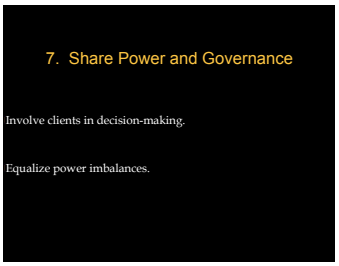
Slide 25, continued

Consider the following points as you facilitate a brief large group discussion:

- Traumatic experiences leave a person feeling powerless. Because trauma survivors have experienced being controlled and overpowered by others, they are used to being in a vulnerable position. A sense of powerlessness and lack of control leads to feelings of terror.
- For trauma survivors to be successfully supported, they require opportunities to participate in a setting and in relationships where they are not in a weak or vulnerable position. Being overpowered by others serves to reinforce that they are helpless and unable to manage life events.
- It is essential for recovery that trauma survivors have control over the direction of their lives. Relationships where providers are in control and are telling survivors what to do and how to do it only serve to re-create traumatizing relationships.
- Within a support system, control, choice and autonomy involve making sure that clients are well-informed about the system in which they reside, outlining expectations, encouraging clients to make choices for themselves, and respecting basic human rights and freedoms that others outside of the system would expect.

Slide 26



The seventh principle, **sharing power and governance**, supports the concept of client control, choice and autonomy.

- Power differentials are common in shelters and other service settings.
- Due to the loss of control and autonomy that results from the experience of trauma, many survivors have not participated in decisions about their own lives or within the larger systems in which they interact.
- In an environment where power and governance are shared, we strive to ensure that all decisions about policies and procedures are made democratically, with inclusion from those at all levels within the system. This means the equalizing of power in relationships between clients and providers and between providers across all levels of an organization.

(You may want to refer back to the earlier discussion of traditional versus trauma-informed approaches).

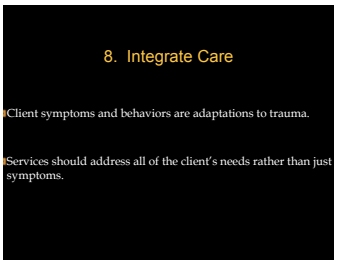
Ask the audience:

What are some examples of power differentials between staff and clients?

Use the following examples and/or some of your own to facilitate a brief, large group discussion.

Examples: Security guards in uniform, staff in position of "rule enforcers" rather than collaborators, room checks, etc.

Slide 27



The final principle is **integrating care.**[6]

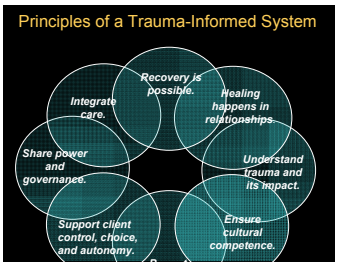
Ask the audience:

Given the discussions we have had today, why do you think integrating care is an essential principle to trauma-informed care?

(If participants need prompting, remind them of the earlier discussion of traditional versus trauma-informed approaches).

- Traditionally, clients have been viewed as the sum of their symptoms. For example, providers sometimes refer to clients by saying "She's borderline." or "He's bipolar."
- Accordingly, symptoms have been treated distinctly and separately from one another (e.g., medications for schizophrenia, substance abuse counseling for drug use, etc.).
- In a trauma-informed system, we consider clients' diagnoses and behaviors as adaptations to the trauma they have experienced. Thus, the services we provide treat the whole client, not individual parts of his/her diagnoses. In other words, understanding the impact of trauma on the individual means understanding that a wide range of behaviors may grow out of an underlying experience of trauma.
- Trauma survivors may struggle with symptoms associated with many disorders such as depression, anxiety, and post trauma responses. They may have many physical complaints and medical issues, and they may abuse substances or exhibit self-injurious behaviors.
- When responding to the wide range of behaviors exhibited by clients, it is important for providers to attempt to understand the "big picture" of how these separate behaviors may be a way for clients to manage overwhelming feelings associated with past traumatic experiences.

Slide 28



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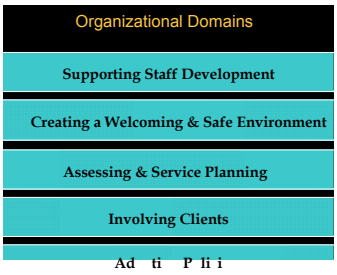
Review the principles one more time by reading each one aloud. This may also be a good point to ask participants if they have any questions.

Transition to the next part of the training.

> Now that we've talked about the principles of a trauma-informed approach, it is time to figure out how we are going to apply these principles to our daily work.

Slide 29



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Thinking about making our whole program or system trauma-informed can be overwhelming.

Instead, we're going to break our work down into domains:

- Supporting Staff Development
- Creating a Welcoming and Safe Environment
- Assessing and Service Planning
- Involving Clients
- Adapting Policies

This framework was developed by the National Center on Family Homelessness as a way to operationalize the principles we just discussed.

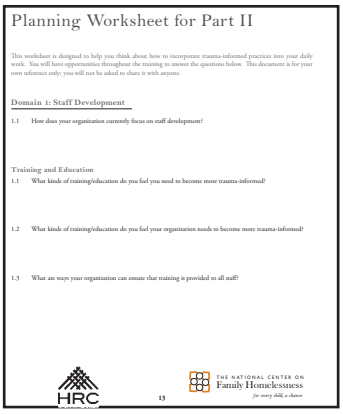
No matter what your role at your organization, you can play a part in providing trauma-informed services

You may want to mention the diagram from slide 14.

Note: Much of the rest of training involves breaking participants into small groups. If you are working with a large group, you may want to assign people to groups ahead of time, or have them seated in small groups from the beginning of the day. For more information on ways to divide participants, see the Trainer's Guide to this training.

Slide 30

Handout


Planning Worksheet for Part II

This worksheet is designed to help you think about how to incorporate trauma-informed practices into your daily work. You will have opportunities throughout the training to answer the questions below. This document is for your own reference only; you will not be asked to share it with anyone.

Domain 1: Staff Development

1.1 How does your organization currently focus on staff development?

Training and Education

1.1 What kinds of training/education do you feel you need to become more trauma-informed?

1.2 What kinds of training/education do you feel your organization needs to become more trauma-informed?

1.3 What are ways your organization can ensure that training is provided to all staff?

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13

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for every child, a chance

Slide is animated

> We will apply the principles when discussing each of these domains.

Cue animation.

> Before we begin talking about each of these domains in depth, let's talk about the overall change process:
>
> - Creating an environment that supports people who have experienced trauma is an ongoing process that takes time.
> - Change happens in phases rather than overnight. It requires commitment and energy from providers at all levels of an organization, including administrators, supervisors, case managers, support staff, and volunteers.
> - It is important to acknowledge that programs may have more strengths in some domains than in others, but ultimately, all domains must be addressed.

Distribute or instruct participants to take out their "Planning Worksheet for Part II."

> - We will refer to the worksheet during each domain.
> - It gives you an opportunity to write down your thoughts and ideas about creating a more trauma-informed environment in your program and will help you break down goals to begin to develop a strategic plan.
> - The worksheet can be something you use on an on-going basis, after this training, as you begin the process of change.
> - The worksheet is for your reference only. Although we will be discussing the questions from the worksheet, you won't have to show it to anyone else or hand it in.

Slide 31

Introduce **Staff Development**.

We are all aware of the high rates of burnout in this work. This may result from ongoing frustrations, failures of the system, and overwhelming demands placed on providers who are often working with limited resources.

- Burnout leads us to feel less effective, less focused, dissatisfied, and exhausted.
- Burnout may happen in many workplaces, but for those who work with trauma survivors the rates are high: hearing about the painful experiences of others, witnessing society's injustices, feeling unable to "fix" or "cure" the problems our clients face puts us at further risk for burnout.
- Because of the unique challenges faced by providers working with trauma survivors, staff development is critical for creating a trauma-informed environment.

Refer participants to question 1.1 on their "Planning Worksheet:" *How does your organization currently focus on staff development?* Give participants about a minute to write before asking them the following questions (one at a time).

- What comes to mind when you think of supporting staff development?
- How does supporting staff develop reflect the principles of trauma-informed services that we've been talking about?

Continued on next page...

Slide 31, continued

Facilitate a brief discussion, being sure to highlight these points:

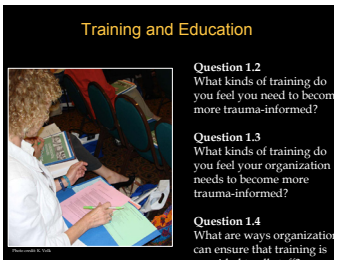
- Staff development helps providers give good care to clients and support them in the process of recovery.
- In a world where traumatic events impact so many, sustaining the work force is especially important.
- Staff development increases provider's sense of satisfaction with work as well as feelings of being effective, which leads to better care.

Conclude the discussion with the following transition:

There are three main components to staff development:

1. Training and education
2. Self-Care
3. Supervision and support

Slide 32



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Training and Education

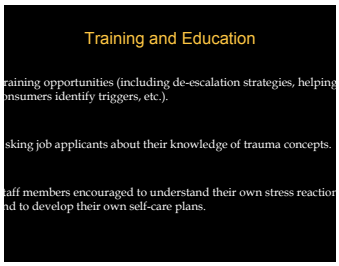
- Trauma and its impact on survivors can be confusing, complicated and difficult to define and understand. Education about trauma, whether through trainings, conferences or on-going consultation, is necessary in order to provide quality care to trauma survivors.
- Trauma survivors have often developed very specific ways of managing their experiences and getting their needs met that can easily be misunderstood by those who do not understand the effects of trauma.
- Training everyone — administrators, providers/clinicians, support staff, clients, maintenance staff and anyone else associated with the organization — about violence and other traumatic stressors creates an open, informed atmosphere that enables people to respond to each other in a trauma-informed way.
- Rather than providing training to a few who then become the "experts," organizations should develop plans to train everyone so the entire environment is altered.

Either break participants into small groups or have them work in pairs to respond to questions 1.2, 1.3, and 1.4 on their worksheet. The questions will also appear on the slide as you scroll through the animation.

- What kinds of training do you feel you need to become more trauma-informed?
- What kinds of training do you feel your organization needs to become more trauma-informed?
- What are ways organizations can ensure that training is provided to all staff?

Give participants 5-7 minutes to discuss the above questions. Then lead a large group discussion. To keep the group focused and within the allotted time, we suggest that you limit the discussion to one of the questions rather than all of them (Pick the question you feel would lead to the most fruitful discussion).

Slide 33



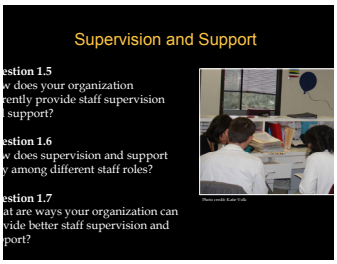
The slide text lists ideas that may or may not have come up in your discussion. Share them with participants.

- Training opportunities (including de-escalation strategies, helping consumers identify triggers, etc.)
- Asking job applicants about their knowledge of trauma concepts
- Staff members encouraged to understand their own stress reactions and to develop their own self-care plans.

Given that many of the participants may work in programs/organizations that are understaffed and under-resourced, they may need help in thinking creatively about training in their organization. Share these examples to help them along:

- Training can be provided in the context of staff meetings, especially for those concerned about staff not having time to attend trainings due to the constraints of their jobs.
- Training can be provided by local experts. Finding out who provides trauma training in your community and how training can be accessed for less cost is one way to utilize local resources.

Slide 34



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Another component of **Supporting Staff Development** is "supervision and support."

Begin by defining supervision.

- One-on-one supervision allows the program to meet the individualized needs of each staff member, enabling them to learn how to apply general trauma concepts to real life work situations, discuss and practice specific ways of responding to and helping consumers, understand their own responses to consumers, and monitor job frustration or burn-out.
- Supervisor training in trauma is essential.
- Smaller team meetings are a forum for open communication, peer support, and additional training and education.
- Large group trainings are essential for initial staff education about trauma, but these trainings alone are insufficient in providing support to staff.

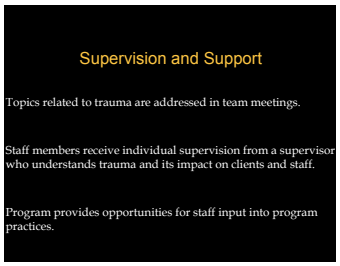
Break participants into small groups to respond to the following questions on their worksheet. The questions will also appear on the slide as you scroll through the animation.

- Question 1.5: How does your organization currently provide staff supervision and support?
- Question 1.6: How does supervision and support vary among different staff roles?
- Question 1.7: What are ways your organization can provide better staff supervision and support?

Ask the audience:

- What stands out about your small group discussion?
- What did you learn?
- What about supervision and support is trauma-informed?

Slide 35



Supervision and support:

- Reduces providers' sense of working in isolation.
- Increases effective communication.
- Offers opportunities for input and feedback into services and policies that creates ownership and increases commitment to the organization.
- Allows providers ways to process difficult or crisis situations.

Example of Staff Support:

- One shelter provides staff support with a weekly team meeting for all staff (case managers, support staff, and administrators). They use this meeting to communicate about resident's needs, giving everyone a chance to share their perspectives. They talk in-depth about clients they may be struggling with, how they are responding, and working together to make decisions as a team about the best strategy to help that client. This time is also used to strengthen their team by sharing snacks, conducting team building activities, and engaging in relaxation and calming activities.

The slide text lists ideas that may or may not have come up in your discussion. Share them with participants.

- Topics related to trauma are addressed in team meetings.
- Staff members receive individual supervision from a supervisor who understands trauma and its impact on clients and staff.
- Program provides opportunities for staff input into program practices.

The relationship of the first two ideas on the list to trauma-informed practice may be more obvious to participants than the third, so ask participants:

Why is staff input into program practices a component of a trauma-informed system?"

Answers may include: staff feels less isolated, more empowered, has more ownership over work environment, etc. If "staff safety" came up in your earlier safety discussion, point out that through staff input into program practices, issues of staff safety can be addressed.

Slide 36

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The final component of **Support and Supervision** is "Self-Care."

- As we have discussed, training is important to better understand how our client's are affected by trauma and how we can best help them. However, using this knowledge to change the way we provide care requires energy, focus, compassion, and commitment.
- This work may be draining and sometimes very frustrating. We run into problems with the system, with clients, and in our own lives that challenge our ability to be present and focused.
- To address these natural aspects of the work, we must pay attention to taking care of ourselves.
- Remember what they say when you board a plane: In the event that the cabin loses air pressure, oxygen masks will drop from the ceiling. Be sure to secure your mask first before assisting others.

Ask the audience:

Why do they tell us to do that?

(Allow participants to offer brief comments.)

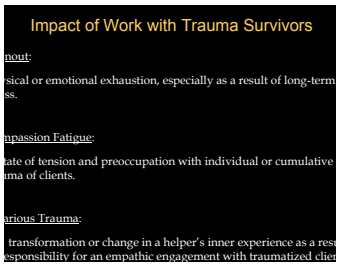
It is important that we take care of ourselves first, so that we are better equipped to take care of those around us.

Instruct participants to answer question 1.8 on their worksheet: "What does self-care mean to you?"

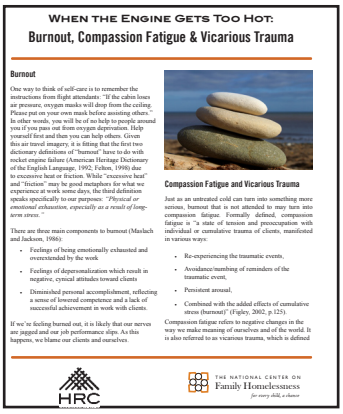
Cue animation.

Facilitate a brief discussion, eliciting participants' ideas about what self-care means to them.

Slide 37



Handout


WHEN THE ENGINE GETS TOO HOT:
Burnout, Compassion Fatigue & Vicarious Trauma

Burnout

One way to think of self-care is to remember the instructions from flight attendants: "If the cabin loses air pressure, oxygen masks will drop from the ceiling. Please put on your own mask before assisting others." In other words, you will be of no help to people around you if you pass out from oxygen deprivation. Help yourself first and then you can help others. Given this air travel imagery, it is fitting that the first two dictionary definitions of "burnout" have to do with rocket engine failure (American Heritage Dictionary of the English Language, 1992; Felton, 1998) due to excessive heat or friction. While "excessive heat" and "friction" may be good metaphors for what we experience at work some days, the third definition speaks specifically to our purposes: *"Physical or emotional exhaustion, especially as a result of long-term stress."*

There are three main components to burnout (Maslach and Jackson, 1986):

- Feelings of being emotionally exhausted and overextended by the work
- Feelings of depersonalization which result in negative, cynical attitudes toward clients
- Diminished personal accomplishment, reflecting a sense of lowered competence and a lack of successful achievement in work with clients.

If we're feeling burned out, it is likely that our nerves are jagged and our job performance slips. As this happens, we blame our clients and ourselves.

Compassion Fatigue and Vicarious Trauma

Just as an untreated cold can turn into something more serious, burnout that is not attended to may turn into compassion fatigue. Formally defined, compassion fatigue is "a state of tension and preoccupation with individual or cumulative trauma of clients, manifested in various ways:

- Re-experiencing the traumatic events,
- Avoidance/numbing of reminders of the traumatic event,
- Persistent arousal,
- Combined with the added effects of cumulative stress (burnout)" (Figley, 2002, p.125).

Compassion fatigue refers to negative changes in the way we make meaning of ourselves and of the world. It is also referred to as vicarious trauma, which is defined

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Handout: "When the Engine Gets Too Hot: Burnout, Compassion Fatigue, and Vicarious Trauma"

Ask the audience:

> Why do we discuss self-care at a training about trauma?

Allow a minute or two for brief responses from participants.

> - Daily, we witness our clients struggle in their relationships, how they feel about themselves, their physical health, and how effective they are as parents, students, and employees.
> - These experiences can leave us with feelings of sadness, anger, frustration, guilt, and anxiety--and lead to less motivation, focus, and empathy. When this occurs it is commonly referred to as **burnout**.

Cue animation.

> - Additionally, as we listen to the stories of survivor's experiences, witness clients re-enact their traumatic experiences, and encounter our client's being re-traumatized, many of us experience symptoms that mimic those of our clients such as having nightmares, difficulty sleeping, replaying situations over and over in our heads, and becoming more agitated or irritable. This is commonly referred to as **Compassion Fatigue** or **Vicarious Trauma**.

Cue animation.

> These occurrences happen as a natural part of our work. Because we are human, we are naturally affected by the work we do and the people we work with. Additionally, many of us who do this work have also experienced trauma in our own lives. Doing this work can serve as a reminder of our own experiences.

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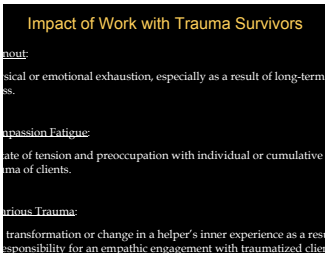

Use the examples from the handout (listed below for your reference) to generate a discussion. We suggest you read the examples aloud, and then ask participants if they can identify with them.

- A female case manager working with women who have been sexually assaulted assumes that all the men she encounters are unsafe.
- A counselor finds himself thinking, "yeah, right – whatever," in response to a story told by a friend/ client/colleague with whom he has always had a trusting relationship.
- Someone you've supervised for years has developed a recent habit of checking in with you before making any decisions, questioning whether his actions have any value to the clients he once worked with confidently.
- A social worker whose favorite way to relax is to spend time with her children finds herself wishing they would go away.

Summarize the discussion.

- If we are burned out, we feel emotionally depleted.
- If we are experiencing compassion fatigue, however, we may experience changes in our ability to trust, have difficulty with intimacy, be concerned about our own safety, and experience intrusive imagery related to the traumatic stories to which we have listened.
- Therefore, a trauma-informed perspective recognizes that trauma impacts staff and creates an organizational culture where self-care is valued and recognized.

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We have to take an active role in protecting ourselves from compassion fatigue/vicarious trauma, which means paying attention to our own self-care and to creating a culture of self-care within our organizations.

One way to think about this is by considering the ABCs[7]:

- **Awareness**: Involves accepting that compassion fatigue is common to our work and doesn't imply anything negative about us.
- **Balance**. Consider the rule of thirds. A third of the day is spent working, a third spent playing, and a third spent resting. How many here can say they follow that rule?
- **Connection** is important both professionally and personally. Remember the second principle: Healing happens in relationships. Just as our clients need relationships to be healthy, so do we. Isolating ourselves is a sure-fire way to become burned out.

Refer back to your worksheet and answer question 1.9: What does it mean to have an organizational culture of self-care? What can you do to foster self-care at your organization? For yourself?

Note: Decide ahead of time whether you want participants to answer these questions individually, discuss them in pairs, talk about them in small groups, etc. and instruct them accordingly.

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Slide 38, continued

Facilitate a discussion based on participants' answers to questions in part 1.9. Use the ideas on the slide (also listed below) as suggestions.

Know your own triggers and warning signs.

- We all have our own triggers. Part of being aware is understanding what those are. This also involves knowing what the warning signs are that we are under too much stress (e.g., snapping at co-workers, having trouble listening to clients, etc.)

Be alert to what you expose yourself to outside of work.

- If we're exposed to many traumatic and difficult stories at work, it may be best to limit our exposure to those types of stories outside of work (e.g., "made-for-tv" dramas that draw on themes similar to those we encounter at work – crime, rape, violence, etc.).

Set boundaries.

- Whenever possible, limit when and where you check work messages and emails.
- Determine what balance between personal and work life is acceptable to you (e.g., Some don't mind working late during the week as long as they never have to work on weekends. For others, the balance might be different).
- For those providing therapy or counseling services to families, sometimes it is helpful to work with clients who are at a different age than your own children (e.g., if you have a five year old, try to take cases with older children or vice versa).

Add variety to your work.

- Eat lunch with colleagues.
- Arrange your day so that you are doing a variety of different kinds of tasks.
- Create times to play and laugh while working.

Maintain your relationships inside and outside of work.

- Spend time with friends and family who are important to you.
- Engage in hobbies with friends/families that involve a new or different skill.

Build self-care into your routine – at work and at home.

- We are more likely to make something a part of our everyday life if it is part of our routine.
- We can model good self-care for our colleagues.

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Summarize the ground you've covered so far:

- We've just finished talking about supporting staff development, the first domain.
- We talked about three components: training and education, supervision and support, and self-care.

Now we're going to talk about the next domain: **Creating a Supportive and Safe Environment.**

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Introduce "Creating a Supportive and Safe Environment."

People who are experiencing homelessness encounter many stressors. Along with other experiences of trauma, they are faced with loss of familiar routines, their home, and their community. They are exposed to environments that are chaotic, unpredictable, and unsafe.

- For those who have experienced ongoing trauma, there is often a general lack of trust in others. Overall, our clients lose a sense of stability and safety. Their experiences are powerful and, unfortunately, the system of care, which can be fragmented, unpredictable, and rigid, can cause survivors to re-experience feelings associated with trauma.
- The environment of an organization impacts how a trauma survivor perceives the care giving experience and plays a pivotal role in supporting recovery. A trauma-informed environment increases a client's sense of safety, ability to feel in control, and sense of competence.

Ask the audience:

What are the components of a supportive and safe environment? What comes to mind when you think of an environment that is supportive and safe?

After participants have given their suggestions and ideas, ask this follow-up question (Refer participants to their "principles" handout to refresh their memories.

How do these components reflect the principles?

Conclude the discussion:

The two components we're going to discuss today are:

- Establishing a safe physical environment
- Establishing a supportive environment

Note: As with the earlier discussion about "Promoting Safety," participant comments will most likely fall into these two categories.

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- Creating a safe and welcoming physical environment provides a sense of safety and security that is essential to the trauma survivor who is always on the look-out for danger.
- This begins from the moment a client walks through the door; the way they are greeted and oriented to the space can set the tone for the developing relationship. When clients are familiarized with the living space, such as being shown light switches and the locations of restrooms and how to lock them, it increases their sense of ease and control.
- Maintaining the overall environment — fixing things when they are broken, sweeping/dusting/mopping, and spraying for bugs — conveys respect for clients.
- Additionally, creating a safe environment by keeping it well-lit, enacting security measures, and making clients aware of these measures can create a sense of comfort and stability for clients.

Give participants the following instructions:

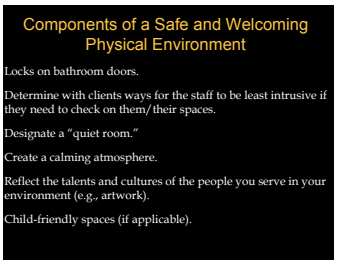
> Close your eyes and picture your organization's physical space. Focus on one of the following places: the community room, an office where clients and staff meet, or the waiting/reception area. What do you see? Notice the physical layout of the room. What about the room's security? What about privacy? What does the overall atmosphere convey? How? Open your eyes.
>
> I'm going to handout paper and crayons, and would like each of you to take 10 minutes to draw the space that you just envisioned, with any additions/changes you would make to the space to make it more welcoming/safe for clients. Be realistic and honest, but also keep in mind what we have been talking about today.

Cue animation.

After you have given instructions, distribute paper and crayons/markers (if you hand these materials out beforehand, it is less likely that people will pay attention to the instructions).

Ask several participants to share their drawings with the group. Ask them what space they chose to focus on, why they chose that space, and to describe the room, including any changes they would make to it.

Slide 42



How does creating a safe and welcoming physical environment help trauma survivors?

- Trauma survivors often have powerful emotional responses they may not have learned how to mange. As a result, some clients can be explosive, oppositional, or withdrawn.
- A relaxing and comforting environment helps increase the likelihood that they can soothe themselves and find comfort.
- It conveys respect. When we have guests in our homes, we like to make sure that our house is clean, inviting, welcoming. Creating welcoming environments is one way to show our clients that we respect them.

Provide participants with some ideas:

Locks on bathroom doors.

- Especially in the bathroom, clients should have a place where they can feel safe and gain some privacy.

Determine with clients ways for the staff to be least intrusive if they need to check on them/their spaces.

- The reality of our work is that we may have to check on clients or their space from time to time, but there are ways that we can go about it in a trauma-informed way. Establish policies in partnership with clients, and make everyone in the program aware of those policies.
- Checking on clients in their private space without their permission serves to reinforce the power differentials between staff and clients and can be re-traumatizing.

Designate a "quiet room" with soft lighting and comforting décor (e.g., blankets, rocking chairs) where clients can go if they need some quiet space to deal with powerful emotions.

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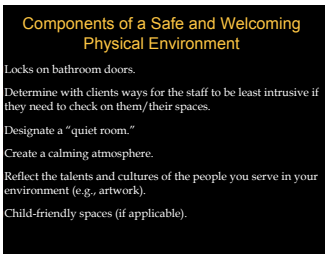

Create a calming atmosphere by having plants, fish tanks, music, comfortable seating, rocking chairs/gliders, bedrooms with new bedspreads, place to exercise, curtains, place for kids to play.

Reflect the talents and cultures of the people you serve in your environment.

Involving clients in designing and decorating, not just in maintenance, creates a sense of community and empowerment. Including clients supports them in becoming part of the program community, not just someone being served by the program.

- Ways to involve clients include: Art (ideally, from projects determined by clients), provide spaces to hang children's artwork, setting up an "environment" committee where clients can determine ways in which they would like to improve/change the physical space, etc.

Child-friendly spaces (if applicable).

- Children relax, learn and express themselves through play.
- Include developmentally appropriate materials, and toys that give children opportunities for creative play (e.g., dress up area, art supplies, etc.) and interactive play (e.g., books, games for families to play together, etc.).

Direct participants to their worksheets and ask them to answer questions in question 2.1: How could you help your organization create a more welcoming and relaxing physical environment? How can clients be involved in this process?

After the discussion, provide a brief summary of the group's responses and move onto the next slide.

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Ask the audience:

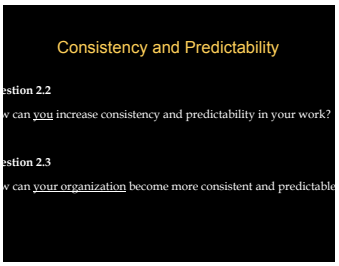
> What comes to mind when you think of creating a supportive environment?

Generate a list of participant ideas and then introduce the list on the slide.

Cue animation.

> There are a few ideas in particular that we are going to highlight:
>
> - Consistency and predictability
> - Transparency
> - Safety and crisis planning
> - Cultural competence
> - Privacy and confidentiality
> - Open and respectful communication
> - Building trusting relationships

Slide 44



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Ask the audience:

> Why is being consistent and predictable an important quality to a trauma-informed environment?

Facilitate a large group discussion. Consider the following points as you facilitate the discussion:

- Remember our early discussions about trauma's impact:
  - Traumatic stress is overwhelming and chaotic.
  - Trauma takes away a sense that the world is safe.
  - When we are triggered, our body reacts as though it is in a dangerous situation, so chemicals are firing and we energy to release. This can leave us – our clients – feeling that even their bodies are out of control.
- Being consistent and predictable can help to instill a sense of calm in clients, which in turn helps them better focus on their goals, whatever they may be.
- Consistency at the service level creates trust between the client and the provider, and is the foundation for building healthy relationships.
- Being consistent and predictable for clients means defining your role, including its obligations and limitations, describing what is confidential and what is not, and being aware of your physical boundaries including touch and tone of voice.
- You must set emotional boundaries as well, such as sharing private information, the intensity of your emotional responses to clients, personalizing a client's responses, and how you react to the success or failure of a client.

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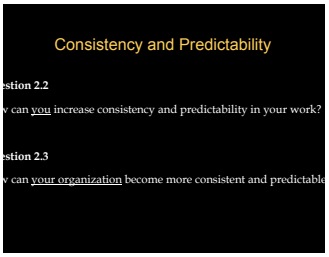

Ask the audience:

> What are some obstacles you may face to achieving consistency?

> Obstacles:
>
> - Difficulty working with multiple systems and providers, many of whom have different agendas.
> - Differences in both staff and client values and experiences, and in trying to meet the needs of everyone all of the time.
> - Unpredictability in the amount of time we work with a client, including the multiple transitions that occur in these settings.
>
> Potential strategies to overcome obstacles:
>
> - Organizations have found ways to overcome obstacles to achieving consistency both at an organizational level and at a service level.
> - The organizational level includes the routines, practices, and policies of a program.
> - Building consistency into the organization provides structure and predictability for clients and increases the ability of staff to follow through and manage crisis situations. When this occurs clients feel safer and more in control and staff feel more competent and satisfied with their jobs.

Refer participants to questions 2.2 and 2.3 on their worksheet. The questions will also appear on the slide as you scroll through the animation.

> - How can you increase consistency and predictability in your work?
> - How can your organization become more consistent and predictable?

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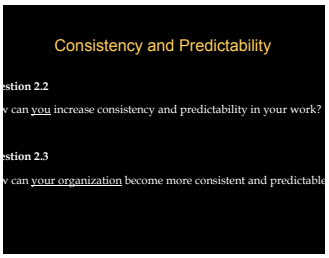


After a few minutes, facilitate a large group discussion on participants' responses to questions. Consider the following points as you facilitate the discussion:

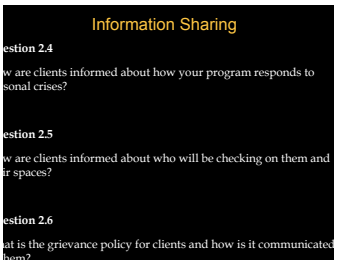
Individual consistency and predictability:

- Being predictable and consistent!
- Meeting with clients at scheduled times and keeping these appointments.
- Using calendars and reminders about appointments.
- Giving advanced notice of changes in meetings.
- Establishing a structure or routine in your meetings.
- Doing what you say you are going to do.
- Being honest.

Organizational consistency and predictability:

- Define staff roles and provide adequate supervision.
- Work as a team and communicate well.
- Use trainings, staff meetings, shift change meetings, and peer supervision as opportunities to reinforce consistency.
- Communicate across departments to ensure everyone is working towards consistent goals.

Slide 45



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Introduce "Transparency and Information Sharing" as part of creating a safe and supportive environment:

- Violent and abusive acts often occur in secret and isolate the victim.
- Survivors are sometimes required to keep their abuse a secret to ensure their safety or the safety of those around them.
- Traumatic experiences can also result in feelings of shame and guilt on the part of trauma survivors, which perpetuates the belief that these experiences must be kept hidden.
- Trauma survivors are not used to being able to express themselves openly and be heard and respected.

Transparency and information sharing, then, become essential components of creating a supportive, trauma-informed, environment.

Ask the audience:

How can we promote transparency and information sharing of decision-making in our daily work with clients?

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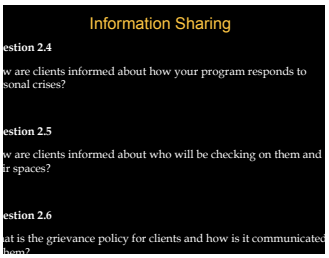


Facilitate a brief brainstorming session with the group, and then instruct them to work in small groups to discuss questions 2.4, 2.5, and 2.6 on their worksheet, which have to do with particular aspects of creating a transparent organizational culture.

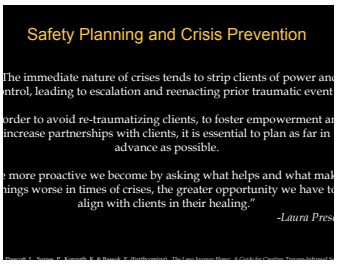
Cue animation.

- How are clients informed about how your program responds to personal crises (e.g., suicidal statements, violent behavior)?
- How are clients informed about who will be checking on them and their spaces (including the process, how often, and why it is important)?
- What is the grievance policy for clients and how is it communicated to them?

When participants are finished answering questions, or after a few minutes (depending on how much time you have left), bring their attention back to the large group and conclude by reminding them the following:

- Rules and expectations should be clearly explained to the client both in discussion and in writing
- Recognize that information may need to be repeated because people who have experienced trauma may have difficulty retaining and processing information.

Slide 46



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We have included examples of safety plans and crisis prevention plans in the training manual. It may be helpful to refer to these during this part of the training.

Introduce "Safety Planning and Crisis Prevention" as a way to create a trauma-informed environment. Depending on the experience of the audience, you may want to start with

asking participants to explain what a safety plan is.

- Safety is a foundational principle of trauma-informed care. If trauma survivors don't feel safe, they will have difficulty focusing on obtaining and maintaining housing, finding and maintaining employment, and caring for children.
- Trauma-informed care requires proactive interventions, rather than being reactive in the moment. In order to achieve this it is helpful to consider potential safety issues and plan ahead to create a sense of safety.
- This can be accomplished by creating plans to keep clients safe from outsiders such as violent partners who may try to locate them (a safety plan) and by helping clients identify ways to feel safe in their own bodies (crisis prevention plan).

These plans are most effective when they are developed before the crisis happens.

Cue animation.

- As Laura Prescott, a consumer-survivor, stated, "Crisis can lead to the use of coercion and force, such as police or security intervention. The immediate nature of crises tends to strip clients of power and control, leading to escalation and reenacting prior traumatic events. In order to avoid retraumatizing clients, to foster empowerment and increase partnerships with clients, it is essential to plan as far in advance as possible. The more proactive we become by asking what helps and what makes things worse in times of crises, the greater opportunity we have to align with clients in their healing."

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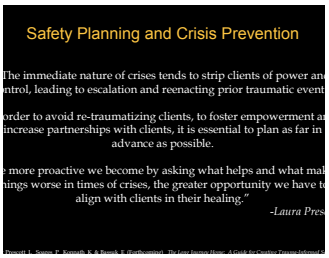


(To illustrate this concept further, read the example below aloud.

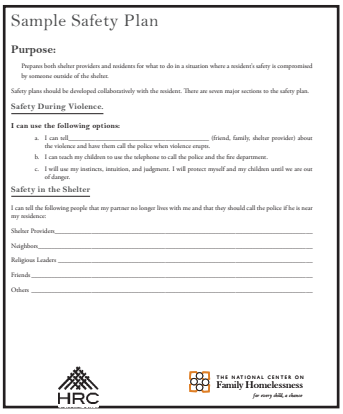
Example:

Anna comes to a shelter after being terminated from other shelters due to her aggressive behavior. On her second day, she gets into an argument with another client who she says was disrespectful. Anna did not become physically aggressive during the argument, but she was yelling and swearing at the other client.

A Reactive Response: Write Anna up for yelling and swearing because it is against the rules of the shelter; remind her of the rules and how many warnings she receives before a termination.

A Proactive Response: Prior to this incident, given Anna's history, sit down with her to talk about her previous experiences in shelters and what she found to be helpful. Use this as the basis for a crisis prevention plan that staff can refer to. After the incident, sit down with Anna to find out what happened and how she defines disrespect. Remind her that yelling and swearing is against the rules in the program, and work with her to identify other ways she can manage her feelings. Add these to the crisis prevention plan. If there was no time prior to this incident to develop a plan, use this time to create one.

Handout


Sample Safety Plan

Purpose:

Prepares both shelter providers and residents for what to do in a situation where a resident's safety is compromised by someone outside of the shelter.

Safety plans should be developed collaboratively with the resident. There are seven major sections to the safety plan.

Safety During Violence.

I can use the following options:

a. I can tell _____ (friend, family, shelter provider) about the violence and have them call the police when violence erupts.
b. I can teach my children to use the telephone to call the police and the fire department.
c. I will use my instincts, intuition, and judgment. I will protect myself and my children until we are out of danger.

Safety in the Shelter

I can tell the following people that my partner no longer lives with me and that they should call the police if he is near my residence:

Shelter Providers_____

Neighbors_____

Religious Leaders _____

Friends_____

Others _____

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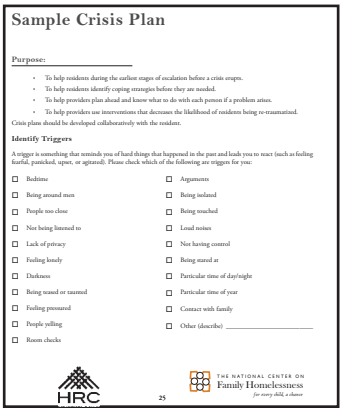
Handout


Sample Crisis Plan

Purpose:

- To help residents during the earliest stages of escalation before a crisis erupts.
- To help residents identify coping strategies before they are needed.
- To help providers plan ahead and know what to do with each person if a problem arises.
- To help providers use interventions that decreases the likelihood of residents being re-traumatized.

Crisis plans should be developed collaboratively with the resident.

Identify Triggers

A trigger is something that reminds you of hard things that happened in the past and leads you to react (such as feeling fearful, panicked, upset, or agitated). Please check which of the following are triggers for you:

- ☐ Bedtime
- ☐ Being around men
- ☐ People too close
- ☐ Not being listened to
- ☐ Lack of privacy
- ☐ Feeling lonely
- ☐ Darkness
- ☐ Being teased or taunted
- ☐ Feeling pressured
- ☐ People yelling
- ☐ Room checks
- ☐ Arguments
- ☐ Being isolated
- ☐ Being touched
- ☐ Loud noises
- ☐ Not having control
- ☐ Being stared at
- ☐ Particular time of day/night
- ☐ Particular time of year
- ☐ Contact with family
- ☐ Other (describe) _____

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Ask the audience:

What happens when we are reactive to a client rather than proactive with a client? Can anyone think of an example of being proactive rather than reactive (or vice versa) with a client?

Conclude the discussion:

- Safety plans and crisis prevention plans may change as you get to know the client better and as the client progresses in his/her healing and recovery.
- Review these plans with the client regularly to ensure they reflect the client's current needs and adapt or refine them as needed.
- At the end of the day today, I'll hand out sample safety and crisis plans for you to take a look at.

Handouts: Sample Safety Plan, Sample Crisis Plan

(Note: We recommend handing these out at the end of the day because it is less disruptive to do so. Use your best judgment about the timing.)

Slide 47

We've already talked a bit about **cultural competence**, so let's begin this section with a little game.

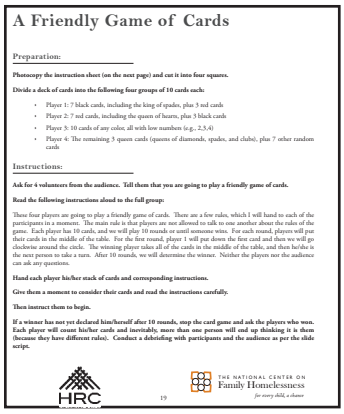
See instructions and handouts for "A Friendly Game of Cards." After the card game has been played, debrief with the players and the rest of the participants:

- What was your card of value?
- What was the highest card?
- What was the object of the game?
- What assumptions did you make about other players or the rules of the game?
- What was the experience like for you?
- Did you feel like you were in control of the game? Why or why not? How did that make you feel?

Be sure to give participants a round of applause for playing such a frustrating game! Draw out these lessons:

- Clients have a lot more at stake than just their [*name whatever people put in the middle of the table*].
- Being culturally competent doesn't mean knowing everything about every culture, but it does mean asking questions and being aware.
  - Ask questions and build relationships to find out what is of value to clients.
  - Pay attention and be aware of our own assumptions and beliefs, and how those may compliment or be in conflict with our clients' beliefs and assumptions.

Handout



A Friendly Game of Cards

Preparation:

Photocopy the instruction sheet (on the next page) and cut it into four squares.

Divide a deck of cards into the following four groups of 10 cards each:

- Player 1: 7 black cards, including the king of spades, plus 3 red cards
- Player 2: 7 red cards, including the queen of hearts, plus 3 black cards
- Player 3: 10 cards of any color, all with low numbers (e.g., 2,3,4)
- Player 4: The remaining 3 queen cards (queens of diamonds, spades, and clubs), plus 7 other random cards

Instructions:

Ask for 4 volunteers from the audience. Tell them that you are going to play a friendly game of cards.

Read the following instructions aloud to the full group:

These four players are going to play a friendly game of cards. There are a few rules, which I will hand to each of the participants in a moment. The main rule is that players are not allowed to talk to one another about the rules of the game. Each player has 10 cards, and we will play 10 rounds or until someone wins. For each round, players will put their cards in the middle of the table. For the first round, player 1 will put down the first card and then we will go clockwise around the circle. The winning player takes all of the cards in the middle of the table, and then he/she is the next person to take a turn. After 10 rounds, we will determine the winner. Neither the players nor the audience can ask any questions.

Hand each player his/her stack of cards and corresponding instructions.

Give them a moment to consider their cards and read the instructions carefully.

Then instruct them to begin.

If a winner has not yet declared him/herself after 10 rounds, stop the card game and ask the players who won. Each player will count his/her cards and inevitably, more than one person will end up thinking it is them (because they have different rules). Conduct a debriefing with participants and the audience as per the slide script.

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Continued on next page...

Slide 47, continued

Ask the audience:

- How can we create more culturally competent organizations?

Off these ideas to participants:

- Posters and other printed materials around the organization that reflect the communities with whom we work.
- Toys for children that reflect their racial/ethnic background.
- Foods that reflect the dietary preferences of our target population.
- Tools/methods of interacting with those with limited English proficiency.
- Using visual aids, gestures, and physical prompts.
- Access to a trained bilingual translator.
- Providing printed material, whenever possible, in the language of origin.
- Screening books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before using them in my work.
- Intervening in an appropriate manner when observing others (staff or clients) engaging in behaviors that show cultural insensitivity, bias or prejudice (including use of slurs).
- Accept and respect the roles of various family members in the family unit (e.g., elders, male/female roles, etc.).
- Understand the role that stigma plays regarding mental health issues, within a cultural context.

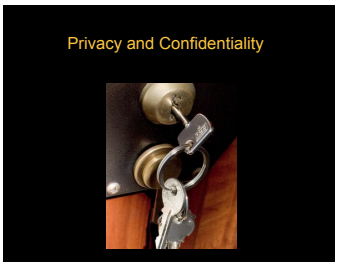
Continued on next page...

Slide 47, continued

An essential component to consider when building relationships is understanding your own cultural context as well as the cultural context of the person you are working with. It is not practical or expected that we know every aspect of every culture we come into contact with, but there are respectful, sensitive ways we can interact cross-culturally:[9]

- We can be quiet and listen.
- We can develop authentic relationships that are based on mutual respect and trust across what may be a world of difference, traditions, beliefs and values.
- We can acknowledge that wellness and healing may have different meanings, for some cultural groups.
- We can acknowledge what we don't know.
- We can ask questions:
    - To understand how certain concepts are viewed and handled by our client's community/culture (e.g., "I don't know how this is interpreted in your community. Can you help me understand it?", "Who are important members of your decision making process?" "Who are the experts in your community that I can consult with?").
    - To learn how/if to include cultural, religious, spiritual, tribal medicine, people/healers.

Slide 48



Introduce "privacy and confidentiality" as a component of creating supportive environments.

Often, trauma survivors have had their privacy violated and their dignity taken away – their bodies may have been invaded by abuse, they have spent long nights on the streets with no where to sleep and no bathroom facilities, they may have had re-traumatizing experiences with other service systems/providers, with law enforcement, etc.

If we aim to treat clients with respect and dignity, we must respect their privacy. This means, for example:

- Being transparent and sharing information about how we conduct "room checks" and other inspections.
- Not forcing clients to disrobe in order to receive medical care.
- Giving clients space (physical and/or psychological) to be alone, to think, and to process.
- Discouraging secret-keeping and/or the withholding of information (either from a client or from others within the system).

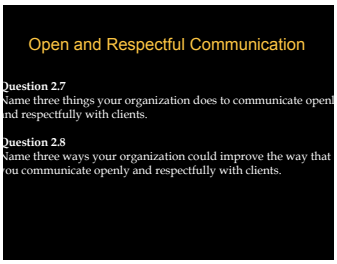
Ask the audience:

In what other ways can we respect client's right to privacy?

Part of respecting privacy is maintaining confidentiality. We can do this by:

- Making clients aware of what kinds of records we keep, where we keep them, and who has access to them (e.g., "I make some notes about your case in this folder, and the only people who have access to it are our other case managers. It never leaves the office and we keep these files locked in the case management file cabinet.")
- Be aware of where we talk about clients' cases (e.g., making sure that we're in private spot when taking a cell phone call about a client's case).

Slide 49



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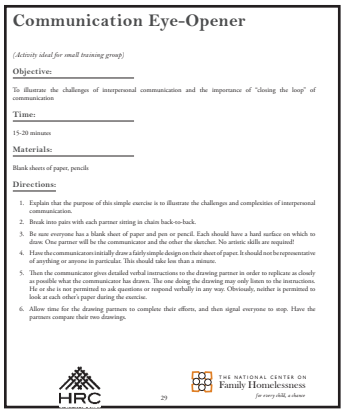
The final component of creating a safe and supportive environment has to do with open and respectful communication.

We are going to start with a brief exercise to help us experience just how important communication is.

Handout



Communication Eye-Opener

(Activity ideal for small training group)

Objective:

To illustrate the challenges of interpersonal communication and the importance of "closing the loop" of communication

Time:

15-20 minutes

Materials:

Blank sheets of paper, pencils

Directions:

1. Explain that the purpose of this simple exercise is to illustrate the challenges and complexities of interpersonal communication.
2. Break into pairs with each partner sitting in chairs back-to-back.
3. Be sure everyone has a blank sheet of paper and pen or pencil. Each should have a hard surface on which to draw. One partner will be the communicator and the other the sketcher. No artistic skills are required!
4. Have the communicators initially draw a fairly simple design on their sheet of paper. It should not be representative of anything or anyone in particular. This should take less than a minute.
5. Then the communicator gives detailed verbal instructions to the drawing partner in order to replicate as closely as possible what the communicator has drawn. The one doing the drawing may only listen to the instructions. He or she is not permitted to ask questions or respond verbally in any way. Obviously, neither is permitted to look at each other's paper during the exercise.
6. Allow time for the drawing partners to complete their efforts, and then signal everyone to stop. Have the partners compare their two drawings.

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Handout

Telephone

Activity ideal for large training group

Objective:

To help participants see the importance of communicating openly.

Time:

15 minutes

Directions:

The facilitator whispers the story into one of the participant's ears. The participant repeats it quietly to the person next to him/her. This continues on until everyone in the room has heard the story. The last person tells the group the story he/she heard. The facilitator reads the original story. In a large group, you may want to divide the participants into two groups.

Processing:

- How close was the final story to the original story?
- How often does this happen in your organization?
- What can be done to make sure that everyone hears the same story?

Story:

Here is a sample story, or make one up on your own. John Smith is planning to visit Jane Doe in Cincinnati.

He lives in Canton and was trying to map out a route so he could drive through Mansfield, Columbus and Wilmington before arriving in Cincinnati. John and Jane were planning on visiting the new elephant exhibit at the zoo. John plans to drive on a route along the Ohio River and travel through southern Ohio on his way back to Canton.

Adapted from Flynn, B. (1995). Communication. Family Nutrition Program. Ohio State University Extension. Downloaded August 30, 2007 from http://www.ag.ohio-state.edu/~hdepfnf/_docs/pf5493.pdf

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See instructions for "Communication Eye-Opener" and "Telephone" activities. Depending on the group size, choose one of these activities. At the conclusion of the activities, facilitate a brief discussion about the experience using the questions on the handout to guide the discussion.

Effective communication between providers or between providers and clients brings us back to our discussion about organizational consistency and the role communication plays in achieving consistency among providers.

One way to ensure effective communication is to have an established way or place where communication can occur.

Use the example below or give one of your own.

Example:

One shelter found that new information or changes in the rules of the program were inconsistently shared with the case managers. The case managers were frustrated because at times it led to the sharing of inaccurate information with clients, which contributed to client's conveying a sense of distrust towards the case managers. The shelter lacked communication technology such as voice mail, e-mail, and cell phones, relying instead on weekly meetings and assigning one staff member to communicate information to everyone. As we have just seen from our activity, messages were not always received nor were they always accurate. To improve communication, the shelter bought a White Board for the office on which they wrote items that needed to be communicated on a daily basis, which helped to ensure that everyone received the same information in a timely manner.

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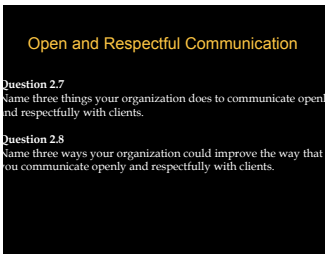
Slide 49, continued



In small groups, instruct participants to answer questions 2.7 and 2.8 on their worksheet. Cue animation to show questions on screen. When participants are done discussing these questions (usually about 10 minutes, depending on the size of the group), conduct a brief discussion about the ideas that their small group discussions generated. You can use the points below as you facilitate and conclude the discussion.

- When ways and places for communication are established, the next step is to ensure that the communication is effective. The most important part of effective communication is the ability to listen.
- When providers communicate effectively, they are more consistent and predictable, better able to enforce the rules and structure of the program, feel more confident and satisfied with their jobs, provide better support to each other, and work together as a team. In addition, these skills are being modeled for clients.
- Communicating openly and respectfully must happen between staff members, between staff and clients, and between clients and staff.
- Part of open communication means respecting the client's right to express him/herself openly. We can do this by providing daily opportunities for the open expression of ideas.

You may want to recall the earlier discussion of the principle of client involvement.

Slide 50

Slide is animated

Each of the components of creating a trauma-informed environment support the development of trusting relationships.

- Many of our clients have been in relationships that have been unpredictable, chaotic, and sometimes abusive. These experiences can lead to mistrust and an unwillingness to ask for or rely on support.
- Consumer-survivor Laura Prescott writes "because trauma so often happens in the contexts of relationships, it is within relationships that healing occurs."[9] These relationships are healing when they are authentic, and built on mutual trust and respect. A trauma-informed environment provides opportunities for people to build healthy relationships.

Remember that relationships are paramount and process is sometimes more important than the content/outcome.

Ask the audience:

How can we build trusting relationships with our clients?

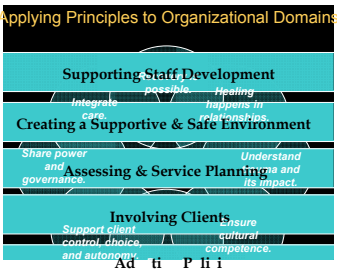
Continued on next page...

Slide 50, continued

Facilitate a brief, large group discussion, being sure to highlight the points below. Cue animation whenever you think it is appropriate.

- **Be patient and persistent.** Remember our discussion of the principles of trauma-informed environments: the path to healing is a long one.
- **Convey respect**. How can you convey respect to your clients? (e.g., not cancelling appointments, refraining from talking in public spaces about clients, etc.)
- **Be validating and affirming**. Use a strengths-based approach, and validate clients' efforts (no matter how small) to take positive control of their lives.
- **Read clients' needs and respond accurately**. Know your client well and ask for more information instead of making assumptions. For example, if you're trying to help your client feel safe, ask her "What makes you feel safe?"
- **Set realistic expectations and goals**. Work with clients collaboratively to set achievable goals. Setting them and then reaching them is empowering. Setting hard-to-reach goals is demoralizing and feeds into a sense of shame and despair.
- **Stay present and active; provide ongoing choices and supports**. Clients need continual support as they heal. It is not enough to provide a client with information about something, then never talk about it again. Be active by role playing with clients how to approach certain situations. Follow-up with clients when they are given tasks, and provide positive reinforcement even if they fail.
- **Knowing your role**. You are not the answer to all of your client's problems. Maintaining clear boundaries is both helpful to us (good self-care) and to our clients.

Slide 51



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Conclude the session by reflecting on what you have covered together, and giving a brief overview of what you will cover in the next and last session in the series. Use the slide animation to help you with your summary.

Today we've talked about:

- The eight principles of trauma-informed services.
- We've then applied those principles to the first two organizational domains, supporting staff development and creating a supportive and safe environment.

In our next session, we will discuss the remaining three domains:

- Assessing and service planning
- Involving clients
- Adapting policies

Part II Endnotes

Slide 7:

[1]Burt, M. et al. (1999). *Homelessness: Programs and the People They Serve*. Washington, DC: The Urban Institute.

Slide 17:

[2]Rog, D., Holupka, S., & McCombs-Thorton. (2002) Rog, D., Holupka, S., and McCombs-Thornton, K. (1995a). Implementation of the Homeless. Families Program: 1. Service models and preliminary outcomes. *American Journal of Orthopsychiatry, 65*(4), 502-513.

[3]Domino, M. E., Morrissey, J. P., Chung, S., Huntington, N., Larson, M. J., & Russell, L.A. (2005). Service use and costs for women with co-occurring mental and substance use disorders and a history of violence. *Psychiatric Services, 56*, 1223-1232.

[4]Community Connections. (2002). *Trauma and Abuse in the Lives of Homeless Men and Women.* Online PowerPoint presentation. Washington, DC: Authors. Retrieved September 3, 2007, from http://www.pathprogram.samhsa.gov/ppt/Trauma_and_Homelessness.ppt

[5]Jennings, A. (2004). *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services.* Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning. Retrieved September 3, 2007, from http://www.annafoundation.org/MDT.pdf

Slide 27:

[6]Moses, D.J., Glover, R., Mazelis, R. & D'Ambrosio, B. (2003). *Creating Trauma Services for Women with Co-Occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse, and Mental Health Disorders Who Have Histories of Violence Study.* Delmar, NY: Policy Research Associates (Women and Violence Coordinating Center).

[7]Kraybill, K. & Olivet, J. (2006). *Shelter Health: Essentials of Care for People Living in Shelter*. Nashville: National Health Care for the Homeless Council.

[8]National Center for Cultural Competence, www11.georgetown.edu/research/gucchd/nccc/documents/ChecklistBehavioralHealth.pdf.

[9]Prescott, L., Soares, P., Konnath, K., & Bassuk, E. (forthcoming). *The Long Journey Home: A Guide for Creating Trauma-informed Services for Mothers and Children Experiencing Homelessness*. Newton, MA: The National Center on Family Homelessness.

Part II Handouts

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Part II:

- Principles of Trauma-Informed Services
- Planning Worksheet for Part II
- When the Engine Gets Too Hot: Burnout, Compassion Fatigue, and Vicarious Trauma
- A Friendly Game of Cards
- Sample Safety Plan
- Sample Crisis Plan
- Communication Eye-Opener
- Telephone

We also recommend that you provide participants with the PowerPoint slides and an agenda.

Principles of Trauma-Informed Services

- Recovery is possible.
- Healing happens in relationships.
- Understand trauma and its impact.
- Ensure cultural competence.
- Promote safety.
- Support client control, choice, and autonomy.
- Share power and governance.
- Integrate care.

Planning Worksheet for Part II

This worksheet is designed to help you think about how to incorporate trauma-informed practices into your daily work. You will have opportunities throughout the training to answer the questions below. This document is for your own reference only; you will not be asked to share it with anyone.

Domain 1: Staff Development

1.1 How does your organization currently focus on staff development?

Training and Education

1.1 What kinds of training/education do you feel you need to become more trauma-informed?

1.2 What kinds of training/education do you feel your organization needs to become more trauma-informed?

1.3 What are ways your organization can ensure that training is provided to all staff?

Supervision and Support

1.4 How does your organization currently provide staff supervision and support?

1.5 How does supervision and support vary among different staff roles?

1.6 What are ways your organization can provide better staff supervision and support?

Self-Care

1.7 What does self-care mean to you?"

1.8 What does it mean to have an organizational culture of self-care?

1.9 What can you do to foster self-care at your organization? For yourself?

Domain 2: Creating a Supportive and Safe Environment

Establishing a Safe and Welcoming Physical Environment

2.1 How could you help your organization create a more welcoming and relaxing physical environment? How can clients be involved in this process?

Establishing a Supportive Environment

2.2 How can you increase consistency and predictability in your work?

2.3 How can your organization become more consistent and predictable?

2.4 How are clients informed about how your program responds to personal crises (e.g., suicidal statements, violent behavior)?

2.5 How are clients informed about who will be checking on them and their spaces (including the process, how often, and why it is important)?

2.6 What is the grievance policy for clients and how is it communicated to them?

Name three things your organization does to communication openly and respectfully with clients.

1.

2.

3.

Name three ways your organization could improve the way that you communicate openly and respectfully with clients.

1.

2.

3.

When the Engine Gets Too Hot:
Burnout, Compassion Fatigue & Vicarious Trauma

Burnout

One way to think of self-care is to remember the instructions from flight attendants: "If the cabin loses air pressure, oxygen masks will drop from the ceiling. Please put on your own mask before assisting others." In other words, you will be of no help to people around you if you pass out from oxygen deprivation. Help yourself first and then you can help others. Given this air travel imagery, it is fitting that the first two dictionary definitions of "burnout" have to do with rocket engine failure (American Heritage Dictionary of the English Language, 1992; Felton, 1998) due to excessive heat or friction. While "excessive heat" and "friction" may be good metaphors for what we experience at work some days, the third definition speaks specifically to our purposes: *"Physical or emotional exhaustion, especially as a result of long-term stress."*

There are three main components to burnout (Maslach and Jackson, 1986):

- Feelings of being emotionally exhausted and overextended by the work
- Feelings of depersonalization which result in negative, cynical attitudes toward clients
- Diminished personal accomplishment, reflecting a sense of lowered competence and a lack of successful achievement in work with clients.

If we're feeling burned out, it is likely that our nerves are jagged and our job performance slips. As this happens, we blame our clients and ourselves.

Compassion Fatigue and Vicarious Trauma

Just as an untreated cold can turn into something more serious, burnout that is not attended to may turn into compassion fatigue. Formally defined, compassion fatigue is "a state of tension and preoccupation with individual or cumulative trauma of clients, manifested in various ways:

- Re-experiencing the traumatic events,
- Avoidance/numbing of reminders of the traumatic event,
- Persistent arousal,
- Combined with the added effects of cumulative stress (burnout)" (Figley, 2002, p.125).

Compassion fatigue refers to negative changes in the way we make meaning of ourselves and of the world. It is also referred to as vicarious trauma, which is defined

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When the Engine Gets Too Hot:
Burnout, Compassion Fatigue & Vicarious Trauma

engagement with traumatized clients" (Saakvitne, Gamble, Pearlman, and Lev, 2001). As human beings, we have core psychological needs that include safety, trust, esteem, control, and intimacy. Compassion fatigue and vicarious trauma affect these core needs.

Consider these examples:

- A female case manager working with women who have been sexually assaulted assumes that all the men she encounters are unsafe.
- A counselor finds himself thinking, "Yeah, right – whatever," in response to a story told by a friend/client/colleague with whom he has always had a trusting relationship.
- Someone you've supervised for years has developed a recent habit of checking in with you before making any decisions, questioning whether his actions have any value to the clients he once felt confident working with.
- A social worker whose favorite way to relax is to spend time with her children finds herself wishing they would go away.

If we are burned out, we feel emotionally depleted. If we are experiencing compassion fatigue, however, we may experience changes in our ability to trust, have difficulty with intimacy, be concerned about our own safety, and experience intrusive imagery related to the traumatic stories to which we have listened.

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American Heritage Dictionary of the English Language, Third Edition. (1992). Boston: Houghton Mifflin.

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Maslach, C. and Jackson, SE (1986). Maslach burnout inventory manual: Second edition. Palo Alto: Consulting Psychologist Press.

Saakvitne, K.W., Gamble, S., Pearlman, L.A., and Lev, B.T. (2001). Risking connection: A training curriculum for working with survivors of childhood abuse. Baltimore: Sidran Institute.

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A Friendly Game of Cards

Preparation:

Photocopy the instruction sheet (on the next page) and cut it into four squares.

Divide a deck of cards into the following four groups of 10 cards each:

- Player 1: 7 black cards, including the king of spades, plus 3 red cards
- Player 2: 7 red cards, including the queen of hearts, plus 3 black cards
- Player 3: 10 cards of any color, all with low numbers (e.g., 2,3,4)
- Player 4: The remaining 3 queen cards (queens of diamonds, spades, and clubs), plus 7 other random cards

Instructions:

Ask for 4 volunteers from the audience. Tell them that you are going to play a friendly game of cards.

Read the following instructions aloud to the full group:

These four players are going to play a friendly game of cards. There are a few rules, which I will hand to each of the participants in a moment. The main rule is that players are not allowed to talk to one another about the rules of the game. Each player has 10 cards, and we will play 10 rounds or until someone wins. For each round, players will put their cards in the middle of the table. For the first round, player 1 will put down the first card and then we will go clockwise around the circle. The winning player takes all of the cards in the middle of the table, and then he/she is the next person to take a turn. After 10 rounds, we will determine the winner. Neither the players nor the audience can ask any questions.

Hand each player his/her stack of cards and corresponding instructions.

Give them a moment to consider their cards and read the instructions carefully.

Then instruct them to begin.

If a winner has not yet declared him/herself after 10 rounds, stop the card game and ask the players who won. Each player will count his/her cards and inevitably, more than one person will end up thinking it is them (because they have different rules). Conduct a debriefing with participants and the audience as per the slide script.

Player 1

Before you begin playing, place something valuable in the center of the table (e.g., your watch or cell phone). This is what you are playing for!

Object of the game: To collect as many cards as you can (so play your highest cards first, because the highest card wins).

Card ranking: The king is the highest card, followed by the queen, jack, ten, etc. The ace is the lowest card.

Card of Value: The King of Spades wins over all other cards.

In case of a dispute about the highest card, the black card always wins. If both cards are the same color, whichever player shouts "House" wins the round.

Player 2

You hold 10 cards. Before you begin playing, place something valuable in the center of the table (e.g., your watch or cell phone). This is what you are playing for!

Object of the game: To collect as many cards as you can (so play your highest cards first, because the highest card wins).

Card ranking: The queen is the highest card, followed by the king, jack, ten, etc. The two is the lowest card.

Card of Value: The Queen of Hearts wins over all other cards.

In case of a dispute about the highest card, the red card always wins. If both cards are the same color, the cards stay in the middle until the next round.

Player 3

Before you begin playing, place something valuable in the center of the table (e.g., your watch or cell phone). This is what you are playing for!

Object of the game: To get rid of all your cards (so place your lowest cards first, because whoever has the highest card takes the pile).

Card of value: Whenever a queen card (of any suit) is played, the first person to call out "Clubs!" gives away two cards.

In case of a dispute about the highest card, the red card always wins. If the two highest cards are the same color, Player 3 decides which player must take the pile.

Player 4

Before you begin playing, place something of little value in the center of the table (e.g., a pen, rubber band, etc.). This is what you are playing for!

Object of the game: To collect as many cards as you can (so play your highest cards first).

Card ranking: The king is the highest card, followed by the queen, jack, ten, etc. The ace is the lowest card.

Card of value: The queen of diamonds is the highest card.

In case of a dispute about the highest card, the red card always wins. If the two highest cards are the same color, the first person to stand up wins the pile.

Sample Safety Plan

Purpose:

Prepares both shelter providers and residents for what to do in a situation where a resident's safety is compromised by someone outside of the shelter.

Safety plans should be developed collaboratively with the resident. There are seven major sections to the safety plan.

Safety During Violence.

I can use the following options:

a. I can tell_____ (friend, family, shelter provider) about the violence and have them call the police when violence erupts.

b. I can teach my children to use the telephone to call the police and the fire department.

c. I will use my instincts, intuition, and judgment. I will protect myself and my children until we are out of danger.

Safety in the Shelter

I can tell the following people that my partner no longer lives with me and that they should call the police if he is near my residence:

Shelter Providers_____

Neighbors_____

Religious Leaders _____

Friends _____

Others _____

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Safety of Children

a. I will teach my children how to use the phone to make collect calls to me and to (friend, family, minister, shelter provider) if my partner tried to take them.

b. I will tell my children's caregivers (e.g., teachers, child care workers) who has permission to pick up my children. My partner is NOT allowed to. Inform the following people:

School _____

Day Care _____

Babysitter _____

Sunday School _____

Teacher _____

Shelter Provider _____

Others _____

Order of Protection

The following steps will help enforce the order of protection:

a. I will keep the protection order _____(the location). I will also always keep a copy with me.

b. I will give a copy of my protection order to the shelter staff.

c. I will give a copy of my protection order to police departments in the areas that I visit my friends, family, where I live, and where I work.

d. I will tell my employer, my religious leader, my friends, my family and others that I have a protection order.

e. If my protection order gets destroyed, I know I can get another copy.

f. If my partner violates the protection order, I will call the police and report it. I will call my lawyer, my advocate, counselor, and/ or tell the courts about the violation.

g. If the police do not help, I will call my advocate or my attorney AND I will file a complaint with the Chief of the Police Department.

h. I can file a private criminal complaint with the district judge in the jurisdiction that the violation took place or with the District Attorney. A domestic violence advocate will help me do this.

Job and Public Safety

I can do the following:

a. I can tell my boss, security, and _____ at work about this situation.

b. I can ask_____ to help screen my phone calls.

c. When leaving work I can do the following:

_____

_____

_____

d. If I am driving home from work and problems arise, I can:

_____

_____

_____

e. If I use public transportation, I can:

_____

_____

_____

f. I will shop at different grocery stores and shopping malls at different hours than I did when I was with my partner.

g. I will use a different bank and bank at different hours than I did when I was with my partner.

h. I can also do the following:

_____

_____

_____

Drug and Alcohol Use

I can enhance my safety if I do the following:

a. If I am going to use, I am going to do it in a safe place with people who understand the risk of violence and who are committed to my safety.

b. I can also

c. If my partner is using, I can

d. I can also

e. To protect my children, I can

Emotional Health

I can do the following:

a. If I feel depressed and ready to return to a potentially violent situation/ partner, I can

b. I can call

c. When I have to talk to my partner in person or on the phone, I can

_____

_____

_____

d. I will use "I can..." statements and I will be assertive with people.

e. I can tell myself " _____

_____

f. " when I feel people are trying to control or abuse me.

g. I can call the following people and/ or places for support:

_____

_____

_____

h. Things I can do to make me feel stronger are:

_____

_____

_____

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Sample Crisis Plan

Purpose:

- To help residents during the earliest stages of escalation before a crisis erupts.
- To help residents identify coping strategies before they are needed.
- To help providers plan ahead and know what to do with each person if a problem arises.
- To help providers use interventions that decreases the likelihood of residents being re-traumatized.

Crisis plans should be developed collaboratively with the resident.

Identify Triggers

A trigger is something that reminds you of hard things that happened in the past and leads you to react (such as feeling fearful, panicked, upset, or agitated). Please check which of the following are triggers for you:

- ☐ Bedtime
- ☐ Being around men
- ☐ People too close
- ☐ Not being listened to
- ☐ Lack of privacy
- ☐ Feeling lonely
- ☐ Darkness
- ☐ Being teased or taunted
- ☐ Feeling pressured
- ☐ People yelling
- ☐ Room checks
- ☐ Arguments
- ☐ Being isolated
- ☐ Being touched
- ☐ Loud noises
- ☐ Not having control
- ☐ Being stared at
- ☐ Particular time of day/night
- ☐ Particular time of year
- ☐ Contact with family
- ☐ Other (describe) _____

Identify Early Warning Signs

A signal of distress is a physical feeling or action that occurs before a possible crisis. Some signals are not observable, but some are, such as:

- ☐ Agitation
- ☐ Sensation of a tightness in the chest
- ☐ Sweating
- ☐ Clenching teeth
- ☐ Wringing hands
- ☐ Bouncing legs
- ☐ Shaking
- ☐ Crying
- ☐ Giggling
- ☐ Heart Pounding
- ☐ Pacing
- ☐ Eating more/less
- ☐ Breathing hard
- ☐ Shortness of breath
- ☐ Clenching fists
- ☐ Loud voice
- ☐ Swearing
- ☐ Restlessness
- ☐ Other _____

_____

Identify Strategies

Strategies are specific calming techniques that work for you to manage and minimize stress, such as:

- ☐ Talking to someone who will listen
- ☐ Time alone
- ☐ Reading a book
- ☐ Pacing
- ☐ Taking a hot/cold shower
- ☐ Deep breathing
- ☐ Talking to other residents
- ☐ Exercising
- ☐ Eating
- ☐ Writing in a journal
- ☐ Listening to music
- ☐ Talking with staff
- ☐ Calling friends or family (who?)
- ☐ Lying down
- ☐ Using a cold/warm face cloth
- ☐ Deep breathing exercises
- ☐ Touch: hug, holding hand, etc.
- ☐ Running cold water on hands
- ☐ Ripping paper
- ☐ Going for a walk
- ☐ Humor
- ☐ Crying
- ☐ Spiritual Practices: prayer, meditation, religious reflection
- ☐ Speaking with therapist
- ☐ Other _____

_____

What Does Not Help When You Are Upset?

- ☐ Being alone
- ☐ Not being listened to
- ☐ Being told what to do
- ☐ Loud tone of voice
- ☐ Being teased/taunted
- ☐ Humor
- ☐ Being ignored
- ☐ Having many people around me
- ☐ Having space invaded
- ☐ Not being taken seriously
- ☐ Other _____

_____

Adapted from: National Association of State Mental Health Program Directors /National Technical Assistance Center. (2006). *Personalized Safety Plan. Seclusion and Restraint/Trauma Informed Care Curriculum*. National Association of State Mental Health Program Directors: Alexandria, VA.

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Communication Eye-Opener

(Activity ideal for small training group)

Objective:

To illustrate the challenges of interpersonal communication and the importance of "closing the loop" of communication

Time:

15-20 minutes

Materials:

Blank sheets of paper, pencils

Directions:

1. Explain that the purpose of this simple exercise is to illustrate the challenges and complexities of interpersonal communication.
2. Break into pairs with each partner sitting in chairs back-to-back.
3. Be sure everyone has a blank sheet of paper and pen or pencil. Each should have a hard surface on which to draw. One partner will be the communicator and the other the sketcher. No artistic skills are required!
4. Have the communicators initially draw a fairly simple design on their sheet of paper. It should not be representative of anything or anyone in particular. This should take less than a minute.
5. Then the communicator gives detailed verbal instructions to the drawing partner in order to replicate as closely as possible what the communicator has drawn. The one doing the drawing may only listen to the instructions. He or she is not permitted to ask questions or respond verbally in any way. Obviously, neither is permitted to look at each other's paper during the exercise.
6. Allow time for the drawing partners to complete their efforts, and then signal everyone to stop. Have the partners compare their two drawings.

Discussion:

In the large group, ask participants to talk about their experience of doing this exercise. How closely did the drawings resemble one another? What were the challenges? How attentive to detail was the person who was giving instructions to size, dimensions, shading, position of objects on the page, etc.? How helpful would it have been if the drawing partner had been permitted to close the communication loop by asking clarifying questions? How does this illustrate the importance of checking out our interpretations of what is communicated with one another?

Adapted from Kraybill, K. (2003). *Creating and Maintaining a Healthy Work Environment: A Resource Guide for Staff Retreats*, Washington, DC: National Health Care for the Homeless Council.

Telephone

Activity ideal for large training group

Objective:

To help participants see the importance of communicating openly.

Time:

15 minutes

Directions:

The facilitator whispers the story into one of the participant's ears. The participant repeats it quietly to the person next to him/her. This continues on until everyone in the room has heard the story. The last person tells the group the story he/she heard. The facilitator reads the original story. In a large group, you may want to divide the participants into two groups.

Processing:

- How close was the final story to the original story?
- How often does this happen in your organization?
- What can be done to make sure that everyone hears the same story?

Story:

Here is a sample story, or make one up on your own. John Smith is planning to visit Jane Doe in Cincinnati.

He lives in Canton and was trying to map out a route so he could drive through Mansfield, Columbus and Wilmington before arriving in Cincinnati. John and Jane were planning on visiting the new elephant exhibit at the zoo. John plans to drive on a route along the Ohio River and travel through southern Ohio on his way back to Canton.

Adapted from Flynn, B. (1995). Communication, Family Nutrition Program. Ohio State University Extension. Downloaded August 30, 2007 from http://www.ag.ohio-state.edu/~bdg/pdf_docs/g/G09.pdf.

Specific Instructions for Part III:

Incorporating Trauma-Informed Concepts into Daily Practice in Settings for People Experiencing Homelessness

In Part III, participants continue to think practically and critically about their programs, practices, and organizational culture using a trauma-lens. Participants are given the opportunity to discuss how to begin implementing ideas talked about during the training. Again, this is meant to be interactive and trainers should use their creative energy and own ideas to enhance this section if possible.

In Part III, training material includes:

- Applying Trauma-Informed Principles to Organizational Domains 3, 4, and 5
- Next Steps and Closing

Sample Agenda – Part III:
Incorporating Trauma-Informed Concepts into Daily Practice in Settings for People Experiencing Homelessness
(8:30-12:30)

8:30 Welcome, Introductions, and Review (Slides 1-4)

9:00 Domain 3: Assessing and Service Planning (Slides 5-10)

10:00 Break

10:15 Domain 4: Involving Clients (Slides 11-14)

11:00 Domain 5: Adapting Policies (Slides 15-17)

11:30 Closing (Slides 18-23)

12:15 Evaluation and wrap up

***Note**: If your budget permits, you may want to offer beverages (e.g., coffee, tea, water) and light refreshments (e.g., fruit, crackers and cheese) during the break.*

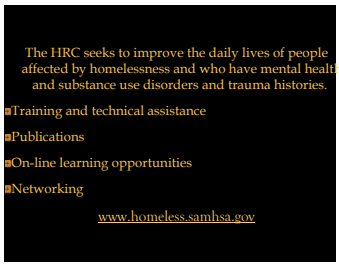
Slide 1

Introduction

- Welcome participants to the training.
- Introduce yourself (and other presenters if applicable).
- Have training participants introduce themselves if time permits.

Participants should be arranged in their small groups before the training begins

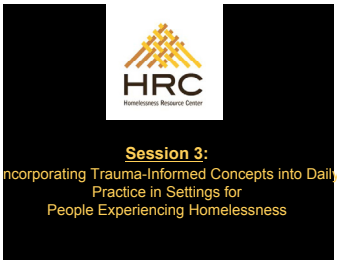
Slide 2



This training curriculum was created by SAMHSA's Homelessness Resource Center, which provides:

- Training and technical assistance.
- Publications
- Online Learning Opportunities.
- Networking.

Slide 3



This training is entitled, "Incorporating Trauma-Informed Concepts into Daily Practice in Settings for People Experiencing Homelessness."

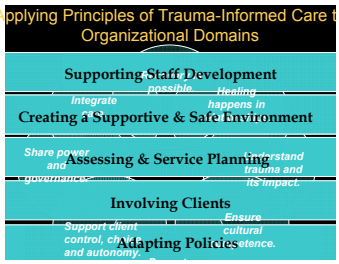
Slide 4

Slide is animated

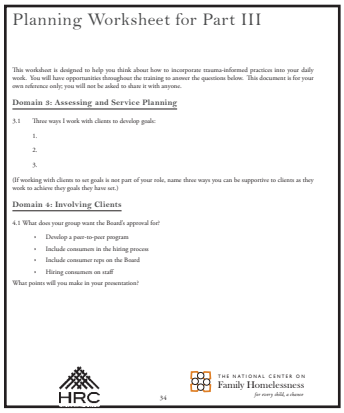
This slide serves as a road map for the training ("You are here").

This is part three of a three-part series on traumatic stress and homelessness.

Slide 5



Handout


Planning Worksheet for Part III

This worksheet is designed to help you think about how to incorporate trauma-informed practices into your daily work. You will have opportunities throughout the training to answer the questions below. This document is for your own reference only; you will not be asked to share it with anyone.

Domain 3: Assessing and Service Planning

3.1 Three ways I work with clients to develop goals:

1.
2.
3.

(If working with clients to set goals is not part of your role, name three ways you can be supportive to clients as they work to achieve their goals they have set.)

Domain 4: Involving Clients

4.1 What does your group want the Board's approval for?

- Develop a peer-to-peer program
- Include consumers in the hiring process
- Include consumer reps on the Board
- Hiring consumers on staff

What points will you make in your presentation?

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Slide is animated

Conduct a brief review with participants. Remind them of the principles (name them one by one) and the domains already covered. Use the slide animation to aid you. You may want to ask a few questions to review:

- What stands out to you from our last session?
- Have you looked at your work differently since we last met?
- What are your impressions of the trauma-informed framework now that you've had some time to think about it in light of your work?

Let participants know what you are going to cover today – the remaining three domains:

- Assessment and Service Planning
- Involving Clients
- Adapting Policies

Handout: Planning Worksheet for Part III

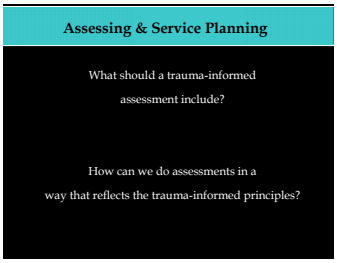
- Just as we did in Part II, we will use this worksheet throughout the session.
- It gives you an opportunity to write down your thoughts and ideas about creating a more trauma-informed environment in your program and will help you break down goals to begin to develop a strategic plan.
- The worksheet can be something you use on an on-going basis, after this training, as you begin the process of change.
- The worksheet is for your reference only. Although we will be discussing the questions from the worksheet, you won't have to show it to anyone else or hand it in.

Slide 6

Introduce "**Assessment and Service Planning.**"

- To build healthy relationships with clients, it is necessary to get to know them from their perspective, and have a clear understanding of what they have experienced, need and want.
- This process of getting to know clients and developing goals is commonly referred to as "assessment and service planning."
- In a trauma-informed environment, this is done "with" the client rather than "for" the client.
- As providers we facilitate this process. We can provide support, validation, and information, while understanding that ownership belongs to the client.
- This approach will support a client's sense of control, autonomy, and ownership.
- Recording assessments and plans in a written format ensures consistency, follow through, and keeps the provider and the client focused.
- Assessment is not a one-time event, but an ongoing process.

Slide 7



Ask the audience:

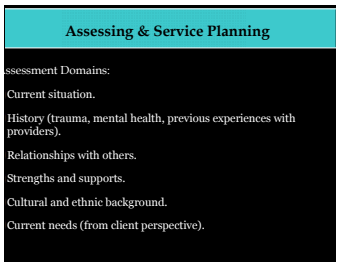
> What should a trauma-informed assessment include? How can we conduct assessments in a way that reflects trauma informed principles?

List the ideas generated on flip chart paper.

Instruct participants to find a partner to practice conducting an assessment. One person should play the client while the other person practices, and then after 5 minutes or so, the partners will switch. After each set of participants has had the opportunity to practice conducting an assessment, debrief with the full group.

- What kinds of things did you do to gain the person's trust?
- What kinds of questions did you ask?
- What was challenging about the experience?
- What did you learn?

Slide 8



Handout


Client Assessment Domains

Assessments may include the following:

- Observing and understanding the client's current situation:
  - Level of independent functioning in the current environment.
  - Current mental health symptoms (e.g. depression, anxiety, mood instability, difficulty focusing, withdrawal).
  - Relationship with child(ren).
  - Relationships with other adults.
  - Current employment and/or school functioning.
  - Client's view of the current situation and challenges faced.
  - Client's ethnic/cultural belief system.
- Getting information about the client's experiences in the past:
  - History of traumatic experiences.
  - History of mental health issues.
  - Medical history.
  - Family history/experiences in childhood.
  - Cultural background/context.
- Observing and understanding the client's strengths and resources/supports:
  - Identify client's individual strengths.
  - Identify who is part of the client's support system.
  - Identify the client's hobbies/interests.
  - Identify client's strengths in education and employment.
  - Identify what has been helpful for the client in the past when faced with challenges.
  - Identify client's current coping skills when faced with challenges.
  - Cultural resources available to client.

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Handout: Client Assessment Domains

- Proper client assessment helps you understand their perspectives and needs.
- Assessment should consider history of trauma, client strengths, and clients' needs.
- While assessment should begin after a client walks through the door, clients may need time to establish rapport before sharing detailed and sensitive information.
- Clients needs and goals will change as they begin to stabilize and heal. Thus, assessment should be considered as an ongoing process rather than a one-time event.

Assessment Domains (some or all of these may have come up in your previous discussion):

- **Current situation**. You can learn about the client's current situation by asking and by observing. Is he/she living in a shelter, doubled up with other family members, or living on the street? Is he/she motivated, disengaged, or distressed right now? What can this tell you about how he/she may be responding to others and to the environment?
- **History (trauma, mental health, previous experiences with providers).** Gathering as much information as possible in a respectful way about the client's history will help you understand how past experiences may impact a person's present response to the environment. Talking about history in an open-ended manner such as "Tell me about your relationship with your boyfriend" or "What was your life like when you were a child" can be helpful in eliciting information and may feel less threatening. This also allows clients to offer information at their own pace. Whenever possible, avoid using jargon such as "Have you experienced physical abuse or neglect?" This may feel threatening or may not be familiar language to a client.
- **Relationships with others**. Who are the important people in the client's life? They may be isolated or have family or friends who are important to them. It is helpful to understand how they experience these relationships. Are they helpful or hurtful? Are these people available as possible resources or barriers to healing? Understanding relationships in the context of the present and the past helps you get a sense of how a client may approach relationships in the program and where the client might turn for support on their road to recovery.

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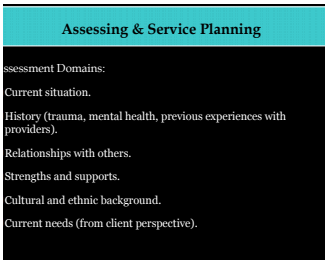
Slide 8, continued

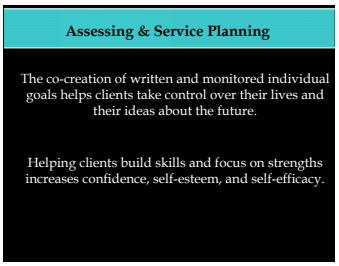


- **Strengths and supports**. You can learn about a client's strengths by asking and observing. Ask clients what they are good at, what they enjoy doing, or what they see as their strengths. Find out what supports they already have. For clients living on the streets, asking about supports may be very basic, such as "Where do you go when it's cold?" or "It's great that you're wearing clean socks to protect your feet. Where do you go to get them?" For families, it might mean asking "What do you like to do together as a family?" or "Who do you call when your children get sick?"
- **Cultural background**. Understanding where clients come from and how that shapes their value and beliefs provides much information about their needs, how they raise their children, how they deal with conflict, what kinds of trauma they may have been exposed to, and how they adapted to those experiences. Ask clients about this in an open-ended manner, such as "Tell me about what it was like growing up in Haiti..."
- **Current needs (from client perspective)**. What you consider a priority may not be a priority for your client. Ask him/her what they need today. What would they like to work on with you?

At the conclusion of the discussion, remind participants:

Not everyone in a program is included in the client assessment process, but all providers can benefit from the completed assessment by understanding the client's needs from her own perspective.

Slide 9



Ask the audience:

> Once you've done an initial assessment with clients, what is the process for planning services in your organization?

Traditionally, programs have narrowly defined goals for clients. They are often driven by crisis, are time-limited, and focus on concrete outcomes. The goals clients are expected to achieve often emphasize the needs/requirements of the system rather than the needs identified by the client.

As providers, we may have to dictate goals to clients based on demands from the larger system or from funding sources (hours spent on housing searches, attendance in school, seeking employment, attending meetings, etc.).

- These goals can be daunting for a trauma survivor whose primary focus is day-to-day survival and meeting basic needs.
- Each client has a different timeline for developing a sense of safety, different reasons why she is experiencing homelessness, and different housing/service needs.
- The experience of having goals dictated rather than being a part of a collaborative process can lead to frustration, distrust, alienation, and feelings of isolation.
- In a trauma-informed system, goals should focus on more than just housing and employment. There should also be goals that are related to healing and recovery.

Use this example (or one of your own) to facilitate this exercise:

> **Exercise**
>
> In one shelter, according to the statewide rules, clients are required to conduct and document on a chart their 20 hours of housing search activities each week. Because there is no affordable housing in the area, case managers advise clients to copy ads out of the classified section and write "unaffordable" next to them. Maria, a young mother with three children, finds this requirement particularly frustrating, saying "I have three children and a job. Doing all of this copying is busy work. There are so many other things I could be doing to improve my situation, but I'm stuck copying ads out of a newspaper."

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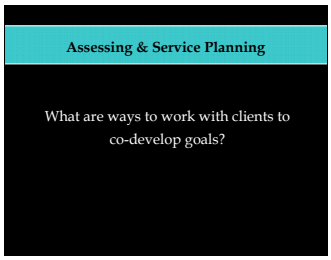
Slide 9, continued



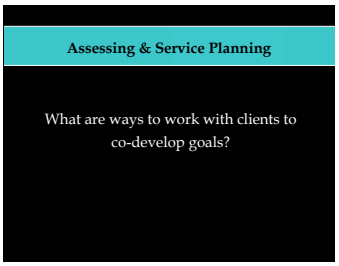
Ask the audience:

> How could you approach this differently with Maria?

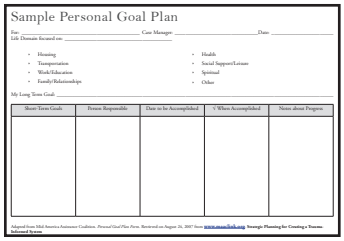
Mention the approach below (if needed):

> **In a trauma-informed approach to goal setting with Maria**: You acknowledge that the housing search goals are frustrating, and work with her to identify additional goals of her choosing that promote a sense of self-efficacy, etc. Whenever possible, you advocate to decision-makers to change the housing goal requirements for families living in shelters, acknowledging that a "cookie-cutter" approach isn't realistic or productive.
>
> Trauma survivors have experienced helplessness and powerlessness in the face of overwhelming stress. Developing goals around housing, employment, and services may be an overwhelming and intimidating task. Having goals and plans created by others without their input may re-create clients' feelings associated with earlier traumatic experiences. The co-creation of written and monitored individual goals helps clients take control over their lives and their ideas about the future. Helping clients build skills and focus on strengths increases confidence, self-esteem, and self-efficacy.

Slide 10



Handout


Sample Personal Goal Plan

Name _____ Case Manager _____ Date _____

Life Domain focused on: _____

- Housing
- Transportation
- Work/Education
- Family/Relationships
- Health
- Social Support/Leisure
- Spiritual
- Other

My Long Term Goal: _____

Short-Term Goals	Person Responsible	Date to be Accomplished	"I Will Be Accomplished	Notes about Progress

Adapted from Mid America Assistance Coalition. *Personal Goal Plan Form*. Retrieved on August 26, 2007 from www.maacbelt.org **Strength Planning for Creating a Trauma-Informed System**

Ask the audience:

> What are ways to work with clients to co-develop goals?

> What works for one client may not work for another. Like the rest of us, clients have a mix of strengths and weaknesses. It is important to "meet clients where they're at," working with them to develop realistic and relevant goals. This includes identifying goals that are achievable so that clients gain a sense of success rather than failure.

Have participants break into groups of three. Have each group role play working with a client to set goals. Be sure each participant has an opportunity to play the role of provider, client, and observer.

Handout: Sample Goal Plan. You can decide if you want to hand it out to participants to use with this exercise, or if you want to distribute it at the end of the session as a reference (or both). Conduct a short debriefing with participants about their goal-setting conversations, being sure to highlight the points below in the discussion:

- An awareness of clients' experiences and their current needs allows for programs to tailor the services that they provide to clients rather than assuming that each client has the same goals and service needs.
- Programs can provide tailored services by creating networks and establishing referral sources that can address the range of their clients' needs.
- Additionally, having connections with agencies that can provide trauma-specific services (e.g. services that are designed specifically to address the needs of those who have experienced trauma) is imperative when considering how to meet the range of service needs of your clients.
- Just as assessment is an ongoing process, goal setting and identifying client needs also happens in an on-going manner. As clients achieve goals or their needs change, their goals should be reevaluated and different service needs considered.

Give participants a minute or two to answer question 3.1 on their planning worksheet. Decide ahead of time if you want them to do this before, during, or after your discussion.

Slide 11

Slide is animated

We're now going to discuss the fourth organizational domain: **Involving Clients.**

Cue animation.

Slide 12

Introduce "**Involving Clients:**"

- Client involvement is critical for ensuring that programs and services are trauma-informed. Clients must be involved both in their own care and at the service/program level.
- Clients have first-hand knowledge of the systems and programs in which we work, and so involving them in all aspects of policy, planning, and implementation enhances the overall effectiveness and quality of services and helps ensure that services, procedures, and policies are trauma-informed.
- Recovery and success for trauma survivors is based in large part on the client's ability to effect change and have control over her life. This can be difficult when a program undermines a client's control by enforcing inflexible rules and requirements that offer few choices. This can lead to feelings of powerlessness that recreate feelings associated with past trauma.
- Increasing a client's ability to effect change and have control can occur when power and control are shared by creating mutual relationships between clients and providers, and giving clients a voice in their own recovery and the services and programs available to them.
- Sharing power and governance helps facilitate client empowerment and peer-to-peer support. It also decreases the stigma and isolation clients may feel, and cultivates a sense of hope and self-efficacy.

Give the example below or use one of your own:

Example

Residents at a shelter may be required to attend a particular group session. They resent being forced to attend and are unclear how it is helpful to them. As a staff member, you become the "enforcer," rounding people up at group time and making sure residents comply with attendance requirements.

Continued on next page...

Slide 12, continued

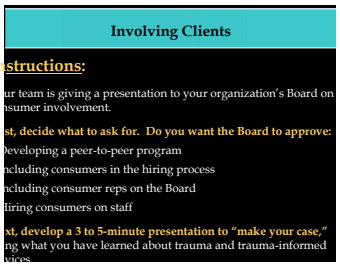
Ask the audience:

> What would be an alternative approach?

Present the alternatives below if they are not posed by the group:

> - Residents are required to attend groups, but have a say in which groups are offered and a choice of which one(s) they attend.
> - Residents are not required to attend groups and instead develop individual plans in collaboration with their case manager based on their needs.

Slide 13



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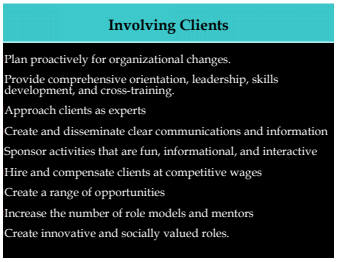
Give participants the following instructions, which are also printed on the slide.

> We have talked a lot about client involvement over the course of our training series, and so now it is time to put what you've learned into action. Each small group is going to work as a team to give a presentation to your organization's board about your plan to increase consumer involvement.
>
> The first step is to decide what you want the board to do:
>
> - Do you want their approval and financial support to develop a peer-to-peer program, hiring consumers to serve as staff for the program?
> - To include consumers in the hiring process?
> - To include consumer reps on the Board?
> - To hire consumers on staff?
>
> Then, develop a short presentation to "make your case" using what you have learned about trauma-informed services.

Give participants 10-15 minutes to prepare their presentations. Indicate that there is space on their planning worksheet (question 4.1) for them to make any notes about their presentation. Then have them make their presentations to you (aka "the Board."). Encourage other participants who are not presenting to ask questions of the group if something needs to be clarified. You may also ask questions that you think will aid in the learning process. Remember that the point of the exercise is to give participants an opportunity to integrate what they have learned, not to have a contentious debate. Also be sensitive to the fact that there may be disclosed and undisclosed consumers in the room. We suggest that you bring a timer so that you can keep the session on schedule.

After each group has presented their case, ask for any comments about the experience. Then make comments you might have as feedback to the large group, moving to the next slide as you transition.

Slide 14



In trauma-informed environments, clients and providers work together to create an environment in which everyone has a voice.

Clients become more involved in the program and have a greater sense of control when:

They are given a voice.

- Support clients in running a "resident voice" meeting, put them in charge of developing the agenda and facilitating the discussion.
- Inform clients of the program's grievance process so they know who to go to and what to do when they have a concern or complaint.

They are given choices.

- Provide clients with choices about their services. If there is a minimum requirement of mandatory services, make more services available to offer choices.
- Involve clients in deciding what services they participate in and what is available at the program.

Partnerships are created. This goes back to developing healthy relationships, and working with clients through the assessment and goal planning process.

- Involve clients in identifying and developing services, and give them an opportunity to evaluate the program and offer their suggestions for improvement in anonymous and/or confidential ways.

Cue the animation and mention the following ways to involve clients:

Plan proactively for organizational changes.

- Involving clients may be a big change for your organization.
- Anticipate potential areas of conflict and level of "buy-in" and meet with multiple stakeholders early in the process.

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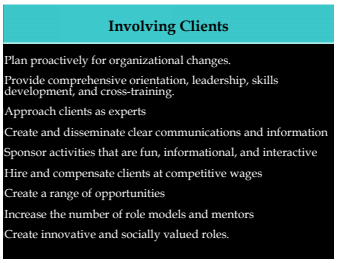
Slide 14, continued



Provide comprehensive orientation, leadership, skills development, and cross-training.

- Provide an orientation to clients who are going to be on staff. Include information on organization mission, goals, and structure; personnel procedures; boundary clarification; diversity; available resources (and how to access them); office technology; conflict resolution and stress management, etc.
- Follow the orientation with leadership, advocacy, and skills development trainings.
- Use a train-the-trainer model to continually expand the available pool of trainers.
- Co-facilitate trainings and other meetings to model partnerships.

Approach clients as experts.

- Encourage clients to "find their own voice." By speaking for themselves, the model of respectful engagement is affirmed.
- Develop relationships with agencies and other groups that clients have identified as helpful.
- Ask clients what interests them about particular projects, what strengths/skills they have to offer, etc.

Create and disseminate clear communications and information.

- Avoid jargon.
- Use "people-first" language (e.g., "people who are homeless rather than "the homeless" or "homeless people").
- Ask clients how they prefer to receive information (e.g., email, paper, phone).

Sponsor activities that are fun, informational, and interactive.

- Clients are more likely to want to be involved if they have a meaningful relationship with the organization.
- Gatherings help build trust and can be simple (e.g., snacks after a meeting, going for walks, playing sports, etc.).
- Ask clients what they do to relax and build gatherings around their ideas.

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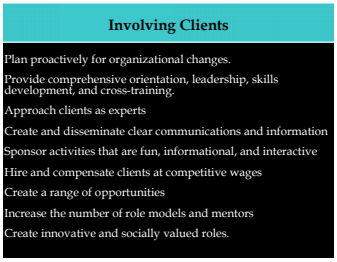
Slide 14, continued



Hire and compensate clients at competitive wages.

- Clients are often unable to participate in meaningful ways if they do not receive competitive compensation for their time.
- Conference calls, meetings, committee work, etc. all take time and by defining the role of clients in those endeavors and then compensating them accordingly, clients won't have to compete with other priorities to be involved.
- When clients are working as staff for the organization but are compensated appropriately, it indicates that their contributions are valued.

Create a range of opportunities.

- Offer a variety of ways for clients to be involved – think about involvement opportunities as a continuum from the least formal (e.g., focus group participation, advisory board members) to less formal (e.g., research interns, training co-facilitators) to most formal (e.g., case managers, director of orientation and training, consumer coordinator, etc.).

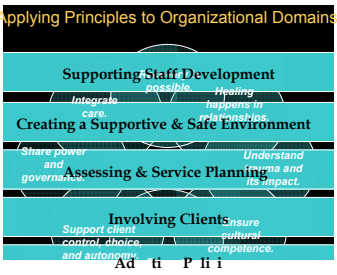
Increase the number of role models and mentors.

- This creates diversity, and increases opportunities for shared learning, collaboration, and retention in program activities.
- It can also decrease the relative burden on the one or two clients who are officially employed with an organization.

Create innovative and socially valued roles.

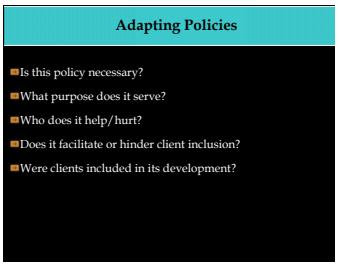
- Clearly define tasks and roles and offer them across all areas of the program (e.g., operations and management, training and education, community relationships, service delivery and outreach, etc.).

Slide 15



The last domain we're going to talk about is "**Adapting Policies.**"

Slide 16



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Introduce "**Adapting Policies.**"

Within a trauma-informed system, written policies take into account the trauma experienced by clients and include a commitment to meeting client needs in a trauma-sensitive manner.

- For example, including in the program mission statement an acknowledgement of the experience of trauma by clients and a commitment to understanding trauma and incorporating that understanding into all aspects of the program.

Using the principles as a guide, all procedures and policies of a program should be reviewed to ensure that they are trauma informed.

Instruct participants to silently answer questions 5.1 and 5.2 on their worksheet: How are rules made in your organization?

Organizations create different policies or rules for a variety of reasons.

- As the needs of clients evolve and as the roles of organizations changes, policies that were once effective may no longer be helpful.
- The more an organization learns about trauma, the more policy modifications they may need to make.
- This requires a regular review of policies to update practices and guidelines and to make them as relevant as possible to the people being served.
- Within a trauma-informed system, written policies take into account the trauma experienced by clients and include a commitment to meeting client needs in a trauma-informed manner.

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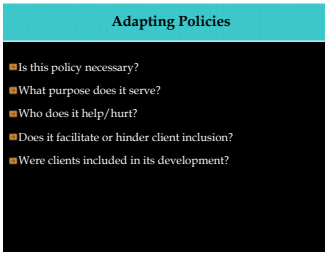
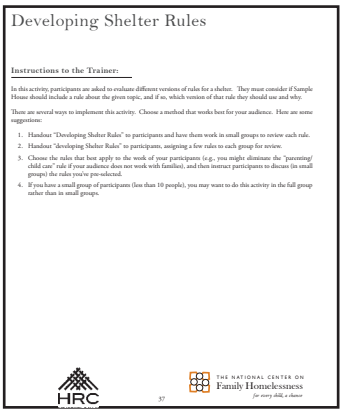
Slide 16, continued



Handout


Developing Shelter Rules

Instructions to the Trainer:

In this activity, participants are asked to evaluate different versions of rules for a shelter. They must consider if Sample House should include a rule about the given topic, and if so, which version of that rule they should use and why.

There are several ways to implement this activity. Choose a method that works best for your audience. Here are some suggestions:

1. Handout "Developing Shelter Rules" to participants and have them work in small groups to review each rule.
2. Handout "developing Shelter Rules" to participants, assigning a few rules to each group for review.
3. Choose the rules that best apply to the work of your participants (e.g., you might eliminate the "parenting/child care" rule if your audience does not work with families), and then instruct participants to discuss (in small groups) the rules you've pre-selected.
4. If you have a small group of participants (less than 10 people), you may want to do this activity in the full group rather than in small groups.

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37

Cue animation.

When evaluating policies or rules, here are some helpful criteria:

- Is this policy or rule necessary?
- What purpose does it serve?
- Who does it help? Who does it hurt?
- Does the policy facilitate/hinder inclusion of clients?
- Were clients included in its development?

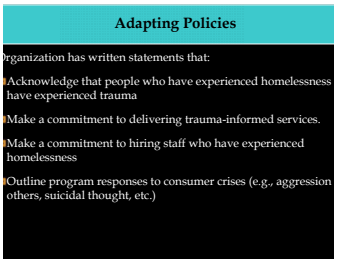
Acknowledge the tensions and challenges in examining rules and regulations. Providers and even programs sometimes do not have control over the rules that they must operate under.

Use the handout "Developing Shelter Rules" and accompanying directions to complete the exercise. The handout includes many rules. Depending on the size of your audience and their focus (e.g., family shelter, congregate shelter for singles, etc.), you may want to pick and choose which rules the group focuses on.

At the end of the activity, conduct a debriefing discussion with participants. Depending on the size of the group and allotted time, you can either review each rule or talk about the process overall.

- What was the process like for your group?
- What were the challenges of using the criteria listed on the slide?
- What worked well about using the criteria listed on the slide?
- How could you apply this criteria to your own organization?

Slide 17



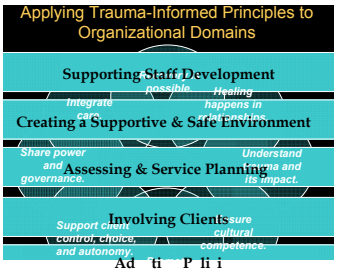
In the exercise we just did, we discussed rules that could be implemented in different ways – a way that acknowledge trauma and a way that doesn't necessarily acknowledge it. But what about having policies that are explicitly about trauma? Here are a few suggestions:

Organization has written statements that:

- Acknowledge that people who have experienced homelessness have experienced trauma.
- Make a commitment to delivering trauma-informed services.
- Make a commitment to hiring staff who have experienced homelessness.
- Outline program responses to consumer crises (e.g., aggression to others, suicidal thought, etc.).

Instruct participants to answer question 5.3 on their worksheet: "If you could change one rule in your organization that would make it more trauma-informed, what would the rule be and how would you change it?" If time permits, you may want to ask a few people to share their answers.

Slide 18



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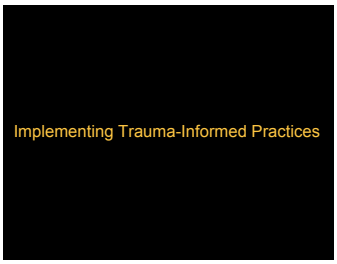
Acknowledge the depth and breadth of the ground you have covered together! Review the principles and domains one by one, reading them aloud in synch with the slide animation.

At this point, you should have filled in all but the last section on your "Planning Worksheet." Please take a minute to look over the work you've done today.

Pause for a minute or two while participants review their worksheets from Parts II and III. Then, lead a large group discussion asking the participants to talk about their reactions to engaging in this process. Allow participants to focus both on the excitement brought about by this process as well as the frustrations or uncertainties. The questions below can serve as your guide.

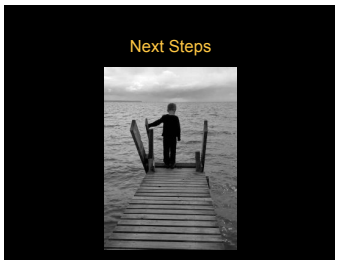
- What has it been like to go through this process?
- What will you do differently?
- What difficulties do you anticipate encountering as you go back to work and try to implement what you have learned?
- What parts of [the domains, principles, process in general] are most exciting/ energizing to you?

Slide 19



Transitional Slide.

Slide 20



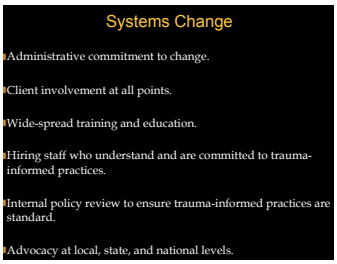
Most organizations serving people experiencing homelessness do not have the opportunity to routinely reflect on their work, and refine their programs and policies to meet the complex needs of the clients they serve. Becoming trauma-informed requires commitment from all levels of the organization as well as careful planning and allocation of sufficient resources. Additionally, change takes time, and often happens slowly, in phases, rather than all at one time.

However, change needs to start somewhere and this training has provided a place to think about the concrete steps to begin this process. To wrap up our training session, let's spend some time strategizing about what happens next.

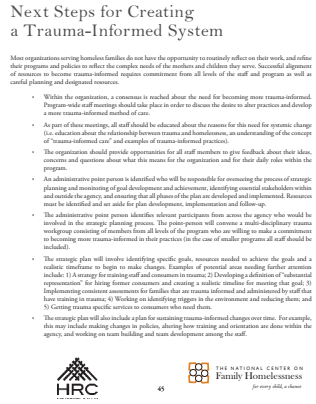
Look over your planning worksheets. Then answer the last question on the last page: What are two concrete next steps that you will take to become more trauma-informed?

Give participants several minutes to write down their next steps, and then invite them to share.

Slide 21



Handout



Next Steps for Creating
a Trauma-Informed System

Most organizations serving homeless families do not have the opportunity to routinely reflect on their work, and refine their programs and policies to reflect the complex needs of the mothers and children they serve. Successful alignment of resources to become trauma-informed requires commitment from all levels of the staff and program as well as careful planning and designated resources.

- Within the organization, a consensus is reached about the need for becoming more trauma-informed. Program-wide staff meetings should take place in order to discuss the desire to alter practices and develop a more trauma-informed method of care.
- As part of these meetings, all staff should be educated about the reasons for this need for systemic change (i.e. education about the relationship between trauma and homelessness, an understanding of the concept of "trauma-informed care" and examples of trauma-informed practices).
- The organization should provide opportunities for all staff members to give feedback about their ideas, concerns and questions about what this means for the organization and for their daily roles within the program.
- An administrative point person is identified who will be responsible for overseeing the process of strategic planning and monitoring of goal development and achievement, identifying essential stakeholders within and outside the agency, and ensuring that all phases of the plan are developed and implemented. Resources must be identified and set aside for plan development, implementation and follow-up.
- The administrative point person identifies relevant participants from across the agency who would be involved in the strategic planning process. The point-person will convene a multi-disciplinary trauma workgroup consisting of members from all levels of the program who are willing to make a commitment to becoming more trauma-informed in their practices (in the case of smaller programs all staff should be included).
- The strategic plan will involve identifying specific goals, resources needed to achieve the goals and a realistic timeframe to begin to make changes. Examples of potential areas needing further attention include: 1) A strategy for training staff and consumers in trauma; 2) Developing a definition of "substantial representation" for hiring former consumers and creating a realistic timeline for meeting that goal; 3) Implementing consistent assessments for families that are trauma informed and administered by staff that have training in trauma; 4) Working on identifying triggers in the environment and reducing them; and 5) Getting trauma specific services to consumers who need them.
- The strategic plan will also include a plan for sustaining trauma-informed changes over time. For example, this may include making changes in policies, altering how training and orientation are done within the agency, and working on team building and team development among the staff.

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We have spent three sessions learning about traumatic stress, its impact on clients, and how to adapt our work as individuals and programs to become more trauma-informed. Transformation a the individual and program is essential, but it also important that the systems that we work within make a real commitment to becoming trauma-informed.

As you move forward into the change process, obstacles to change become more evident. These obstacles are often present due to the larger systems that our organizations function within (e.g., welfare, child protective services, law enforcement, etc.). These obstacles can leave people feeling powerless and helpless, which can effect the motivation to continue to change. However, it is important to keep in mind that there are both big and small ways that individuals within an organization and organizations themselves can influence broader systems to bring about a more widespread understanding of the needs of trauma survivors and to support change.

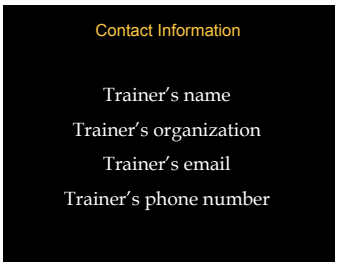
Handout: "Planning for Creating a Trauma-Informed System"

Your handout "Planning for Creating a Trauma-Informed System" discusses various ways of beginning the change process. Take a few minutes to read this.

Facilitate a discussion with participants, asking them what ideas seem practical for their organization.

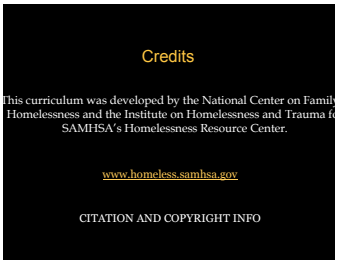
Thank participants for attending the training and offer some positive reflections on the work accomplished during the training session.

Slide 22



We suggest that you put your contact information here.

Slide 23



Part III Handouts

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Part III:

- Planning Worksheet for Part III
- Client Assessment Domains
- Sample Goal Plan
- Developing Shelter Rules
- Next Steps for Creating a Trauma-informed System
- Sample Evaluation
- Training Post-Test

We also recommend that you provide participants with the PowerPoint slides and an agenda.

Planning Worksheet for Part III

This worksheet is designed to help you think about how to incorporate trauma-informed practices into your daily work. You will have opportunities throughout the training to answer the questions below. This document is for your own reference only; you will not be asked to share it with anyone.

Domain 3: Assessing and Service Planning

3.1 Three ways I work with clients to develop goals:

1.

2.

3.

(If working with clients to set goals is not part of your role, name three ways you can be supportive to clients as they work to achieve they goals they have set.)

Domain 4: Involving Clients

4.1 What does your group want the Board's approval for?

- Develop a peer-to-peer program
- Include consumers in the hiring process
- Include consumer reps on the Board
- Hiring consumers on staff

What points will you make in your presentation?

Domain 5: Adapting Policies

5.1 How are rules made in your organization?

5.2 When was the last time you reviewed your organization's rules?

5.3 If you could change one rule in your organization that would make it more trauma-informed, what would the rule be and how would you change it?

Next Steps

What are two concrete next steps that you will take to become more trauma-informed?

1.

2.

Client Assessment Domains

Assessments may include the following:

- Observing and understanding the client's current situation:
  - Level of independent functioning in the current environment.
  - Current mental health symptoms (e.g. depression, anxiety, mood instability, difficulty focusing, withdrawal).
  - Relationship with child(ren).
  - Relationships with other adults.
  - Current employment and/or school functioning.
  - Client's view of the current situation and challenges faced.
  - Client's ethnic/cultural belief system.
- Getting information about the client's experiences in the past:
  - History of traumatic experiences.
  - History of mental health issues.
  - Medical history.
  - Family history/experiences in childhood.
  - Cultural background/context.
- Observing and understanding the client's strengths and resources/supports:
  - Identify client's individual strengths.
  - Identify who is part of the client's support system.
  - Identify the client's hobbies/interests.
  - Identify client's strengths in education and employment.
  - Identify what has been helpful for the client in the past when faced with challenges.
  - Identify client's current coping skills when faced with challenges.
  - Cultural resources available to client.

Sample Personal Goal Plan

For: _____ Case Manager: _____Date: _____
Life Domain focused on: _____

- Housing
- Transportation
- Work/Education
- Family/Relationships
- Health
- Social Support/Leisure
- Spiritual
- Other

My Long Term Goal: _____

Short-Term Goals	Person Responsible	Date to be Accomplished	√ When Accomplished	Notes about Progress

Adapted from Mid America Assistance Coalition. *Personal Goal Plan Form*. Retrieved on August 24, 2007 from **www.maaclink.org**. **Strategic Planning for Creating a Trauma-Informed System**

Developing Shelter Rules

Instructions to the Trainer:

In this activity, participants are asked to evaluate different versions of rules for a shelter. They must consider if Sample House should include a rule about the given topic, and if so, which version of that rule they should use and why.

There are several ways to implement this activity. Choose a method that works best for your audience. Here are some suggestions:

1. Handout "Developing Shelter Rules" to participants and have them work in small groups to review each rule.
2. Handout "developing Shelter Rules" to participants, assigning a few rules to each group for review.
3. Choose the rules that best apply to the work of your participants (e.g., you might eliminate the "parenting/ child care" rule if your audience does not work with families), and then instruct participants to discuss (in small groups) the rules you've pre-selected.
4. If you have a small group of participants (less than 10 people), you may want to do this activity in the full group rather than in small groups.

Developing Shelter Rules

Participant Instructions:

Sample House is a family shelter that will be opening its doors in just a few weeks. They are nearly finished developing rules and policies for their program, but have been struggling with some sections. They want to ensure that their shelter is trauma-informed.

Beginning on the next page, we have listed topics and potential rules (labeled A and B) for those topics. Please review the potential options and choose which one you think best suits a trauma-informed shelter. Be prepared to "make your case" for including (or not including) that rule.

To assist you in deciding which rules to include, use the following criteria:

- Is this policy or rule necessary?
- What purpose does it serve?
- Who does it help? Who does it hurt?
- Does the policy facilitate/hinder inclusion of clients?
- How could clients be included in developing this rule?

Sample House Rules

Welcome to Sample House! Our mission is to help you become self-sufficient. Read the rules below and sign your name on the last page. **BE AWARE THAT ANY RULE VIOLATION MAY RESULT IN A WARNING FROM SAMPLE HOUSE STAFF!**

1. Compliance with Individual Service Plans

You will work with the case manager assigned to your case to write a Service Plan, required by the Department of Human Services. The goal of the Service Plan is to help your family become more self-sufficient. Residents are mandated to schedule and attend ALL meetings with Case Management and attend 2 in-house or approved off-site meetings each week.

Self-sufficiency is a term that you will hear often during your stay at Sample House. Self-sufficiency means having the skills and resources to meet your family's financial needs and to prevent future homelessness. We want to work with you to strengthen your education, training and financial management skills, etc. You will work with your case manager to identify goals for saving money, gaining training/employment, obtaining housing, etc. Your case manager is _____. Her phone number is _____.

Should Sample House include a rule about this topic? If no, why? If yes, which version should they use and why?

2. Weekday Quiet Hours

On weekdays, the hours between 11 pm and 5:30 am are quiet hours to ensure the rest and comfort of all. Please be aware that TVs and radios are turned down in your room and are not on in the living room. There should be no congregating in common areas and other residents' rooms during quiet hours. Early quiet hours (9 pm to 5:30 am) may be instituted at staff's discretion.

On weekdays, the hours between 11 pm and 5:30 am are quiet hours to ensure the rest and comfort of all. We encourage listening to music as it is a great stress reliever. Please listen to your music at a reasonable volume; your music should be for your own listening pleasure.

Should Sample House include a rule about this topic? If no, why? If yes, which version should they use and why?

3. Parenting/Child care

Violence or the threat of violence is not an appropriate way to communicate with each other or to discipline your children. It is important that we work to teach your children ways of dealing with anger that does not involve hitting others. We take the threat of violence against children very seriously therefore we have a "No Hitting Policy." The staff of Sample House are MANDATED REPORTERS of child abuse and neglect.

In order for all adults and children to feel safe at Sample House, parents are asked not to use physical punishment to discipline their children. Physical discipline is defined as hitting, slapping, or spanking. If you need support in developing alternate methods of disciplining your child, please speak with your Case Manager or join our Mother's Group.

Should Sample House include a rule about this topic? If no, why? If yes, which version should they use and why?

4. Children's Bedtimes

Children must be in bed by 8:30 pm (or earlier, depending on age). Children under 12 months are permitted to be with their mothers past regular children's bedtimes.

Children are required to be in their bedrooms by 8:30 pm. This is a great opportunity to begin bedtime routines. Please stay in your room with your child until he/she is asleep. If you need help establishing bedtime routines to ensure that your child gets a good rest, please speak with one of the residential counselors or with your case manager.

Should Sample House include a rule about this topic? If no, why? If yes, which version should they use and why?

5. Weekday Curfew

Any resident not returning to the shelter by the end of quiet hours with case manager's approval will be issued a warning for an unapproved absence without leave ("AWOL").

All residents (including children) must return to the shelter by 9 pm on weekdays, within a five minute grace period. Please be on time. Set your watch by the clock that is located outside the main office. Any curfew violation will result in no weekend pass (resident or child).

Should Sample House include a rule about this topic? If no, why? If yes, which version should they use and why?

6. Transportation

In Sample House's van, you are not permitted to smoke or consume food/beverages. Appropriate language and behavior must be used at all times. Children weighing less than 40 pounds must be in car seats, and all passengers must wear seatbelts. If any passengers are non-compliant with the above van rules, they will be asked to leave the van and may lose van privileges.

For your safety, please follow the rules posted in the Sample House van concerning car seats, seat belts, and appropriate conduct.

Should Sample House include a rule about this topic? If no, why? If yes, which version should they use and why?

7. Drugs and Alcohol Usage

Many families living at Sample House have been touched by the devastating effects of drug and alcohol abuse. There are often women at Sample House who are courageously struggling with their own substance abuse issues and are committed to working on their own recovery. We ask that you remain drug and alcohol free throughout your stay at Sample House.

While residing at Sample House, residents are NOT allowed to use alcohol or drugs in or out of the shelter.

Should Sample House include a rule about this topic? If no, why? If yes, which version should they use and why?

8. Drug and Alcohol Screening

It is critical to the safety of everyone living here to understand that Sample House is a drug and alcohol free zone. As a result, anyone found to be in possession of drugs or alcohol will be terminated from Sample House. We reserve the right to do random urine screening for drugs and alcohol and currently have an outside agency come to Sample House twice a week to do testing.

Staff will conduct alcohol/drug screens of residents based on suspicion. If a resident refuses to submit to a drug/alcohol screen or tests positive for alcohol/drugs, he/she will be terminated from the program.

Should Sample House include a rule about this topic? If no, why? If yes, which version should they use and why?

9. Your Room

Upon your arrival, you will have a private room with a shared bathroom. We ask that you keep your room clean and free of clutter. You may have a small refrigerator in your room. Microwaves and hot plates are not allowed, as these are fire hazards.

You have been assigned to room _____. You are expected to keep your room clean. The following appliances are not permitted: holiday lights, hot plates, electric heaters, air conditioners, microwaves, and refrigerators. Towels, sheets, and clothing cannot be hung out the window.

Should Sample House include a rule about this topic? If no, why? If yes, which version should they use and why?

10. Room Decorations

We encourage you to display posters, photos, and other artwork on the bulletin boards provided in your room. Please do not place these items directly onto the walls, as the walls can become damaged over time.

Residents may not put stickers or posters on the room walls. Room cabinets are appropriate places for displaying pictures and posters.

Should Sample House include a rule about this topic? If no, why? If yes, which version should they use and why?

11. Room Checks

To ensure that residents are keeping their rooms clean and organized, residents are required to do complete cleaning in their rooms once a month on the designated day. To maintain health and sanitation standards for everyone, residential counselors will check your room daily to see that it is clean.

Staff may check the bedroom and bathroom to which you have been assigned on a daily basis. At any time, staff has the right to search your room.

Should Sample House include a rule about this topic? If no, why? If yes, which version should they use and why?

Next Steps for Creating a Trauma-Informed System

Most organizations serving homeless families do not have the opportunity to routinely reflect on their work, and refine their programs and policies to reflect the complex needs of the mothers and children they serve. Successful alignment of resources to become trauma-informed requires commitment from all levels of the staff and program as well as careful planning and designated resources.

- Within the organization, a consensus is reached about the need for becoming more trauma-informed. Program-wide staff meetings should take place in order to discuss the desire to alter practices and develop a more trauma-informed method of care.
- As part of these meetings, all staff should be educated about the reasons for this need for systemic change (i.e. education about the relationship between trauma and homelessness, an understanding of the concept of "trauma-informed care" and examples of trauma-informed practices).
- The organization should provide opportunities for all staff members to give feedback about their ideas, concerns and questions about what this means for the organization and for their daily roles within the program.
- An administrative point person is identified who will be responsible for overseeing the process of strategic planning and monitoring of goal development and achievement, identifying essential stakeholders within and outside the agency, and ensuring that all phases of the plan are developed and implemented. Resources must be identified and set aside for plan development, implementation and follow-up.
- The administrative point person identifies relevant participants from across the agency who would be involved in the strategic planning process. The point-person will convene a multi-disciplinary trauma workgroup consisting of members from all levels of the program who are willing to make a commitment to becoming more trauma-informed in their practices (in the case of smaller programs all staff should be included).
- The strategic plan will involve identifying specific goals, resources needed to achieve the goals and a realistic timeframe to begin to make changes. Examples of potential areas needing further attention include: 1) A strategy for training staff and consumers in trauma; 2) Developing a definition of "substantial representation" for hiring former consumers and creating a realistic timeline for meeting that goal; 3) Implementing consistent assessments for families that are trauma informed and administered by staff that have training in trauma; 4) Working on identifying triggers in the environment and reducing them; and 5) Getting trauma specific services to consumers who need them.
- The strategic plan will also include a plan for sustaining trauma-informed changes over time. For example, this may include making changes in policies, altering how training and orientation are done within the agency, and working on team building and team development among the staff.

Homelessness and Trauma Training Series
SAMPLE EVALUATION FORM

Please place a check mark next to the trainings you attended in this series:

- ☐ **Session 1:** Understanding Traumatic Stress in People Experiencing Homelessness
- ☐ **Session 2:** Creating Trauma-Informed Services and Settings for People Experiencing Homelessness
- ☐ **Session 3:** Incorporating Trauma-Informed Concepts into Daily Practice in Settings for People Experiencing Homelessness

Learning Objectives

Please rate how much you agree or disagree with the following statements, which comprise the learning objectives for this training series:	Strongly Disagree — Somewhat Agree — Strongly Agree
1. I can describe the human stress response and its impact on people, particularly as it relates to homelessness.	1…….2……..3……4……5
2. I can define what it means to be trauma-informed and give 2 examples of how trauma-informed principles relates to my work.	1…….2……..3……4……5
3. I can explain, with examples, how supporting staff development and creating a welcoming and safe environment lead to a more trauma-informed organization.	1…….2……..3……4……5
4. I can explain, with examples, how assessment and service planning, involving clients, and adapting policies lead to a more trauma-informed organization.	1…….2……..3……4……5
5. I have completed my planning worksheet that outlines the five domains of trauma-informed services with concrete next steps that I and/or my organization can take to become more trauma-informed.	1…….2……..3……4……5

Please complete the other side of this evaluation form ➔

Training Quality

Thinking about the workshop overall, *please rate how much you agree or disagree with the following statements:*	**Strongly Disagree**	**Somewhat Agree**	**Strongly Agree**
I was satisfied with the quality of the training series.	**1…….2…….3……4……5**		
I found the training series personally relevant to my work.	**1…….2…….3……4……5**		
I had the opportunity to participate in the training series.	**1…….2…….3……4……5**		
I feel more confident in understanding how traumatic impacts people experiencing homelessness.	**1…….2…….3……4……5**		
I will be able to incorporate material from the training series into my work.	**1…….2…….3……4……5**		
I understand more about the importance of being trauma-informed.	**1…….2…….3……4……5**		
The training series covered new material.	**1…….2…….3……4……5**		
I feel confident discussing with my colleagues how to incorporate a trauma-informed perspective into our work.	**1…….2…….3……4……5**		
The handouts provided were helpful.	**1…….2…….3……4……5**		
The trainer(s) had adequate knowledge of the topics covered.	**1…….2…….3……4……5**		
The training series was well organized.	**1…….2…….3……4……5**		
The training topics appropriately addressed the population with whom I work.	**1…….2…….3……4……5**		
The training venue was appropriate, comfortable, and easily accessible.	**1…….2…….3……4……5**		

Thank you!

Sample Post-Test

Homelessness and Trauma: A Three Part Training Series

Place a checkmark next to each session you attended in this training series.

- ☐ **Session 1**: Understanding Traumatic Stress in People Experiencing Homelessness
- ☐ **Session 2**: Creating Trauma-Informed Services and Settings for People Experiencing Homelessness
- ☐ **Session 3**: Incorporating Trauma-Informed Concepts into Daily Practice in Settings for People Experiencing Homelessness

Please complete the following questions by checking the appropriate box(es).

1. **The human stress response is the body's way of protecting itself against danger.** ☐ True ☐ False

2. **The fight-flight-freeze response is something we can control.** ☐ True ☐ False

3. **Which of the following factors influence a person's response to trauma?**

   - ☐ Current living situation
   - ☐ Duration of the trauma experience
   - ☐ Stage of development
   - ☐ Social relationships
   - ☐ All of the above
   - ☐ None of the above

4. **Someone who has experienced traumatic stress will most likely develop Post-Traumatic Stress Disorder.** ☐ True ☐ False

5. **Your shelter is required to have resident curfews. You work to implement this rule in a trauma-informed way by: (Check all that apply.)**

   - ☐ Setting up a system of penalties for clients who miss curfew.
   - ☐ Helping your clients plan their time so that they can arrive at the shelter on time.
   - ☐ Working with the shelter director to establish a procedure that avoids penalizing clients who have jobs that make it difficult for them to arrive on time.
   - ☐ Reminding your clients to stay at the shelter in the afternoons so that they don't risk missing curfew.

6. Which of the following are possible definitions of trauma-informed services?

☐ Services that strive to "do no harm" – to avoid re-traumatizing clients or blaming them for their efforts to manage their traumatic reactions – are considered trauma-informed services.

☐ All services provided to clients who have experienced trauma are considered "trauma-informed" services.

☐ Both of the above

☐ None of the above

7. Many who are homeless have experienced multiple traumas, which are often interpersonal in nature, prolonged, repeated, and severe. This is an example of:

☐ Complex trauma

☐ Typical trauma

☐ Acute trauma

☐ Post Traumatic Stress Disorder

8. Which of the following is <u>not</u> a principle of trauma-informed services?

☐ Understanding trauma

☐ Promoting safety

☐ Establishing clear staff authority

☐ Integrating care

9. A trauma-informed safety plan… (Check all that apply.)

☐ Is reactive

☐ Is made in partnership with the client

☐ Promotes staff safety

☐ None of the above

10. Asking a question such as "I don't know how this is interpreted in your community, can you help me understand it?":

☐ Fosters cultural competence

☐ Invades the client's privacy

☐ Undermines professional credibility

☐ None of the above

11. Client goals should be: (Check all that apply.)

- ☐ Made collaboratively
- ☐ Determined by service providers
- ☐ Best kept long-term
- ☐ Dictated by funders
- ☐ None of the above

12. Complex trauma alters the way the brain responds to danger. ☐ True ☐ False

13. Which of the following promotes a client's sense of safety? (Check all that apply.)

- ☐ Good lighting
- ☐ Random room checks
- ☐ Predictable routines
- ☐ None of the above

14. Which of the following is the definition for "Vicarious Traumatization"?

- ☐ Trauma that occurs when a by-stander witnesses a traumatic event happening to someone else
- ☐ When work with clients results in providers experiencing post-traumatic stress responses that can eventually impact their view of themselves and others
- ☐ When children are traumatized by their parents' experiences

15. Building trusting relationships with clients: (Check all that apply.)

- ☐ Involves providing clients with choice and control
- ☐ Includes setting realistic expectations
- ☐ Happens early in the relationship
- ☐ Includes giving clients a set number of chances to achieve their goals
- ☐ Involves many setbacks and challenges

Thank you!

Sample Post-Test ANSWER KEY

Homelessness and Trauma: A Three Part Training Series

Place a checkmark next to each session you attended in this training series.

- ☐ **Session 1**: Understanding Traumatic Stress in People Experiencing Homelessness
- ☐ **Session 2**: Creating Trauma-Informed Services and Settings for People Experiencing Homelessness
- ☐ **Session 3**: Incorporating Trauma-Informed Concepts into Daily Practice in Settings for People Experiencing Homelessness

Please complete the following questions by checking the appropriate box(es).

1. **The human stress response is the body's way of protecting itself against danger.** ☒ True ☐ False

2. **The fight-flight-freeze response is something we can control.** ☐ True ☒ False

3. **Which of the following factors influence a person's response to trauma?**

   - ☐ Current living situation
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   - ☒ Working with the shelter director to establish a procedure that avoids penalizing clients who have jobs that make it difficult for them to arrive on time.
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☒ Is made in partnership with the client

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- ☐ Happens early in the relationship
- ☐ Includes giving clients a set number of chances to achieve their goals
- ☒ Involves many setbacks and challenges

Thank you!

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