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Trauma-Informed Organizational Toolkit

for homeless services

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Acknowledgments

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Additional SAMHSA Resources

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Introduction

The prevalence of traumatic stress in the lives of families experiencing homelessness is extraordinarily high. Often these families have experienced on-going trauma throughout their lives in the form of childhood abuse and neglect, domestic violence, community violence, and the trauma associated with poverty and the loss of home, safety and sense of security. These experiences have a significant impact on how people think, feel, behave, relate to others, and cope with future experiences. Families have learned to adapt to these traumatic circumstances in order to survive, but their ways of coping may seem confusing and out-of-place in their current circumstances.

Given the high rates of traumatic exposure among families who are homeless, it has become clear that understanding trauma and its impact is essential to providing quality care in shelters and housing programs. This realization has lead to the suggestion that programs serving trauma survivors adapt their services to account for their clients' traumatic experiences, that is, they become "trauma-informed". In order to respond empathically to the needs of trauma survivors, ensure their physical and emotional safety, develop realistic treatment goals, and at the very least avoid re-traumatization, all practices and programming must be provided through the lens of trauma.

With support from the Daniels Fund, the National Child Traumatic Stress Network, the Homelessness Resource Center, and the W.K. Kellogg Foundation, the National Center on Family Homelessness (NCFH) has created the *Trauma-Informed Organizational Toolkit* to provide programs with a roadmap for becoming trauma-informed. The *Toolkit* offers homeless service providers with concrete guidelines for how to modify their practices and policies to ensure that they are responding appropriately to the needs of families who have experienced traumatic stress. The *Trauma-Informed Organizational Toolkit* includes:

1. The *Trauma-Informed Organizational Self-Assessment.* The *Self-Assessment* is designed to help programs evaluate their practices and based on their findings, adapt their programming to support recovery and healing among their clients.
2. A *User's Guide*. The *User's Guide* is designed to assist programs in implementing the *Self-Assessment* and contains additional information about this assessment tool and what it means to provide trauma-informed care.
3. A *How-To Manual for Creating Organizational Change*. The *Manual* identifies concrete steps that organizations can take if they are interested in becoming trauma-informed. These steps include the use of the *Self-Assessment* and *User's Guide* to begin this process.

Section I: Trauma-Informed Organizational Self-Assessment

Instructions:

The *Trauma-Informed Organizational Self-Assessment* is a tool that organizations can use to examine their current practices and take specific steps to become trauma-informed.* The *Self-Assessment* should be completed by all staff within an organization, including direct care staff (full time, part time and relief), supervisors, case managers, clinicians, administrators (e.g., program managers, directors, executive directors, etc.) and support staff (e.g., office support, maintenance, kitchen staff, etc.).

In the *Self-Assessment*, the term "consumer" refers to adults who are being served by the program. There are also items that refer specifically to a consumer's child or children. The term "staff" refers to paid and voluntary individuals providing services, which include but are not limited to: those working directly with consumers and children, administrators, policymakers, groundskeepers, maintenance, and transportation specialists.

The *Self-Assessment* can be completed in one sitting or in sections. It takes approximately 30-40 minutes to complete the entire *Self-Assessment* at once. When responding to *Self-Assessment* items, please answer based on your experience in the program over the past 6 months. For each item, please consider the extent to which you agree that the program incorporates this practice using the following scale:

Strongly Disagree
Disagree
Agree
Strongly Agree
Do not know
Not applicable to my role

For example:

> *"Consumers are asked about the least intrusive ways for staff to check on them and their spaces."* Staff respond *"Strongly Disagree, Disagree, Agree, Strongly Agree, Do not know, or Not applicable to my role."*

Please answer as honestly and accurately as possible. Remember that you are not evaluating your individual performance, but rather, the practices of the program as a whole. If you have questions or are confused about the items, instructions, etc., please contact the person or persons that your organization has identified to help with the completion of the *Self-Assessment*. Please return your copy of the *Self-Assessment* to the designated person or drop-off location.

* See *User's Guide* for additional information about the *Self-Assessment* and what it means to provide trauma-informed care.

I. Supporting Staff Development

A. Training and Education	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
Staff at all levels of the program receive training and education on the following topics:						
1. What traumatic stress is.						
2. How traumatic stress affects the brain and body.						
3. The relationship between mental health and trauma.						
4. The relationship between substance use and trauma.						
5. The relationship between homelessness and trauma.						
6. How trauma affects a child's development.						
7. How trauma affects a child's attachment to his/her caregivers.						
8. The relationship between childhood trauma and adult re-victimization (e.g., domestic violence, sexual assault).						
9. Different cultures (e.g., different cultural practices, beliefs, rituals).						
10. Cultural differences in how people understand and respond to trauma.						
11. How working with trauma survivors impacts staff.						
12. How to help consumers identify triggers (i.e., reminders of dangerous or frightening things that have happened in the past).						
13. How to help consumers manage their feelings (e.g., helplessness, rage, sadness, terror, etc.).						
14. De-escalation strategies (i.e., ways to help people to calm down before reaching the point of crisis).						
15. How to develop safety and crisis prevention plans.						
16. What is asked in the intake assessment.						
17. How to establish and maintain healthy professional boundaries.						

B. Staff Supervision, Support and Self-Care	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
18. Staff members have regular team meetings.						
19. Topics related to trauma are addressed in team meetings.						
20. Topics related to self-care are addressed in team meetings (e.g., vicarious trauma, burn-out, stress-reducing strategies).						
21. Staff members have a regularly scheduled time for individual supervision.						
22. Staff members receive individual supervision from a supervisor who is trained in understanding trauma.						
23. Part of supervision time is used to help staff members understand their own stress reactions.						
24. Part of supervision time is used to help staff members understand how their stress reactions impact their work with consumers.						
25. The program helps staff members debrief after a crisis.						
26. The program has a formal system for reviewing staff performance.						
27. The program provides opportunities for on-going staff evaluation of the program.						
28. The program provides opportunities for staff input into program practices.						
29. Outside consultants with expertise in trauma provide on-going education and consultation.						

II. Creating a Safe and Supportive Environment

A. Establishing a Safe Physical Environment	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
1. The program facility has a security system (i.e., alarm system).						
2. Program staff monitors who is coming in and out of the program.						
3. Staff members ask consumers for their definitions of physical safety.						
4. The environment outside the program is well lit.						
5. The common areas within the program are well lit.						
6. Bathrooms are well lit.						
7. Consumers can lock bathroom doors.						
8. Consumers have access to private, locked spaces for their belongings.						
9. The program incorporates child-friendly decorations and materials.						
10. The program provides a space for children to play.						
11. The program provides consumers with opportunities to make suggestions about ways to improve/change the physical space.						
B. Establishing a Supportive Environment						
Information Sharing						
12. The program reviews rules, rights and grievance procedures with consumers regularly.						
13. Consumers are informed about how the program responds to personal crises (e.g., suicidal statements, violent behavior).						
14. Consumers are informed about who will be checking on them and their spaces (e.g., how often and why it is important).						

Information Sharing, cont...	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
15. Expectations about room/apartment checks are clearly written and verbalized to consumers.						
16. Consumer rights are posted in places that are visible.						
17. Material is posted about traumatic stress (e.g., what it is, how it impacts people, and available trauma-specific resources).						
Cultural Competence						
18. Program information is available in different languages.						
19. Consumers are allowed to speak their native language within the program.						
20. Consumers are allowed to prepare or have ethnic-specific foods.						
21. Staff shows acceptance for personal religious or spiritual practices.						
22. The program provides on-going opportunities for consumers to share their cultures with each other (e.g., potlucks, culture nights, incorporating different types of art and music, etc.).						
23. Outside agencies with expertise in cultural competence provide on-going training and consultation.						
Privacy and Confidentiality						
24. The program informs consumers about the extent and limits of privacy and confidentiality (e.g., the kinds of records that are kept, where they are kept, who has access to this information, and when the program is obligated to report information to child welfare or police).						

Privacy and Confidentiality, cont...	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
25. Consumers are asked about the least intrusive ways for staff to check on them and their spaces.						
26. The program gives notice prior to doing room/apartment checks.						
27. The program gets permission from consumers prior to giving a tour of their room/apartment.						
28. If permission is given, the consumer is notified of the date, time and who will see their room/apartment.						
29. Staff does not talk about consumers in common spaces.						
30. Staff does not talk about consumers outside of the program.						
31. Staff does not discuss the personal issues of one consumer with another consumer.						
32. Consumers who have violated rules are approached in private.						
33. There are private spaces for staff and consumers to discuss personal issues.						
Safety and Crisis Prevention Planning						
For the following items, the term "safety plan" is defined as a plan for what a consumer and staff members will do if the consumer feels threatened by another person outside of the program.						
34. Consumers work with staff to create written, individualized safety plans for their family.						
35. Written safety plans are incorporated into consumers' individual goals and plans.						

Safety and Crisis Prevention Planning, cont...	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
For the following items, the term "crisis-prevention plan" is defined as an individualized plan for how to help each consumer manage stress and feel supported.						
36. Every **adult** in the program has a written crisis-prevention plan.						
37. Every **child** in the program has a written crisis-prevention plan.						
Written crisis prevention plans include the following:						
38. A list of triggers (i.e., situations that are stressful or overwhelming and remind the consumer of past traumatic experiences).						
39. A list of ways that the consumer shows that they are stressed or overwhelmed (e.g., types of behaviors, ways of responding, etc.).						
40. Specific strategies and responses that are **helpful** when the consumer is feeling upset or overwhelmed.						
41. Specific strategies and responses that are **not helpful** when the consumer is feeling upset or overwhelmed.						
42. A list of people that the consumer feels safe around and can go to for support.						

Open and Respectful Communication	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
43. Staff members ask consumers for their definitions of emotional safety.						
44. Staff members practice motivational interviewing techniques with consumers (e.g., open-ended questions, affirmations, and reflective listening).						
45. The program uses "people-first" language rather than labels (e.g., "people who are experiencing homelessness" rather than "homeless people").						
46. Staff uses descriptive language rather than characterizing terms to describe consumers (e.g., describing a person as "having a hard time getting her needs met" rather than "attention-seeking").						
Consistency and Predictability						
47. The program has regularly scheduled community meetings for consumers.						
48. The program provides advanced notice of any changes in the daily or weekly schedule.						
49. Program staff responds consistently to consumers (e.g., consistency across shifts and roles).						
50. There are structures in place to support staff consistency with consumers (e.g., trainings, staff meetings, shift change meetings, and peer supervision).						
51. The program is flexible with rules if needed, based on individual circumstances.						

III. Assessing and Planning Services

A. Conducting Intake Assessments	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
The intake assessment includes questions about:						
1. Personal strengths.						
2. Cultural background.						
3. Cultural strengths (e.g., world view, role of spirituality, cultural connections).						
4. Social supports in the family and the community.						
5. Current level of danger from other people (e.g., restraining orders, history of domestic violence, threats from others).						
6. History of trauma (e.g., physical, emotional or sexual abuse, neglect, loss, domestic/community violence, combat, past homelessness).						
7. Previous head injury.						
8. Quality of relationship with child or children (i.e., caregiver/child attachment).						
9. Children's trauma exposure (e.g., neglect, abuse, exposure to violence).						
10. Children's achievement of developmental tasks.						
11. Children's history of mental health issues.						
12. Children's history of physical health issues.						
13. Children's history of prior experiences of homelessness.						

Intake Assessment Process	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
14. There are private, confidential spaces available to conduct intake assessments.						
15. The program informs consumers about why questions are being asked.						
16. The program informs consumers about what will be shared with others and why.						
17. Throughout the assessment process, the program checks in with consumers about how they are doing (e.g., asking if they would like a break, water, etc.).						
18. The program provides an adult translator (not another consumer in the program) for the assessment process if needed.						
Intake Assessment Follow-up						
19. Based on the intake assessment, **adults** are referred for specific services as necessary.						
20. Based on the intake assessment, **children** are referred for further assessment and services as needed.						
21. The intake assessment is updated on an on-going basis.						
22. The program updates releases and consent forms whenever it is necessary to speak with a new provider.						
B. Developing Goals and Plans						
23. Staff supports consumers in setting their own goals.						
24. Consumer goals are reviewed and updated regularly.						
25. Consumers work with staff to identify a plan to address their children's needs.						

Developing Goals and Plans, cont...	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
26. Before leaving the program, consumers and staff develop a plan to address potential safety issues.						
27. Before leaving the program, consumers and staff develop a plan to address future service needs related to trauma.						
28. Before leaving the program, consumers and staff develop a plan that addresses their children's service needs related to trauma.						
C. Offering Services and Trauma-Specific Interventions						
29. The program provides opportunities for consumers to receive a variety of services (e.g., housing, employment, legal and educational advocacy, and health, mental health and substance abuse services).						
30. When mental health services are needed (e.g., individual therapy, group therapy and/or family therapy), the program refers **adults** to agencies with expertise in trauma.						
31. When mental health services are needed (e.g., individual therapy, group therapy and/or family therapy), the program refers **children** to agencies with expertise in trauma.						
32. The program coordinates on-going communication between mental health and substance abuse providers.						
33. The program coordinates on-going communication between early intervention and mental health service providers.						
34. The program educates consumers about traumatic stress and triggers.						
35. The program provides opportunities for consumers to express themselves in creative and nonverbal ways (e.g., art, theater, dance, movement, music).						
36. The program has access to a clinician with expertise in trauma and trauma-related interventions (on-staff or available for regular consultation).						

IV. Involving Consumers

A. Involving Current and Former Consumers	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
Current Consumers						
1. The needs and concerns of current program consumers are addressed in community meetings.						
2. The program provides opportunities for consumers to lead community meetings.						
3. Current consumers are involved in the development of program activities.						
4. Current consumers are given opportunities to evaluate the program and offer their suggestions for improvement in anonymous and/or confidential ways (e.g., suggestion boxes, regular satisfaction surveys, meetings focused on necessary improvements, etc.).						
Former Consumers (refers to anyone who has experienced homelessness)						
5. Former consumers are hired at all levels of the program.						
6. The program recruits former consumers for their board of directors.						
7. Former consumers are involved in program development.						
8. Former consumers are involved in providing services (e.g., peer-run support groups, educational, and therapeutic groups.).						
9. Former consumers are invited to share their thoughts, ideas, and experiences with the program.						

V. Adapting Policies

A. Creating Written Policies	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
1. The program has a written statement that includes a commitment to understanding trauma and engaging in trauma-sensitive practices.						
2. Written policies are established based on an understanding of the impact of trauma on consumers.						
3. The program has a written commitment to demonstrating respect for cultural differences and practices.						
4. The program has a written commitment to hire staff who have experienced homelessness.						
5. The program has a written policy to address potential threats to consumers from persons outside of the program.						
6. The program has a written policy outlining program responses to consumer crises (e.g., self-harm, suicidal thinking, aggression towards others).						
7. The program has written policies outlining professional conduct for staff (e.g., boundaries, responses to consumers, etc.).						
B. Reviewing Policies						
8. The program reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors.						
9. The program involves staff in its review of policies.						
10. The program involves consumers in its review of policies.						

Section II: User's Guide

I. Introduction

Nearly 600,000 families and more than 1.3 million children experience homelessness annually in the United States (Burt & Aron, 2000). The majority of these families consist of a young, single mother in her late 20s with two young children, most often under the age of six (National Center on Family Homelessness [NCFH], 1999). Often, these women and children have experienced high rates of traumatc stress (NCFH, 1999).

"There is a need for shelter and housing programs to be "trauma-informed" in all of their practices."

Despite research findings that confirm the presence of traumatic exposure in the lives of families experiencing homelessness, few programs have been able to organize their services in ways that address and mitigate the effects of traumatic stress. There is a need for shelter and housing programs to be "trauma-informed" in all of their practices. In response to this great need, the National Center on Family Homelessness created the *Trauma-Informed Organizational Self-Assessment* to assist shelters in examining their practices by offering concrete guidelines on how to provide trauma-informed care. This *User's Guide* is designed to be used in conjunction with the *Self-Assessment*, and offers information on:

- What it means to be "trauma-informed", including definitions and underlying principles of trauma-informed care.
- The purpose of the *Self-Assessment*, how it was developed, who should use it, how it should be used, and how to compile and examine the results.
- The five domains that make up the *Self-Assessment*, including a discussion of the specific items and their importance within a trauma-informed program.

The *Trauma-Informed Organizational Self-Assessment* and *User's Guide* were informed by the seminal work of other leaders in the field who have begun to define what it means to be trauma-informed. These works include:

- Maxine Harris and Roger Fallot's *New Directions for Mental Health Services: Using Trauma Theory to Design Service Systems* and *Trauma-Informed Services: A Self-Assessment and Planning Protocol.*
- Women Embracing Life and Living (WELL) Project and the WELL Project State Leadership Council of the Institute for Health and Recovery's *Developing Trauma-Informed Organizations: A Toolkit*.
- Sandra Bloom's *Creating Sanctuary: A Model of Organizational Change.*

II. Trauma-Informed Care

A traumatic experience involves a threat to one's physical or emotional well-being, and elicits intense feelings of helplessness, terror, and lack of control (American Psychiatric Association, 2000). Traumatic experiences can significantly alter a person's perception of themselves, their environment, and the people around them. As traumatic experiences accumulate, responses become more intense and have a greater impact on functioning. On-going exposure to traumatic stress can impact all areas of people's lives, including biological, cognitive, and emotional functioning; social interactions/relationships; and identity formation. Because people who have experienced multiple traumas do not relate to the world in the same way as those who have not had these experiences, they require services and responses that are sensitive to their experiences and needs.

Definition of Trauma-Informed Care

Meeting the needs of trauma survivors requires that programs become "trauma-informed" (Harris & Fallot, 2001). Maxine Harris (2004) describes a trauma-informed service system as "a human services or health care system whose primary mission is altered by virtue of knowledge about trauma and the impact it has on the lives of consumers receiving services". This means looking at all aspects of programming through a trauma lens, constantly keeping in mind how traumatic experiences impact consumers. Programs that are informed by an understanding of trauma respond best to consumer needs and avoid engaging in re-traumatizing practices.

Principles of Trauma-Informed Care

The *Trauma-Informed Organizational Self-Assessment* is based on eight foundational principles that represent the core values of trauma-informed care. These principles were identified on the basis of knowledge about trauma and its impact, findings of the Co-Occurring Disorders and Violence Project (Moses, Reed, Mazelis, & D'Ambrosio, 2003), literature on therapeutic communities (Campling, 2001), and the work of Maxine Harris and Roger Fallot (Harris & Fallot, 2001; Fallot & Harris, 2002) and Sandra Bloom (Bloom, 2004). Principles of trauma-informed care include:

- **Understanding Trauma and Its Impact:** Understanding traumatic stress and how it impacts people and recognizing that many behaviors and responses that may be seem ineffective and unhealthy in the present, represent adaptive responses to past traumatic experiences.
- **Promoting Safety:** Establishing a safe physical and emotional environment where basic needs are met, safety measures are in place, and provider responses are consistent, predictable, and respectful.
- **Ensuring Cultural Competence:** Understanding how cultural context influences one's perception of and response to traumatic events and the recovery process; respecting diversity within the program, providing opportunities for consumers to engage in cultural rituals, and using interventions respectful of and specific to cultural backgrounds.
- **Supporting Consumer Control, Choice and Autonomy:** Helping consumers regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy; keeping consumers well-informed about all aspects of the system, outlining clear expectations, providing opportunities for consumers to make daily decisions and participate in the creation of personal goals, and maintaining awareness and respect for basic human rights and freedoms.

- **Sharing Power and Governance:** Promoting democracy and equalization of the power differentials across the program; sharing power and decision-making across all levels of an organization, whether related to daily decisions or in the review and creation of policies and procedures.
- **Integrating Care:** Maintaining a holistic view of consumers and their process of healing and facilitating communication within and among service providers and systems.
- **Healing Happens in Relationships:** Believing that establishing safe, authentic and positive relationships can be corrective and restorative to survivors of trauma.
- **Recovery is Possible:** Understanding that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for consumer and former consumer involvement at all levels of the system, facilitating peer support, focusing on strength and resiliency, and establishing future-oriented goals.

Why Programs Need to be Trauma-Informed

Families often enter the homeless service system with significant histories of trauma that impact their current functioning and needs. The connection between homelessness and trauma underscores the need for specific programming for these families. The following realities highlight the need for trauma-informed programming in organizations serving families who are homeless:

- **Homeless families have experienced traumatic stress.** Most families experience multiple traumas prior to becoming homeless. Traumatic experiences include childhood abuse and neglect, family separations, violent relationships and witnessing domestic violence (Bassuk et al., 1996). In addition, the experience of being homeless is, in and of itself, traumatic (Goodman and Harvey, 1991).
- **Trauma impacts how people access services.** People who have experienced on-going trauma may view the world and other people as unsafe. Those who have repeatedly been hurt by others may come to believe that people cannot be trusted. This lack of trust and a need to be constantly on-guard for danger makes it difficult for families to ask for help, trust providers, or form relationships.
- **Responses to traumatic stress are adaptive.** In the face of traumatic experiences, people learn to adapt to keep themselves safe. Responses to traumatic stress may include withdrawing from others, becoming aggressive, dissociating ("spacing out" or disconnecting from certain thoughts, feelings or memories associated with traumatic experiences), engaging in self-injurious behaviors such as cutting, or abusing substances in an effort to manage overwhelming feelings. While these behaviors may appear to be unhealthy or ineffective to providers, they should be understood as coping skills that were once useful in the past, and which can slowly be replaced with healthier alternatives.
- **Trauma survivors require specific, tailored interventions.** Given the far-reaching impact of trauma and the adaptations survivors are forced to develop, they require responses and interventions not offered by traditional service systems. Healing for trauma survivors is not supported by "one size fits all" services that fail to consider trauma and its impact. How a program responds to the needs of families who have experienced trauma has a significant impact on their process of recovery.

III. The Trauma-Informed Organizational Self-Assessment

While an organization may value the principles of trauma-informed care, such as safety, relationship-building and recovery, it is difficult to transform these concepts into specific practices designed to meet the unique needs of trauma-survivors. Within homeless service settings, there is often little access to education about trauma or concrete guidelines for becoming trauma-informed.

The National Center on Family Homelessness (NCFH) developed the *Trauma-Informed Organizational Self-Assessment* to translate the principles of trauma-informed care into concrete practices that can be incorporated into daily programming in shelter and housing programs. This tool is designed to be used by programs to: 1) evaluate programming based on how well they incorporate *Self-Assessment* practices; 2) identify areas for organizational growth; and 3) make practical changes using the *Self-Assessment* as a guide.

Developing the Self-Assessment

The *Self-Assessment* was developed over several years. The process involved many revisions based on feedback from trauma and research experts, consumers, and community providers. The *Self-Assessment* was piloted locally, in Boston, MA, and nationally, in emergency shelter and transitional housing programs across the United States.

A detailed description of the phases of development of the *Self-Assessment*, including methodology, recommendations for use, and limits of the tool is offered in Appendix I.

Piloting the Self-Assessment

The *Trauma-Informed Organizational Self-Assessment* was first piloted locally in nine Massachusetts area shelters. A total of 87 providers used the tool to examine their systems and evaluate the extent to which they incorporated the trauma-informed practices listed in the *Self-Assessment*. Two of the programs participated in 4 months of on-going consultation with NCFH, using the *Self-Assessment* as a guide for beginning the organizational change process.

In the final year of its development, the *Self-Assessment* was piloted in 3 programs serving families experiencing homelessness in California, Iowa and Georgia. NCFH provided each site with training on trauma and trauma-informed care and 7-8 months follow-up consultation on trauma and trauma-informed practices. Program administrators and staff members used the results of the *Trauma-Informed Organizational Self-Assessment* to guide their strategic planning towards becoming more trauma-informed. At the end of the project year, programs were able to identify concrete changes in their daily practice as well as attitudinal and cultural shifts within the broader organization. Lessons learned from these piloting experiences informed the creation of the *How-to Manual for Creating Organizational Change* (see p. 50 of the *Toolkit*).

How the Self-Assessment is Organized

The *Self-Assessment* is organized into five main "domains" or areas of programming to be examined:

- Supporting Staff Development
- Creating a Safe and Supportive Environment
- Assessing and Planning Services
- Involving Consumers
- Adapting Policies

Within each domain is a list of specific, concrete "items" or trauma-informed practices (e.g. "Staff at all levels of the program receive training and education on how traumatic stress affects the brain and body."). There is a corresponding scale ranging from "strongly disagree" to "strongly agree" that people use to evaluate the extent to which they agree that their program incorporates each practice.

Who Should Use the Self-Assessment

The *Self-Assessment* can be used by residential programs serving homeless families including emergency shelters, domestic violence shelters, and transitional and supportive housing programs*.

The *Self-Assessment* should be completed by all staff within an organization, including direct care staff, supervisors, case managers, clinicians, administrators (i.e. program managers, directors, executive directors, etc.), and support staff (i.e. office support, maintenance, kitchen staff, etc.). To create lasting organizational change, all employees should be involved in the process of organizational self-assessment in order to understand why change is necessary, and what it means to be trauma-informed. Including all staff members in this process offers the most accurate picture of how the program runs, as well as opportunities to look for inconsistencies in how staff members assess practices and clarify discrepancies and confusion within the organization.

How to Complete the Self-Assessment

Program staff completing the *Self-Assessment* are asked to read through each item and use a scale ranging from "strongly disagree" to "strongly agree" to evaluate the extent to which they agree that their program incorporates each practice into daily programming. Staff members are asked to answer based on their experience in the program over the past 6 months.

Example Item: *"Consumers are asked about the least intrusive ways for staff to check on them and their spaces."* Staff respond "*Strongly Disagree, Disagree, Agree, Strongly Agree, Do not know, or Not applicable to my role".*

Staff responses to the *Self-Assessment* items should remain anonymous and staff should be encouraged to answer as honestly and accurately as possible. Staff members are not evaluating their individual performance, but rather, the practices of the program as a whole. Staff should complete the *Self-Assessment* when they have time to consider the items carefully. The *Self-Assessment* may be completed in one sitting, which will take approximately 30-40 minutes. It may also be filled out section by section if staff members are not able to complete it all at one time.

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* **Limits of the tool with various populations:**

The *Self-Assessment* was initially created for use in programs serving women and children. While it is also applicable in mixed gender settings, its use in these settings may require further refinement of the tool to respond to gender-specific issues that have not been addressed. Research is necessary to thoroughly explore additional issues that may arise in programs that house different types of families. The *Self-Assessment* is also designed primarily for congregate settings and has been completed by staff in emergency shelters, domestic violence shelters and transitional programs. For use in supportive housing programs and scattered site settings, the *Self-Assessment* will likely require additional adaptations to adequately address issues that are unique to these types of programs.

How to Compile and Examine Self-Assessment Results

It is helpful for the program to have a point person to collect the completed assessments from all staff and compile the results. The following is a suggested method for compiling this information:

1. Using an Excel spreadsheet, enter each staff member's response to each *Self-Assessment* item.

Sample:

Staff Development	Staff member 1	Staff member 2	Staff member 3
Staff at all levels of the program receive training and education on the following topics:			
1. What traumatic stress is.	Strongly Agree	Agree	Do not know
2. How traumatic stress affects the brain and body.	Agree	Strongly Agree	Agree
3. The relationship between mental health and trauma.	Strongly Agree	Strongly Agree	Agree

2. Using the information entered above, count the total number of strongly disagree, disagree, agree, strongly agree, do not know, and not applicable responses for each *Self-Assessment* item accross staff members. Enter these totals on a blank *Self-Assessment* that can be copied and distributed to all staff.

Sample:

Staff Development	Agree	Strongly Agree	Do not know
Staff have education on the following:			
1. What traumatic stress is.	1	1	1
2. How traumatic stress affects the brain and body.	2	1	
3. The relationship between trauma and mental health problems.	1	2	

To identify areas for change, the program looks for items where staff responses are mainly "strongly disagree" and "disagree", as these are practices that most staff feel the program does not incorporate. The program may also look at items where many people responded "do not know", as these may be practices that either are not done or there is a lack of staff understanding about what is done that requires clarification. Finally, it is helpful to examine items where the range of responses are extremely varied (i.e. staff responses to the same item range from "strongly disagree" to "strongly agree"). This lack of consistency among staff responses may be due to a lack of understanding about the item itself, a difference of perspective based on a person's role in the program, or a misunderstanding on the part of some staff members about what is actually done on a daily basis.

See the *How-To Manual for Creating Organizational Change* on p. 50 for ways to use the *Self-Assessment* results to begin the strategic planning process.

IV. Understanding the Self-Assessment Domains

This section explores the five domains within the *Trauma-Informed Organizational Self-Assessment* offering:

- **An explanation of the subcategories and items.** A review of the five domains and sub-categories to explain why they were chosen as the primary areas of focus.
- **Essentials for providing quality programming.** The *User's Guide* offers general guidelines for providing quality care to families experiencing homelessness. Adopting trauma-specific practices assumes that these "essentials for quality programming" are already well-established. If an organization is struggling with these foundational components of programming, they should incorporate these practices in addition to trauma-specific practices outlined in the *Self-Assessment*.
- **Additional tips for creating trauma-informed settings.** These tips supplement the *Self-Assessment* items, and provide programs with additional ideas about how to incorporate trauma-informed practices.

Domain 1: Supporting Staff Development

Trauma can impact every aspect of a survivor's life, and its effects can appear in areas directly related to the trauma as well as those that seem initially unrelated. Coping strategies used to survive and manage traumatic experiences may be seen by others as inappropriate or "maladaptive." A lack of awareness of trauma and its impact on adults and children often leads to misunderstandings between staff and consumers that can re-traumatize consumers and cause them to disengage from services.

Figure 1: Essentials for Quality Programming

- Staff members are required to complete a certain amount of staff development time (e.g., trainings, conferences, etc.) per year.
- Coverage is in place to support training.
- Financial assistance/paid time-off is available for staff to attend trainings.
- The program educates staff members about:
  - Confidentiality
  - Informed consent
  - Roles and responsibilities
  - Professional boundaries
- The program includes staff members from different cultures.
- The program includes staff members who speak different languages.
- Staff members are welcomed to discuss concerns about the program with administrators without negative consequences (e.g., being treated differently, feeling like their job is in jeopardy or having it impact their role on the team).

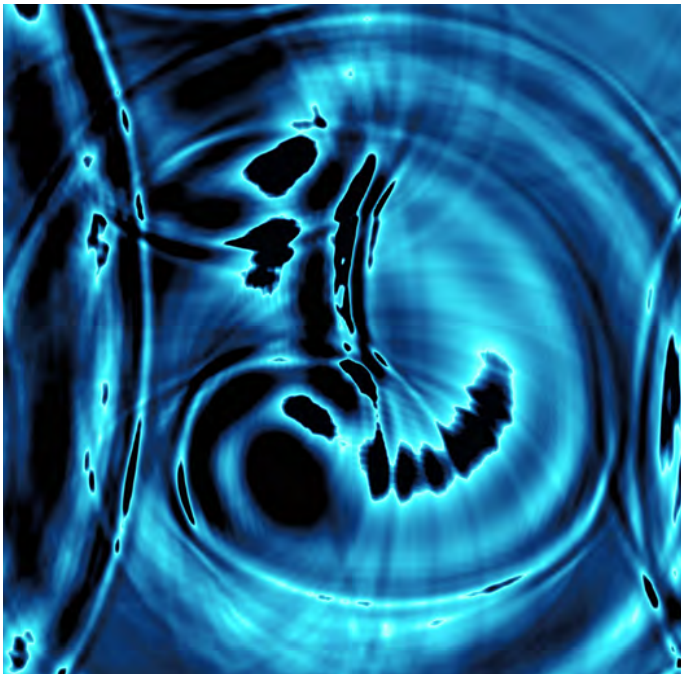
Creating trauma-informed services and settings requires programs to expand on basic, traditional staff development efforts (see figure 1) to include a range of trauma-related training and support activities. Training and education on trauma, supervision that includes discussions about trauma, and a focus on self-care for the provider are all key components of a trauma-informed organization.

Training and Education

Staff training and education is crucial to becoming trauma-informed. Training everyone–administrators, direct care staff, case managers, support staff etc.–about trauma and trauma-related topics ensures that all staff members are working from the same level of understanding and are capable of providing the same types of trauma-sensitive responses.

> *"With just a brief introduction to trauma dynamics, all of the personnel at a service agency can become more sensitive and less likely to frighten or re-traumatize a consumer seeking services"*
>
> *—Harris & Fallot, 2001, p. 7*

To provide trauma-informed care, a program must ensure that all staff receive training and education on a variety of topics. Programs may begin with basic training about traumatic stress and its impact, and then address the relationship between trauma and mental health, substance use, and homelessness. To understand the impact of early trauma on adults and children, it is important for staff to learn about how trauma impacts child development and attachment to caregivers. Becoming trauma-informed involves incorporating education about the cultural backgrounds of consumers being served, including how different cultures understand and respond to trauma. Training should also focus on how working with trauma survivors can impact staff (e.g., vicarious traumatization or "compassion fatigue") to raise staff awareness about their own triggers and level of burn-out, and how these issues can impact their work with consumers.



Once educated about trauma and its impact on consumers and providers, staff members need to learn how to apply this information to their daily work. This type of training involves helping staff avoid responding to consumers in ways that are punitive, disrespectful, and re-traumatizing. Learning to respond proactively helps both providers and consumers feel safe and in control. Staff training in crisis management may include learning how to help consumers identify triggers, express their feelings safely, and use healthy coping skills. Proactive responses may also include helping consumers developed safety and self-care plans prior to a crisis (see p. 28).

Additional Resources for Training and Education:

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.

Figure 2: Tips for Sustaining Trauma Education and Awareness

One-time trainings are insufficient to support organizational change. Organizational change is a continuous process, and new approaches take time to be reinforced and deepened. Additionally, high turnover rates necessitate repeated training to provide knowledge and skills to new staff. To be trauma-informed, programs can build an infrastructure for sustaining trauma-awareness and growth in the following ways:

- **Creation of a "trauma workgroup"**— A core group of staff members from all levels of the organization, sanctioned by management, who come together to take what they have learned about trauma and strategize about how to apply this knowledge to daily program practices, and facilitate continued education about trauma for all staff. Workgroup activities may include examining the environment and program practices for potential triggers, arranging for further staff training and consultation by outside agencies, and identifying and taking advantage of smaller opportunities such as supervision and staff meetings to provide further education about trauma, and how these concepts can be applied in real world situations.
- **Incorporating trauma language—** Using the term "trauma" in program mission statement, hand-books, etc**..** incorporate questions about a potential employee's understanding of trauma concepts into the interview process. This represents another way to integrate trauma into daily practice, and convey the message that understanding trauma and providing trauma-sensitive care is a priority.
- **Establishing external networks of support—** Programs can sustain trauma-awareness by establishing regular contact with outside agencies with expertise in trauma, including the use of outside consultants with expertise in trauma to provide on-going education and case consultation. Making these types of connections offers providers a way to stay abreast of new information, avoid isolation, and focus on areas where the program is most in need of guidance.

In conjunction with trauma-specific education and training, all staff should be educated about the intake assessment process, including what questions are asked and how this information is used. A lack of understanding about the assessment process contributes to a lack of knowledge among staff who work directly with consumers about trauma histories and how best to respond. For additional tips on sustaining trauma education and awareness see figure 2.

Staff Supervision, Support and Self-Care

Staff support is crucial to providing quality care to trauma survivors. Issues such as poor working conditions, confusion about roles and responsibilities, lack of attention to self-care, inconsistent supervision, and minimal input into programming contributes to high rates of burn-out and staff turnover within shelter settings. Making staff support a priority sends the message to employees and consumers that all are valued and respected. Elements of staff support include regular supervision and team meetings, an organizational commitment to promoting staff self-care, and opportunities for staff members to have a voice in programming decisions.

Large group trainings are helpful forums for initial staff education about trauma, but these trainings alone are insufficient. Supervision and team meetings

offer smaller settings in which to convey and clarify information. Smaller team meetings are a forum for open communication, peer support, and additional training and education. Individual supervision by someone who is trained in understanding trauma is an essential follow-up strategy to a general trauma training. 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.

An organization is not trauma-informed if its staff feel disempowered and have little say in what happens in the program. Ensuring that all staff have input into how a program is run is essential to creating an environment in which sharing power with consumers is possible. Structures such as supervision and team meetings can be utilized to seek regular staff input into program practices.

As a result of the challenges faced by providers who work with trauma survivors, organizations must focus on how to encourage self-care at individual and programmatic levels. Mechanisms for encouraging self care include addressing topics related to self-care in team meetings, encouraging staff members to understand their own stress reactions and develop their own self-care plans, devoting part of supervision to talking with staff members about the impact of working with trauma survivors, and providing trainings about compassion fatigue and self-care strategies. The program can support staff over the long-term by creating a culture of self-care that includes encouraging staff members to take breaks, eat lunch, use vacation time, and develop strategies for creating a balance between their personal and professional lives. The program may also develop on-going ways to assess job satisfaction and staff need for additional support.

Additional Resources for Supporting Staff Self-Care:

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 by visiting **www.sidran.org**.

Stamm, B.H. (2005). The ProQOL Manual: The Professional Quality of Life Scale: Compassion Satisfaction, Burnout and Compassion Fatigue/Secondary Traumatic Stress Scales. Washington, DC: Register Report: A Publication of the National Register of Health Service Providers in Psychology.

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.

National Health Care for the Homeless Council - **http://www.nhchc.org/healthyenviron.html**. – "Self-Assessment Tool: Self-Care" found in *Shelter Health: Essentials of Care for People Living in Shelter.*

Volk, K., Guarino, K., Grandin, M.E., Clervil, R. (2008). What About You? A Workbook for Those Who Work with Others. Newton, MA: National Center on Family Homelessness.

Domain 2: Creating a Safe and Supportive Environment

Traumatic experiences violate our fundamental belief that the world is a safe place and people can be trusted. Creating a safe, supportive, welcoming, and respectful environment is essential in any service setting. People are not successful in environments where they do not feel physically and emotionally safe, heard, and respected. For people who have experienced trauma, issues of safety become even more prominent. Accessing services requires consumers to enter into new relationships at a time when this is most difficult. Establishing a sense of physical and emotional safety is essential to relationship-building and recovery.

> *"The first task of recovery is to establish the survivor's safety. This task takes precedence over all others, for no other therapeutic work can possibly succeed if safety has not been adequately secured."*
>
> *—Herman, 1992, p. 159*

Establishing a Safe Physical Environment

Creating a safe physical environment is one of the primary components of a trauma-informed program (see figure 3.1). For programs serving families who have experienced trauma, additional attention to physical safety is required. Specific areas within the building, such as bathrooms and bedrooms can be particularly triggering for those who have abuse histories. Poor lighting or building security, and a lack of control over personal space and belongings can also trigger past feelings of fear and helplessness. Key safety features include providing adequate lighting inside and outside of the program, making sure consumers can lock bathroom doors and have locked spaces for their belongings, and having a program security system. Creating a safe physical space for children includes making sure that they feel comfortable and welcomed by having child-friendly areas, decorations, and engaging play materials. For additional ideas for enhancing the physical environment see figure 3.2 on p. 27.

Figure 3.1: Essentials for Creating a Safe Physical Environment

- The building is well maintained and clean.
- Things are fixed when they are broken.
- The building is swept/dusted/mopped, sprayed for bugs, etc..
- The building is locked.
- Transportation is provided or accessible for consumers to get to and from the program.
- The building is accessible for people with hearing, visual, and mobility impairments.

Establishing a Supportive Environment

In addition to ensuring physical safety, establishing a supportive environment is an essential aspect of trauma-informed care. How consumers are welcomed and how staff responds to their individual needs sets the stage for future success or difficulty. Establishing a safe and welcoming emotional environment requires programs to create a culture of open communication, tolerance, respect, and community (see figure 5 on p. 29). Trauma-informed programming involves providing consumers with as much information as possible, being aware of the impact of culture, demonstrating respectful interactions, maintaining consistency, predictability and transparency, and thinking pro-actively.

Information Sharing

Experiences of trauma leave people feeling helpless and powerless. To avoid re-creating these same feelings, providers must be conscious of sharing detailed information about program rules, expectations, schedules, etc.. Providing consumers with information enhances their sense of safety and control. Programs should inform consumers about who will be checking on them, when room or apartment checks will happen, and why. Consumers should be informed about how the program responds to personal crises such as suicidal statements or violent behavior. Information about program rules and consumer rights need to be given to consumers verbally and in written form, and posted throughout the building. Programs should also post information about trauma, how it impacts people, and available trauma-specific resources. It is important to note that traumatic experiences can have a significant impact on people's ability to integrate information, particularly under stressful circumstances. Consumers are often extremely overwhelmed upon entering the program and are likely to have difficulties processing the information received. This requires providers to be ready to review program information on a continual basis.

Figure 3.2: Tips for Enhancing the Physical Environment

- Put up colorful, culturally diverse and child-friendly artwork.
- Incorporate living items into the decorating such as plants and fish tanks.
- Provide calming music.
- Have comfortable, soft seating.
- Offer quiet rooms or spaces and places to exercise.
- Have rocking chairs/gliders.
- Provide new, clean bedspreads and linens and curtains.
- Involve consumers in designing and decorating the space.
- Set up an "environment" committee where clients can determine ways in which they would like to improve/change the physical space.

Cultural Competence

Traumatic events happen to people from all racial and ethnic backgrounds, and the brain's response to trauma is consistent for all trauma survivors. However, culture 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 takes place within one's own cultural and "meaning-making" system. Providers must be aware of their own cultural attitudes and beliefs, as well as those of the families being served. Cultural awareness 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 respectful environment in which survivors can begin to rebuild a sense of self and a connection to their communities.

Privacy and Confidentiality

Often, trauma survivors have had their privacy violated and their dignity taken away – their bodies may have been invaded by abuse, they may 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 providers aim to treat consumers with respect and dignity, they must respect their privacy. Respecting privacy and confidentiality includes asking permission and

outlining clear boundaries before entering consumers' spaces, providing private, confidential spaces to conduct assessments and have conversations with consumers, addressing individual issues in private, avoiding having discussions about consumers in public places, and clearly explaining the limits of privacy and confidentiality.

Safety and Crisis Prevention Planning

Trauma-informed care requires proactive interventions that consider potential safety issues ahead of time. Ways to incorporate proactive responses into daily practice include creating plans to keep consumers safe from outsiders such as violent partners who may try to locate them (i.e., safety plans) and by helping consumers to identify and respond to potential triggers before they become overwhelmed (i.e., crisis prevention plans or "self-care plans"). These plans are most effective when they are in writing, developed before the crisis happens, communicated to all providers working with a family, and incorporated into individual goals and plans. Components of a crisis prevention plan can be found in figure 4.

Figure 4: Creating Consumer Crisis Prevention Plans

A written, individualized consumer self-care or crisis-prevention plan should include the following:

- A list of situations that the consumer finds stressful or overwhelming and remind him/her of past traumatic experiences (i.e., triggers).
- Ways that the consumer shows that he/she is stressed or overwhelmed (e.g. types of behaviors, ways of responding, etc.).
- Staff responses that are **helpful** when the consumer is feeling upset or overwhelmed.
- Staff responses that are **not helpful** when the consumer is feeling upset or overwhelmed.
- A list of people to go to for support.

See Appendix II for a sample crisis-prevention or "self-care" plan that may be integrated into the intake process.

Open and Respectful Communication

Trauma survivors often enter service settings with past experiences that include being mistreated, ignored, and silenced. Providers are faced with the challenge of encouraging honest communication with consumers and demonstrating an ability to listen to and accept the range of thoughts and feelings that consumers may share. Open communication with consumers involves using active listening skills such as open-ended questions, affirmations and reflective listening (see Miller and Rollnick in references for additional information on motivational interviewing). These techniques are designed to demonstrate respect and empathy for the consumer experience at any given point on the road to recovery. Respectful communication also involves an awareness of the language used to talk to or about consumers. This includes using "people first language" such as "people experiencing homelessness" rather than "homeless people" and avoiding negative and derogatory labels that foster disrespect (e.g. referring to the consumer as "manipulative" or "lazy").

Consistency and Predictability

Feelings of uncertainty and confusion can trigger intense trauma responses related to past experiences. Maintaining a consistent and predictable environment can help to instill a sense of calm, which in turn allows the consumer to focus on recovery. Consistency at the service level creates trust between the consumer and the provider, serves as a foundation for building healthy relationships. Ways to establish consistency and predictability with consumers include having regular meetings, keeping and being on time for appointments, following up on consumer requests or concerns, clearly defining roles and boundaries, and maintaining empathic responses to consumers in the face of both successes and set-backs.

Figure 5: Essentials for Creating a Safe Emotional Environment

Welcoming Clients

- Immediate needs such as food, clothing, and medical attention are addressed.
- Consumers are introduced to staff and other consumers.
- Consumers are given a tour of the physical space when they arrive.
- Consumers are asked about their preferred language in which to communicate.
- Consumers are shown where the common light switches are and have access to them.

Providing Information

- Consumers are informed about program rules and regulations and how they are enforced within 24-48 hours of arrival.
- Consumers receive a copy of the rules and mission statement upon arrival.
- Consumers receive a copy of consumer rights upon arrival.
- If it is required that consumers provide urine samples, the rules about collecting samples are explained.
- Informed consent is obtained from consumers for services.
- Consumers are made aware of the grievance process and how to engage in the process when they have a complaint.
- Written documentation of the grievance process is given to consumers in their primary or preferred language.
- Written information about program rules and consumer rights and responsibilities is given to consumers in their primary or preferred language.
- Program rules and mission statement are posted in places that are visible

Maintaining a respectful and responsive culture

The following represent practices that should be well-integrated into a system of care that is striving to become more trauma-informed:

- Staff members are able to interact with people in distress without telling them what to do or immediately giving consequences.
- Staff members listen to and validate a wide range of emotions (e.g., grief, sadness, anger and fear) from consumers.

Additional resources on creating trauma-informed environments:

Prescott, L., Soares, P., Konnath, K., and Bassuk, E. (2008). A Long Journey Home: A Guide for CreatingTrauma-Informed Services for Mothers and Children Experiencing Homelessness. Rockville, MD: Centerfor Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, National Child Traumatic Stress Network, and the W.K. Kellogg Foundation. Available at www.homeless.samhsa.gov

Domain 3: Assessing and Planning Services

In all service settings, completing a thorough intake assessment and referring consumers to appropriate services is essential to providing quality care (see figure 7 on p. 32). Consideration of traumatic experiences and the impact of these experiences on families must be a routine part of the assessment and service planning process.

Conducting Intake Assessments

Adults and children who have experienced trauma have specific needs that may remain mislabeled or misinterpreted if their experiences of trauma are not addressed as part of the intake process. In a trauma-informed program, the intake assessment process includes gathering information about experiences of emotional, physical and sexual abuse and other types of trauma (e.g., neglect, loss, community violence, and combat). Also included are questions about current level of danger from other people (e.g., restraining orders, history of domestic violence, and threats from others). In light of the fact that many families have experienced physical violence, it is important to ask about previous head injuries. Head injuries can impact a person's ability to process information and communicate with others, requiring providers to modify how they offer help and support.

Intake assessments involve asking consumers to meet with a new person and share intimate details about their life experiences, including experiences of trauma. This process involves telling what is often a painful and emotional story. This experience can be intense and may trigger many difficult feelings and emotions for the consumer. It is important for providers to be aware of these challenges throughout the intake process. This means creating an environment that is as safe, secure and respectful as possible during the assessment process. Conducting the intake assessment in a trauma-informed manner may include conducting the intake in a private space, offering consumers options about where to sit, who is in the room with them, what to expect, asking consumers how they are doing throughout the assessmentt, offering water and breaks, and being aware of body language that may indicate that a consumer is feeling overwhelmed. Using a strengths-based approach also sets a tone of respect for the consumer and enhances the process of relationship-building between consumer and provider.

Most programming in shelter settings is focused on the adults. Obtaining and maintaining housing and employment is the first step towards stability and success for the family as a whole. However, this focus on adults means that children's needs are often overlooked. Research has found that among children experiencing homelessness rates of family violence and separation are high (NCFH, 1999). As a result of these traumatic experiences, children who are homeless have more mental health issues, poorer physical health, and increased learning difficulties (NCFH, 1999). The impact of trauma on child development and the parent/child relationship is profound, and it is essential that children receive services as soon as possible to lessen the negative impact of these experiences on their emotional, physical, cognitive, and social development.

Programs serving families who are experiencing homelessness have an opportunity to address children's needs and connect them to appropriate services. To meet children's needs, questions about their exposure to trauma must be included in the intake assessment. In addition to questions about traumatic experiences, it is important to ask about children's achievement of developmental tasks, and the quality of the parent/child relationship.

Intake assessments are only the first step in a process of connecting families with appropriate services. Both adults and children should be referred for more in-depth assessments when there is a need for further intervention and more specific types of services that require outside professionals.

Developing Goals and Plans

For trauma survivors, developing goals and plans for obtaining housing, employment and other types of services may seem intimidating and overwhelming. In these situations, it is easy for the consumer to "freeze" and for providers to take over. This pattern only serves to recreate past traumatic experiences and dynamics, and leaves consumers feeling helpless and powerless. Encouraging and helping consumers to create their own goals allows them to take control of their lives and futures. Trauma-informed goal planning is individualized and addresses the needs of both parents and children. Goals and plans are reviewed on a regular basis, and updated as needed. Prior to leaving the program, consumers work with staff to develop aftercare plans that take into consideration safety and service needs that should be addressed prior to and after discharge. Planning ahead provides a sense of comfort, confidence and security that is essential to recovery. Anticipating future difficulties before they happen reduces the likelihood that families will end up back in shelter.

Offering Services and Trauma-Specific Interventions

Programs provide opportunities for consumers to receive a variety of services, such as housing services, legal and educational advocacy, employment services, and mental health and substance abuse services (see figure 6 for important services to consider). In mainstream settings, many services are provided separately, in isolation from each other. A trauma-informed organization makes it a priority to facilitate communication among different service providers, because integration of services is a key principle of trauma-informed care. Ignoring trauma and treating each symptom individually does a disservice to the consumer and often leads to provider misunderstandings about the real roots of consumer difficulties. When possible, it is also helpful for organizations serving families who are homeless to have referral relationships with agencies that have expertise in providing trauma-specific mental health services for children and adults.

Figure 6: Important Services to Consider

- Legal advocacy on or off-site (e.g., to obtain restraining orders, retain custody of children).
- Advocacy on or off-site regarding access to entitlement services (e.g., TANF, TAFDC, early intervention, SSI, SSDI).
- Opportunities for parent education and skill-building.
- Opportunities for kid-friendly activities (e.g., going to the zoo, the park, movies).

The impact of trauma is often felt first in the body. It may be extremely difficult for trauma survivors to verbalize their thoughts, feelings and memories related to their trauma. People who have experienced trauma sometimes disconnect from emotions and physical sensations in an attempt to cope. As a result, trauma survivors often require specific types of services and supports to meet their needs. Body-oriented, non-verbal activities serve as a way for trauma survivors to reconnect to their bodies, manage their feelings, and communicate in non-traditional ways. It is helpful for programs to provide opportunities for consumers to express themselves using these types of alternate strategies (e.g. art, theater, dance, movement, and music).

Figure 7: Essentials for Assessing and Planning Services

Conducting Intake Assessments

The following are basic components of the assessment assumed to be in place within an organization:

- Initial intake assessments are conducted within the first 24-72 hours of families arriving at the program.
- Intake assessments are completed by trained staff members who have on-going contact with consumers and responsibility for carrying out plans.
- Intake assessments are conducted in a private area to ensure confidentiality.
- The limits of confidentiality are explained, including who has access to the intake assessment information and how that information is used.
- Intake assessments include questions about consumers' current needs.
- Intake assessments include questions about consumer resources and strengths.
- Intake assessments include questions about consumers' mental and physical health.
- Intake assessments include questions about consumers' history of substance use.
- Intake assessments include questions about consumers' cultural backgrounds and related cultural strengths.
- Intake assessments are written and use the same format for each client.
- Intake assessments are updated on an on-going basis.
- Intake assessments are confidential and kept in locked storage.

Developing Goals and Plans

The following are basic components of goal development that are assumed to be routinely implemented:

- Consumer goals are recorded in written, individualized plans.
- Consumer goals are reviewed and updated regularly.
- A system of follow-up is applied consistently across the program.

Providing Services and Interventions

The following are basic practices that are assumed to be present in an organization that is using the *Self-Assessment*:

- There are a variety of services that consumers can choose from.
- Consumers are informed about the benefits and limits of available services.
- Information is provided to consumers about services that are mandatory, including information regarding rationale, attendance, extent of participation required, and the length of time the service is provided.
- Consequences of breaking "rules" regarding mandatory services are reviewed.

Additional Resources for Assessing and Planning Services:

www.maaclink.org/hcm.htm: Mid American Assistance Coalition (MAAC) – Homeless Case Management.

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.

Domain 4: Involving Consumers

> *"In order to be trauma-informed, an organization must integrate consumers in designing, providing and evaluating services. Significant consumer involvement not only creates a better program, but provides an empowering growth experience for the consumers involved"*
>
> *—Elliot et al., 2005, p.14*

Recovery and success for trauma survivors is largely based on their ability to regain control of their lives. Organizations can facilitate empowerment by giving consumers a voice in what happens on a daily basis in the program. Giving consumers a voice can begin by facilitating regular meetings where consumers can address questions, concerns, and ideas about the program. Involving consumers also means providing opportunities for them to be directly involved in developing program activities and evaluating program practices. Involving consumers in program development enhances the quality of the services provided and affirms the belief that consumers are the experts in what works best for them. See figure 8 for additional ways to involve consumers.

Former consumers have a unique and invaluable perspective. People who have experienced homelessness in the past know first hand what was helpful and what was not along their road to recovery. To learn from their experiences and knowledge, programs must make a commitment to hiring former consumers at all levels of the organization, from the board of directors and administrative staff to the direct care staff. It is also important to involve former consumers directly in program development and service provision (e.g., peer-run support groups, educational and therapeutic groups). In addition, programs can also find formal ways to allow former consumers to share their thoughts, ideas, and experiences. Whether they are on staff, visiting the program to share their stories, or helping to run a support group, the presence of former consumers sends a message of hope that homelessness is not a permanent condition and people do recover.

Figure 8: Tips and Strategies for Involving Consumers

- Support consumers running a "resident voice" meeting, put them in charge of developing the agenda and facilitating the discussion.
- Provide consumers with choices about their services. If there is a minimum requirement of mandatory services, make more services available to offer choices.
- Give consumers opportunities to evaluate the program and offer their suggestions for improvement in anonymous and/or confidential ways (e.g., suggestion boxes, regular satisfaction surveys, meetings focused on necessary improvements, etc.).

Additional Resources on Consumer-Involvement:

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 from **www.mentalhealth.samhsa.gov/cmhs/womenandtrauma**.

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**

Domain 5: Adapting Policies

Establishing Written Policies

Establishing policies that protect the safety and well-being of those being served is essential to providing quality care (see figure 9). A trauma-informed program considers trauma and its impact when creating policies to avoid recreating feelings associated with traumatic experiences (e.g., powerlessness, shame, lack of control, etc.). As the needs of consumers evolve and the role of the organization changes, policies that were once effective may no longer be helpful.

Trauma-informed policies include a formal acknowledgement that consumers have experienced trauma and a commitment to understand trauma and its impact and engage in trauma-sensitive practices. As part of this commitment, programs establish written policies based on an understanding of the impact of trauma on consumers. Programs focus first on creating policies that address issues of safety, including the program's response to threats made to consumers by others outside of the program. A policy outlining the program's response to consumer crisis is also important when serving trauma survivors who may frequently feel unsafe within their own bodies. The program should also have a written commitment to hire staff who have experienced homelessness.

Figure 9: Essentials for Quality Programming

- The program mission statement and policies are written in clear, simple language for staff and consumers.
- The program mission statement and policies are written in all of the primary and preferred languages of the consumers who are represented by the agency.
- Written policies are in place to outline emergency responses to situations such as fire or natural disasters.
- Written policies are in place to obtain the informed consent of consumers.
- Written policies are in place to protect the confidentiality/privacy of consumers.
- The program has a formal grievance process.
- Written policies are in place to outline professional conduct for staff (e.g. boundaries, responses to consumers, etc.).

Reviewing Policies

Creating trauma-informed programs requires continual review of policies to see what works and what may be re-traumatizing to trauma survivors. For policies to be effective, they must be enforced properly, considered helpful, and not be re-traumatizing. The more a system learns about trauma, the more modifications they may need to make to their policies and services. This requires a regular review of policies to update practices and guidelines to make them as relevant as possible to the people being served (see figure 10 on p. 35). The effectiveness of policies and the impact of enforced policies on consumers can be accurately assessed only when staff and consumers are part of the policy review process.

Figure 10: Tips and Strategies for Reviewing Policies

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 consumer inclusion and control?
- Were consumers included in its development?
- Could this policy or rule re-traumatize the consumer (e.g., limit consumer control and power, lead to fear and confusion, etc.).

V. Conclusion

Next Steps

Creating and sustaining organizational change is a long and challenging process. Some initial changes may be relatively easy to make, while long-term goals require continued time and attention. Sustaining organizational change requires programs to be both thoughtful and creative about how to thoroughly integrate trauma-informed principles and practices into the culture and practice of an organization.

As programs move forward with the change process, obstacles to change become more evident. These obstacles are often present due to the larger systems that organizations function within (e.g., welfare, child protective services, law enforcement, etc.). 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.

The National Center on Family Homelessness has developed a *How-To Manual for Creating Organizational Change* to guide programs interested in beginning this process (see p. 50). The *Manual* includes steps that programs can take to become trauma-informed. Steps include the use of the *Self-Assessment* and *User's Guide* to begin this change process.

Additional Tools for Assessing Organizations:

Hopper, E. & Spinazzola, J. (2006). Trauma-Informed Facility Assessment. Brookline, MA: The Trauma Center at Justice Resource Institute, unpublished instrument.

Institute for Health and Recovery. (2002). Developing Trauma-Informed Organizations: A Toolkit. Cambridge, MA: Women Embracing Life and Living (WELL) Project and the WELL Project State Leadership Council of the Institute for Health and Recovery, unpublished instrument.

Fallot, R.D., & Harris, M. (2002). Trauma-Informed Services: A Self-Assessment and Planning

Protocol. Washington, D.C.: Community Connections, unpublished.

Additional Resource for Creating Trauma-informed Homeless Service Settings: (Includes a summary of the tools listed above)

Hopper, E., Bassuk, E., & Olivet, J. (2007). Shelter from the Storm: Creating Trauma-Informed Homeless Services. DHHS Publication No. (XXXXX). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Appendix I

Development of the *Trauma-informed Organizational Self-Assessment*

The National Center on Family Homelessness (NCFH) created the *Trauma-Informed Organizational Self-Assessment* in an effort to operationalize organizational sensitivity and responsiveness to persons who have experienced trauma. Our purpose in developing this *Self-Assessment* is to offer organizations an easy-to-use tool that can help them 1) assess their organizational practices and procedures; 2) identify areas in which the organization is performing well and areas in which it needs improvement in terms of its trauma-responsiveness; and 3) develop trauma-informed quality improvement plans. Development of the *Self-Assessment* was a multi-step process that began with specifying a conceptual framework for understanding a trauma-informed organization and then continued with the creation, evaluation and refinement of survey items intended to capture the essential conceptual elements within that framework. This process proceeded as follows:

Phase I: Initial Development of the Self-Assessment

1. Our first task was to identify the foundational principles on which the *Self-Assessment* items would be based. Identification of these principles was based on the trauma expertise of the NCFH staff creating the tool, the findings of the Co-Occurring Disorders and Violence Project (Moses, Reed, Mazelis, & D'Ambrosio, 2003), and the work of experts including Maxine Harris and Roger Fallot (Harris & Fallot, 2001; Fallot & Harris, 2002) and Sandra Bloom (Bloom, 2004), who have begun to identify key trauma-informed principles. Our next task was to identify and define the important organizational domains or areas of focus for programs working with trauma survivors. Experts in the fields of homelessness and trauma, including staff from NCFH, staff from the Trauma Center (leading experts in providing trauma-informed services), along with a former consumer and trauma survivor, proposed an initial set of domains, including subdomains, and then reviewed and refined the domains and their subdomains until consensus was reached. Using this process, we identified 5 organizational components that manifest the degree to which an organization is trauma-informed: 1) Staff Development; 2) Atmosphere and Environment; 3) Assessment and Service Planning; 4) Consumer Involvement; and 5) Policies. These 5 organizational components provided the conceptual framework for operationalizing organizational trauma-responsiveness (i.e. the extent to which an organization is trauma-informed) and also provided the structural framework for organizing the *Trauma-Informed Organizational Self-Assessment*.

2. Our team of experts then engaged in the iterative process of developing a paper and pencil survey instrument suitable for pilot-testing in the field. Within each domain and subdomain, team members specified indicators of organizational responsiveness to trauma survivors and then proposed items intended to capture these concepts. This resulted in a set of 200+ closed response items about specific practices that demonstrate excellence within a "trauma-informed" organization. This set of items was organized by organizational domain and then put into a draft survey tool that was presented to shelter-based focus groups for feedback on its content, structure and format. Based on feedback from the focus groups and in consultation with experienced survey researchers, our panel of trauma experts then added/eliminated items, refined the wording of items and decided on appropriate response dimensions. This process resulted in a set of 160 items with 5-point Likert style responses that we then compiled into a draft tool for preliminary field-testing. Preliminary field-testing was conducted with nine staff members who represented administrators, case managers and direct care staff from family shelters in the Boston area. These staff completed the draft tool and provided detailed feedback regarding the format and length of the tool and the clarity of each of the items. Our team of trauma experts used this feedback to further refine the tool into a 151-item pilot version.

IV. Involving Consumers

A. Involving Current and Former Consumers	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know	Not applicable to my role
Current Consumers						
1. The needs and concerns of current program consumers are addressed in community meetings.						
2. The program provides opportunities for consumers to lead community meetings.						
3. Current consumers are involved in the development of program activities.						
4. Current consumers are given opportunities to evaluate the program and offer their suggestions for improvement in anonymous and/or confidential ways (e.g., suggestion boxes, regular satisfaction surveys, meetings focused on necessary improvements, etc.)						
Former Consumers (refers to anyone who has experienced homelessness)						
5. Former consumers are hired at all levels of the program.						
6. The program recruits former consumers for their board of directors.						

Phase II: Local Piloting and Refinement of the Self-Assessment

3. The 151-item version of the tool was pilot-tested at selected sites in the Boston area. The purpose of pilot testing was to assess whether items included in the tool would discriminate between programs that varied in the extent to which they were trauma-informed. To test this out, NCFH used the procedures outlined in Table 1 (p. 40) to rate potential pilot sites from low to high in their organizational responsiveness to trauma. This procedure resulted in a set of Boston-area shelters that we then sorted into three groups: highly trauma-informed (high), moderately trauma-informed (medium) and minimally trauma-informed (low). NCFH recruited three pilot sites from each group for a total of nine pilot sites. We then administered the pilot instrument to 87 staff across the 9 sites. These staff varied by type of position within the organization (e.g., administrator, case manager, etc.). Some respondents were observed as they completed the instrument and, after completing the instrument, were questioned about their understanding of individual items and their decision-making process in selecting their responses. These inquiries revealed two types of problems in responses to some of the items in the pilot instrument. One fairly prevalent problem was a general lack of understanding of trauma, particularly among staff from organizations in the less trauma-informed group. This lack of knowledge, often in combination with a desire to provide responses that put their organization in a favorable light, led may respondents to answer items by guessing or by making assumptions without any direct knowledge about how their organization operated. In addition, respondents sometimes misunderstood the intent of an item, a problem that suggested the need for more specificity and clarity in the wording of some items. We also performed an item by item analysis using ANOVA to determine whether response differences between groups (high, medium and low) were in the expected direction. We assessed group differences using a cut-off alpha of .15.

4. The next step in developing the *Trauma-Informed Organizational Self-Assessment* was to further refine the tool based on the results of the pilot-testing. Using the ANOVA analyses, we looked for items that showed a tendency to discriminate between organizations in the high, medium and low trauma-informed groups. We

identified those items that had response differences in the expected direction and ANOVA results significant at the level of .15. We also identified items that had face validity as indicators of program quality but that did not meet our criteria for selection based on the ANOVA results. From this set of identified items, we sorted items into those that were specifically related to trauma and those that were related to program quality more generally. We retained those items that were specifically related to trauma and put the other items into the *User's Guide*. While we were compiling the results of the pilot testing, NCFH was also providing consultation and technical assistance to two of the nine pilot sites. We used this additional experience to further assess whether the survey items were capturing all the essential aspects of a trauma-informed organization. Taking all of these analyses and observational learnings into consideration, we further refined the tool and created an 87-item instrument.

Phase III: National Piloting and Final Revisions to the Self-Assessment

5. The final step in developing the *Trauma-Informed Organizational Self-Assessment* was to pilot the tool in programs serving homeless families in different geographic and cultural regions in the United States. NCFH partnered with 3 programs serving homeless families across the U.S. who agreed to complete the *Self-Assessment* and participate in a 7-8 months of consultation sessions with NCFH around providing trauma-informed care. After focused discussions with program staff about this assessment and consultation process and interviews with consumers about programming needs, NCFH was able to identify concrete strategies and practices that programs can incorporate to begin to create trauma-informed organizational change. With this information, NCFH made the final revisions to the *Self-Assessment* format, response scales, and items, and created the current assessment tool.

Use of the *Trauma-Informed Organizational Self-Assessment*

Recommendations and Limitations

1) This version of the *Trauma-informed Organizational Self-Assessment* is not a fully developed instrument and, therefore, should not be considered a valid and reliable measure of the extent to which an organization is trauma-informed. In its present form, this instrument does not provide a score and, therefore, it is not appropriate to use this instrument to compare or rate organizations. Despite this limitation, the present version of the tool offers a useful guide for organizational assessment and quality improvement planning in the area of organizational sensitivity and responsiveness to trauma.

2) This tool is designed with the assumption that the staff who complete it have a general understanding of traumatic stress and how it impacts people. If staff with little or no knowledge about trauma complete this instrument, the results may not accurately reflect the organization's level of trauma-responsiveness. Therefore, we recommend that programs have some initial training on trauma before they use this tool. The initial steps to be taken prior to completing the tool are outlined in our *How-To Manual for Creating Organizational Change* (see p. 50).

3) Staff who complete this instrument must have knowledge of their organization. Staff members who lack adequate knowledge of their organization will not be able to provide accurate responses and the results of the survey will not be reflective of the organization.

4) As discussed at the beginning of the *User's Guide*, encouraging staff to answer honestly is an essential part of the preparation for using this tool. The results depend on the accuracy of the responses of those who complete the tool. If staff members feel that their responses are not anonymous or that their opinions are not valued or respected, they may not answer honestly. This will affect the accuracy of the results.

Table 1. - Criteria and Procedure for Rating Organizations

I. The following characteristics were specifed as necessary elements of a fully trauma-informed organization:

1. Consideration is given to the trauma histories of families being served (e.g., education about trauma, trauma-specific services, consideration of trauma in written policies/mission statements).
2. A safe, supportive and empowering environment is provided for consumers (e.g., clean, healthy environment, consumer input and involvement, consideration for cultural differences, supportive responses to consumer distress/ crisis).
3. A wide variety of supportive services are offered (e.g., individual, group, family therapy, day-care, employment supports, advocacy).
4. A variety of children's services are offered (e.g., play areas, early intervention, child assessments, clinical services).
5. There is consistent support in place for staff (e.g., supervision, staff meetings, training, and education).
6. There are opportunities for former consumers to be involved throughout the organization at all levels.

II. Based on these 6 program elements, we established standards for assessing the extent to which a program is trauma-informed and used these standards to define organizations that are highly trauma-informed, somewhat trauma-informed and minimally trauma-informed.

Highly Trauma-Informed Programs (High):

The organization incorporates, at least to some extent, all of the above criteria (1-6) within their system of care.

Somewhat Trauma-Informed Programs (Medium):

The organization incorporates Criteria #1 and #2 (mandatory) and at least 3 additional criteria from the above list.

Minimally Trauma-Informed Programs (Low):

The organization does not incorporate Criteria #1 and #2 or incorporates a total of 3 or fewer of the above criteria.

III. The procedure for rating organizations was as follows:

NCFH team members working in area shelters, along with outside colleagues working in the shelter system, were asked the following:

- Identify family shelters that you feel incorporate all 6 characteristics of trauma-informed organizations specified above
- Identify family shelters that you feel are strong in some of the areas listed above and specifiy area(s) which are strengths for each shelter.
- Identify any family shelters that you feel are lacking in most, if not all of the above areas.

Based on the responses provided to these questions, NCFH sorted the identified shelters into three groups: Highly trauma-informed, Somewhat trauma-informed, and Minimally trauma-informed.

Appendix II

The *Self-Assessment* refers to each adult and child in the program having a crisis prevention plan that is created with staff. We used the term crisis prevention plan because this is the language that seemed most familiar to service providers. We recommend that programs consider changing this language from crisis prevention plan to self-care plans. A crisis prevention plan implies that a plan is only necessary for consumers who are at risk of escalating or becoming "unsafe", as opposed to a self-care plan that is important for all consumers. The self-care plan represents a proactive strategy for providing individualized support for consumers with the goal of reducing and/or avoiding crises. We have included a template for creating a self-care plan that includes the components outlined in the *Self-Assessment*. The self-care plan may be introduced as part of the initial intake process or completed a short time after the consumer arrives. The goal is to offer consumers the opportunity to let staff know how they can be most helpful and supportive and what responses to avoid. Consumers may need help and guidance from staff while completing the questions (e.g., offering examples of potentially stressful situations, reading and explaining each question, writing their responses for them if requested, etc.)

Sample Self-Care Plan

1. Make a list of situations or experiences that you find stressful or overwhelming.
2. What does it look like when you start to become more stressed or overwhelmed? (e.g., how do you act, look, talk, etc.)
   - Beginning to feel overwhelmed (e.g., start to raise voice, sound irritated, face looks upset):
   - Feeling like you are losing control (e.g., face red, voice louder, start swearing more, not able to listen to others, walking away from people):
   - Feeling very overwhelmed/out of control (e.g., yelling, crying, avoiding people, shutting down, getting aggressive):
3. Make a list of those things that you find **helpful** when you are feeling upset, stressed-out or overwhelmed. (This list may include things that you do for yourself and ways that other people can help you.)

Examples:

- ☐ Talking a walk
- ☐ Reading
- ☐ Writing in a journal
- ☐ Drawing/Painting
- ☐ Taking a shower
- ☐ Taking a nap
- ☐ Listening to music
- ☐ Other: Create your own list of things that are not included above.
- ☐ Looking at pictures
- ☐ Exercising
- ☐ Having someone sit and listen
- ☐ Having time and space to calm down
- ☐ Watching T.V.
- ☐ Deep breathing
- ☐ Having someone give you suggestions

4. Make a list of responses that are **not helpful** when you are feeling upset, stressed-out or overwhelmed (e.g., things that other people may do or say that are not helpful).

- ☐ People making suggestions
- ☐ People raising their voice
- ☐ People telling me it will be fine
- ☐ Other: Create your own list of things that are not included above.
- ☐ People touching me
- ☐ Being told what to do
- ☐ People talking to me

5. Make a list of people you can go to for support if needed.

Appendix III

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: **http://www.apa.org/releases/MilitaryDeploymentTaskForceReport.pdf**

Van der Kolk B.A., McFarlane, A.C., & Weisaeth L. (Eds.). (1996). *Traumatic Stress: Theeffects of overwhelming experience on mind, body, and society. The Body Keeps the Score: Approaches to the Psychobiology of Post-Traumatic Stress Disorder*. 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 from the National Child Traumatic Stress Network,* **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). TheCharacteristics 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.* Swords to Plowshares: San Francisco.

Goodman, L., Saxe, L., and Harvey, M. (1991). Homelessness as Psychological Trauma: Broadening Perspectives. *American Psychologist.* Nov: 46 (11): 1219-25.

Homeless Children: America's New Outcasts. (1999). The National Center on FamilyHomelessness. Newton, MA. **www.familyhomelessness.org**.

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. *Available by visiting* **www.familyhomelessness.org**.

Nyamathi, A., Wenzel S., Lesser J., Flaskerud J., & Leake B. (2001). *Comparison ofPsychosocial 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*. National Center on Cultural Competence. Georgetown Center for Child and Human Development. Washington, DC.

Good, T.D. & Jones, W. (2000, Revised 2006). *A Guide to Advancing Family Centered and Culturally and Linguistically Competent Care.* National Center on Cultural Competence, Georgetown Center for Child and Human Development. Washington, DC.

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: **http://www.nctsnet.org/nccts/asset.do?id=885**

Website

National Child Traumatic Stress Network - **www.NCTSN.org**

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, Available by visiting **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. *Available from* **www.mentalhealth.samhsa.gov/cmhs/womenandtrauma**.

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

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 inCollaboration. Delmar, NY: Policy Research Associates. *Available from* **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.). *UsingTrauma 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 by visiting* **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. Washington, DC: Register Report: A Publication of the National Register of Health Service Providers in Psychology.

Website

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 from* **www.mentalhealth.samhsa.gov/cmhs/womenandtrauma**.

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

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Websites

Child Trauma Academy - **www.childtrauma.org**

Child Trauma Institute - **www.childtrauma.com**

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Young Children (3-7)

Asch, F. (1986). Goodbye House. Aladdin Paperbacks/Simon and Schuster.

Bunting, E. (1991), Fly Away Home. Clarion Books/Houghton Mifflin.

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

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Polacco, P. (1999). I Can Hear the Sun. Putnam.

Testa, M. (1996). Someplace to Go. Albert Whitman and Company.

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

Elementary School (5-10)

Gunning, M. (2004). A Shelter in Our Car. Children's Book Press.

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Berck, J. (1992). No Place to Be: Voices of Homeless Children. Houghton Mifflin.

Carey, J.L. (2004). The Double Life of Zoe Flynn. Atheneum Books for Young Readers/Simon and Schuster.

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Hubbard, J. (1991). Shooting Back: A Photographic View of Life by Homeless Children. Chronicle Books.

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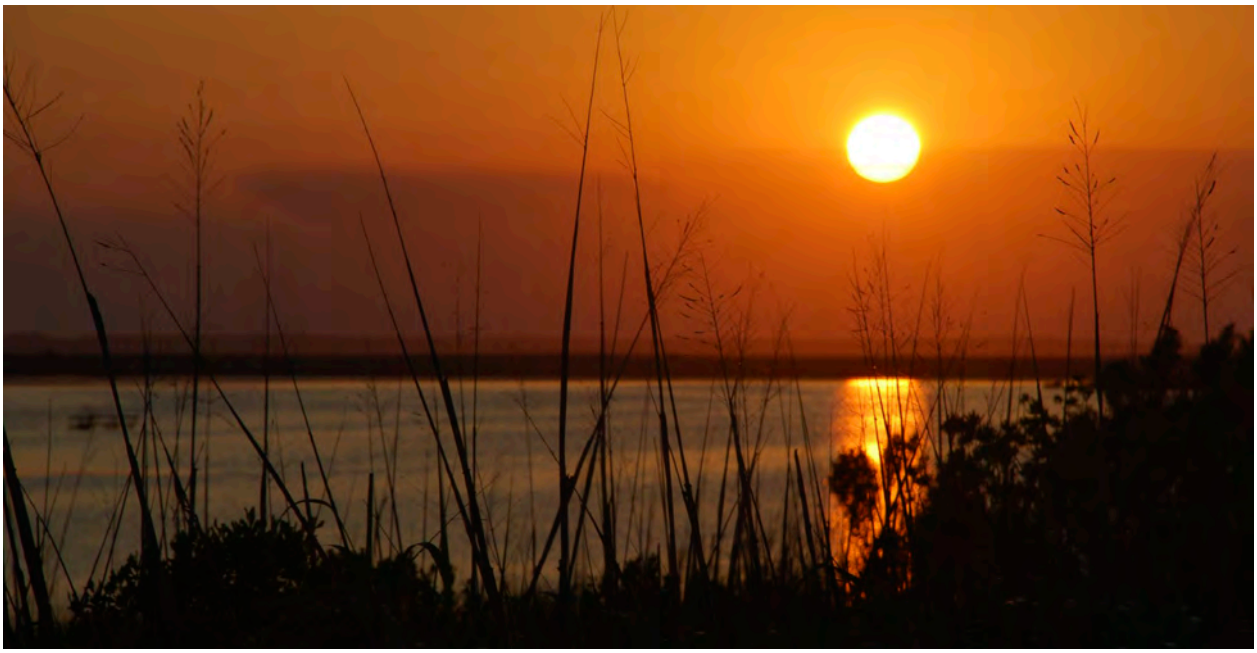
Section III: How-To Manual for Creating Organizational Change



The *How-To Manual for Creating Organizational Change* was developed by the National Center on Family Homelessness in response to our experiences creating and piloting our *Trauma-Informed Organizational Self-Assessment* in homeless service programs across the United States. In this *Manual*, NCFH has identified concrete steps that organizations can take if they are interested in becoming trauma-informed. These steps are based on experiences and lessons learned while working with programs as they moved through the assessment process and worked to create changes in both individual behaviors and organizational processes. We dedicate this *Manual* to those providers who partnered with us and committed their time and energy to providing the highest quality of care to the families they serve.

"Nobody can go back and start a new beginning, but anyone can start today and make a new ending."

– Maria Robinson

I. Becoming Trauma-Informed

"In an ever-changing world, change can be beautiful."

– Chris Guinn
Isabel Bloom Artisan

Creating a trauma-informed organization requires system-wide transformation. This type of change is not found just at the direct care level or only in the administrative arena. Becoming trauma-informed means making a commitment to changing the practices, policies and culture of an entire organization. This type of change requires that staff at all levels and in all roles modify what they do based on an understanding of the impact of trauma and the specific needs of trauma survivors. Embarking on this journey can be difficult, and there are often very few guidelines for how to proceed. For those leaders who are interested in championing this type of organizational change, the following are steps that programs can take, using the *Trauma-Informed Organizational Self-Assessment* as a tool to facilitate this process.

Setting the Stage

Step 1:

The program has a person or group of people who have the desire to help their organization become trauma-informed. At least one of these people has the authority to make system-wide changes in the program. This person or group of people is willing to shepherd the program through the transformation process. These are the "leaders" or "champions of change" for the organization.

Lessons learned:

- It is helpful to have co-leaders to facilitate the change process so that one person is not the sole champion of this cause.

- Program leaders must have the authority to institute programmatic change and the support of the broader agency to implement these changes. Program leaders who are dedicated to the change process but have no real authority to make programmatic changes will have a difficult time implementing new practices and creating a new culture. Program leaders also need to be given the time in their work life to devote to the change process. A program may have a strong desire to become trauma-informed, but without the time to devote to the process, change efforts are likely to fall by the wayside.

Step 2:

In order to "set the stage" for trauma-informed organizational change, program leaders take the following steps:

- Program leaders bring all staff together to begin talking about the goal of becoming trauma-informed. This is where leaders begin to introduce concepts and information that will be helpful in gaining staff "buy-in" to the need for organizational change.* Education and discussions about these concepts can be done in all-staff meetings, in smaller lunch meetings or shift change meetings, or in whatever ways work best in your program to include everyone in the conversation.

- Leaders introduce the need for an organization-wide trauma training. Program leaders gather possible dates and times for all staff to attend a preliminary training that will provide staff with additional information about traumatic stress and its impact and what it means to provide trauma-informed care.

* General information on the relationship between homelessness and trauma and what it means to be trauma-informed can be found in the *User's Guide.* Additional resources, including articles, books and related websites, can be found on p. 92 of the *User's Guide.* This resource list or selected articles from this list may be provided to staff members as a way to offer all staff with foundational information about trauma and homelessness and a background for why becoming trauma-informed is relevant and important.

"The first step toward change is awareness. The second step is acceptance."

– Nathaniel Branden

Lessons learned:

- It is important to clarify that this process is not just about increasing individual trauma knowledge but about setting the stage for organization-wide change.
- Addressing the need for change with all staff is not a one-time conversation. Commitment to change is a process that requires on-going discussions around what it means to be trauma-informed and what it will take to begin the transformation.
- All staff needs to have an understanding of how the change process is going to begin and what to expect moving forward.

Step 3:

Based on discussions begun in Step 2, it is necessary to provide all staff with training on trauma and trauma-informed care. Program leaders arrange for a consultant or consultants with expertise in trauma to provide initial training for all staff on the following: 1) what trauma is and how it impacts people; 2) the relationship between homelessness and trauma; 3) information about what it means to provide trauma-informed care; and 4) how secondary trauma can impact the lives of staff.

Lessons Learned:

- It is essential to the change process that all staff receive training on traumatic stress and its impact and what it means to be "trauma-informed". This includes everyone from the executive director to the maintenance staff, kitchen staff, and administrative assistants. The concept of being trauma-informed involves educating all who come into contact with consumers on how to respond in a safe and sensitive manner. A cohesive staff that has the same level of understanding about trauma and what needs to be changed is more likely to be successful in making and sustaining these changes.

- When using outside trainers, it is helpful when possible, to have experts who can also provide on-going consultation and can be called on for additional help and support during other steps in the change process.

Additional Tools and Resources:

If programs have people on-staff who have an understanding of traumatic stress and trauma-informed care, they may choose to do the staff trauma trainings themselves, instead of using an outside consultant. For those professionals who have the background but do not have a trauma training package developed or do not have access to a consultant who can provide this type of training, the following resources are available:

» ***Homelessness and Traumatic Stress Training Package***. This training package includes a trainer's guide, power-point slides, a trainer's script, hand-outs, and evaluation 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". This package includes activities and ideas for ways to provide trauma-informed care that correspond to the *Trauma-Informed Organizational Self-Assessment*. The *Homelessness and Traumatic Stress Training Package* can be accessed electronically at **www.homeless.samhsa.gov**.

» ***"Developing Trauma-Informed Services for Families Experiencing Homelessness" An Interactive Training Video and Guide***. This training video and manual includes information about traumatic stress and trauma-informed care and includes concrete suggestions for incorporating trauma-informed practices and activities for skill-building. This package can be accessed by contacting the National Center on Family Homelessness at **www.familyhomelessness.org**.

Step 4:

Once all staff have participated in the initial discussions about the need for change (Step 2) and have received a more formal training in trauma and trauma-informed care (Step 3), it is essential that the program leaders evaluate the organization's interest in and readiness for change prior to beginning the assessment process. If staff "buy-in" is an issue or if there are conflicting views within the organization about whether this type of change is necessary or helpful, these issues must be addressed before the *Trauma-Informed Organizational Self-Assessment* is introduced as a tool for change.

Lessons learned:

- It is important to read and acknowledge staff frustrations or confusion about the need for change early in the process. Use initial meetings to gauge readiness. If there is an overarching negativity about change, you may want to think about how to begin the process more slowly and on a smaller scale (e.g. start with additional training and conversations about trauma before you begin to talk about evaluating and changing program practices).

- In order to get buy-in, the process has to identify "hooks" for all participants, addressing the benefits of becoming "trauma-informed". For some staff, the "hook" may be improved safety due to a reduction in patterns of interaction are more likely to lead to escalation and crises. For others, directly addressing the emotional impact of this work on the provider, via discussions of secondary trauma, is immensely relieving and worthwhile. For some, gaining insight into the effective treatment strategies and approaches for consumers previously thought to be "untreatable" is the value. The possibility of improved outcomes as a result of trauma-informed programming provides administrators with the potential for new funding opportunities or evidence that that this type of work has benefits for the broader system.

- Communication is an important key to success. If communication between staff is strong, it is easier to lay out a plan and assess people's interest, understanding and readiness. If communication between staff members in various roles is a challenge, it is essential that these issues be resolved before attempting to make system-wide changes that will require on-going dialogue and peer support.

Step 5:

Program leaders introduce the *Trauma-Informed Organizational Self-Assessment* as a guiding tool to help the organization become trauma-informed. Leaders explain that the *Self-Assessment* includes a list of concrete practices that should be incorporated into daily programming in a "trauma-informed" organization. Leaders inform staff members that they will begin by evaluating the extent to which they currently incorporate the practices outlined in the *Self-Assessment*, and based on the results, develop an action plan for implementing those *Self-Assessment* practices that are not currently being done. The *Self-Assessment* should not be handed out or completed until after all staff attends a formal trauma training.

Conducting the *Self-Assessment*

Step 6:

Program leaders provide each staff member with a copy of the *Trauma-Informed Organizational Self-Assessment*, review instructions for completion, and set a deadline for when completed assessments should be returned (see the *User's Guide* and the first page of the *Self-Assessment* for information about the tool and instructions for use). Instructions are provided in ways that everyone can understand. Confidentiality of answers is reinforced to ensure that staff members are able to answer freely and with no repercussions for honest answers.

Simultaneously, program leaders explain to consumers that the organization is looking to make changes and would like their feedback about the program. Program leaders provide consumers with the opportunity to assess the program using a modified version of the *Trauma-Informed Organizational Self-Assessment* (see Appendix I of this *Manual*). Information from this assessment process is an essential component of goal-setting moving forward.

Lessons learned:

- It is important to stress the need for staff and consumers to be honest when assessing the strengths and challenges of the program. While this request to "be honest" may sound simple, it often brings up bigger issues within a program. Sometimes it becomes necessary to examine the culture of your organization and whether or not staff and consumers really feel that they can be honest without concern that their feedback will impact them in a negative way. If this is an issue in your program, it needs to be addressed before the assessment process continues. Safety is a fundamental construct of a "trauma-informed" organization and must be a given for both staff and consumers.

- People are less likely to invest in a process if they feel that their feedback will not ultimately be used. Explaining the ways that the program will take all information given by staff and consumers into consideration when developing goals, is a way to empower all individuals in the program to feel that they are contributing to the change process.

- Staff and consumers often have different perspectives on the program and different ideas about consumer needs. Becoming trauma-informed involves reconciling these perspective, and on-going consumer involvement is necessary to every aspect of the change process.

Step 7:

All staff members complete the *Self-Assessment* within the designated timeframe (this will vary by program and will be based on discussions between program leaders and staff). Consumers are also given a timeframe in which to complete the *Self-Assessment*. There should be a designated box or location where consumers can return the Self-*Assessment*. It is important that consumers maintain their anonymity, and returning their completed *Self-Assessment* to a location rather than a person is helpful.

Lessons learned:

- It is helpful for program leaders to be available to offer additional help and support throughout the assessment process. There may be confusion about what a specific assessment item means. Asking clarifying questions increases the likelihood of accurate answers.

- It is important to remind people that they are not assessing their behaviors alone, but rather, the daily practices of the organization as a whole.

- It can be difficult for staff members to talk about a program's weaknesses without feeling defensive. Presenting the assessment process as an opportunity for change and growth rather than a judgment on the program is helpful.

Compiling *Self-Assessment* Results

Step 8:

The program leaders gather all *Self-Assessments* and compile responses. Leaders should compile staff and consumer responses separately so that they can be compared for similarities and differences. The following is a suggestion for how to gather responses and examine assessment results. This process can be used for compiling both the staff and consumer assessment results:

Using an excel spread sheet, enter each staff member's response to each Self-Assessment item.

Example:

I. Staff Development	Staff Member 1	Staff Member 2	Staff Member 3
A. Training & Education			
Staff receive training on the following topics:			
1. What traumatic stress is.	Strongly Agree	Agree	Do not know
2. How traumatic stress affects body and brain.	Agree	Disagree	Agree
3. The relationship between mental health and trauma.	Strongly Disagree	Strongly Agree	Agree

1. Using the information entered above, count the total number of strongly disagree, disagree, agree, strongly agree and do not know responses for each *Self-Assessment* item across staff members. Enter these totals on a blank *Self-Assessment* that can be copied and distributed to all staff.

Example:

I. Staff Development

A. Training & Education	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know
Staff receive training on the following topics:					
1. What traumatic stress is.			1	1	1
2. How traumatic stress affects body and brain.		1	2		
3. The relationship between mental health and trauma.	1		1	1	

Step 9:

The results of the assessment process are distributed to all staff members (see Step 6). Program leaders arrange for staff meetings to begin to discuss the results. These meetings should include all staff members who completed the *Self-Assessment*.
The results of the consumer assessment process are distributed to all consumers. The program uses forums such as community meetings to discuss ways that they are going to improve the program and respond to consumer needs and concerns.

Understanding *Self-Assessment* Results

Step 10:

During the assessment process, staff members are asked to evaluate the extent to which the program incorporates each of the practices listed in the *Self-Assessment.* For each item in the *Self-Assessment,* staff responses may range from "strongly disagree", meaning the program does not do this, to "strongly agree", meaning the program does incorporate this practice. The goal is for the program to be incorporating as many of the *Self-Assessment* items or practices as possible (i.e. most staff are responding "strongly agree" to most items on the *Self-Assessment).* To become trauma-informed, program staff need to examine assessment results, identify those areas where practice is not consistently "trauma-informed", and develop a plan for incorporating those *Self-Assessment* practices.

Reviewing results can take a considerable amount of time and focus. The *Self-Assessment* is divided into the following 5 domains: 1) Supporting Staff Development; 2) Creating a Safe and Supportive Environment; 3) Assessing and Planning Services; 4) Involving Consumers; and 5) Adapting Policies. It may be helpful to begin by examining each of these domains one at a time. Program leaders can facilitate these conversations in all staff meetings or in smaller group meetings, based on what is realistic and feasible for the program. Program staff also use forums such as community meetings to gather consumers' ideas for short and long-term goals.

The following is an example of how this process may work:

1. Program leaders and staff members agree to begin by focusing on the domain "Supporting Staff Development", looking for practices listed in the *Self-Assessment* that are not currently being done in the program. In addition, staff examines the consumer assessment results in this area and considers those places where there are considerable differences between staff and consumer perspectives.

2. All staff members share ideas about what types of training, supervision and self-care practices from the *Self-Assessment* they would like to incorporate.

3. Program leaders keep an on-going list of staff ideas and possible short and long-term goals.

Lessons learned:

- Programs are most successful when the assessment process is transparent and all staff participates in discussions about *Self-Assessment* results.

- Successful discussions must involve giving staff at all levels of the program a space to voice their opinions about areas of need and changes that would be helpful.

- If communication between staff is a challenge or there are tensions between staff in different roles, these issues should be addressed before moving forward with goal setting.

Developing a Strategic Plan

Step 11:

Based on the staff discussions begun in Step 10, program leaders identify specific goals for incorporating *Self-Assessment* items. A strategic plan for the program includes the following: 1) identified and agreed upon goals; 2) specific steps to reach each goal; 3) resources need to achieve each goal; and 4) a realistic timeframe for achievement of each goal. When identifying areas of change, the program may choose to focus on one *Self-Assessment* domain at a time or identify specific short and long-term goals within several of the domains. Each goal includes the necessary action steps, resources, timeframe for achievement, and persons responsible for monitoring progress towards the goal.

The following is sample plan for becoming more trauma-informed in the area of "Staff Development":

Staff Development Goal #1: "Topics related to trauma are addressed in team meetings."

Action Steps:

1. Staff generates a list of topics related to trauma that are of interest and would be helpful to their work with consumers. The specific needs of staff in different roles are taken into consideration.

2. Staff discusses ways that they would like to address these topics (e.g., small group discussions, case presentations, more formal trainings, presentations by program staff and/or outside consultants).

3. If needed, outside experts are contacted for times that they could come to the program to provide information and trainings.

4. Program leaders come up with a schedule of topics to be discussed at upcoming meetings.

Resources:

- Staff time for discussionsand brainstorming sessions.

- Sources of funding for trainings by outside providers and professional development opportunities that staff can attend off-site.

Timeframe: 4 months

Persons responsible for monitoring progress on action steps: Program identifies specific people responsible for monitoring progress towards this goal.

The sample above can be used for all goal setting that a program does based on the *Self-Assessment* domains.

Lessons learned:

- It is very important that the goals identified are realistic in the current organization. If an organization has a great goal but no time or resources to achieve that goal, it could impact the entire change process. If people begin to feel hopeless that change can be made, it may impact their drive to make smaller, more manageable changes. With the creation of each goal, all staff has to have a sense that it can be achieved, whether in the short term or in the long-term.
- Change is most effective when identified goals reflect the needs of service providers in varying roles, at all levels of the organization

Example:

> Program A has just completed the *Self-Assessment*. Direct care staff is feeling burnt-out and unsupported by the larger organization. They would like to focus their program goals in the area of "Supporting Staff Development". Administrative staff has other priorities and while they believe that staff support is important, they would like to focus their efforts in the area of "Adapting Policies". Program A needs to have additional discussions, in order to identify goals that meet everyone's needs. Ideally this type of democratic change process encourages the "flattening" of these hierarchies among staff, and models the need for all to have a voice in how the program is run.

- Becoming trauma-informed is as much about changing a program's culture as it is about changing program practices. Changing the culture of an organization can be much more difficult, as attitudes and values are often subtle, ingrained and hard to identify and shift. As a program begins to incorporate new practices, it is helpful to have continued discussions about the ways that these practices are attempts to shift tone, culture and atmosphere in the program.

Implementing Trauma-Informed Changes

Step 12:

Once program leaders and staff members identify goals for incorporating the trauma-informed practices outlined in the *Self-Assessment*, it is helpful to put structures in place to monitor progress towards goals and keep the commitment to being trauma-informed in the forefront. One way that a program can do this is by creating a multi-disciplinary "trauma workgroup" consisting of a core group of staff representing all roles in the agency. This group makes a commitment to: 1) making sure objectives are being met for identified short-term and long-term goals related to being trauma-informed; 2) generating new ideas about further changes that may be necessary as the process continues; and 3) looking for additional education and training opportunities for the program at large.

If a program is small enough (e.g., a staff of 12-15), the trauma workgroup can include all staff. In this case, trauma workgroup topics may be included in regular staff meetings or be discussed at a different time. In larger programs, it may be unrealistic to get all staff together on a regular basis to discuss trauma and trauma-informed care in addition to general topics covered in staff meetings. Creating a smaller multi-disciplinary group of staff may make things more manageable. This trauma workgroup can report back to all staff in order to give updates on progress towards goals and get staff feedback on how the change process is going. This includes discussions about challenges and barriers to change that inevitably arise. The trauma workgroup should maintain on-going contact with program consumers, as one key method of assessing whether they are making progress on identified goals.

Lessons Learned:

- Staff at all levels of an organization should have a voice in the trauma workgroup. If all staff roles within a program are not represented in the workgroup, it leads to a sense that some positions are less valued than others.

- On-going feedback from consumers provides organizations with essential information about whether daily programming and services actually seem different.

Step 13:

Becoming trauma-informed is a process that involves on-going growth and development. There is no specific end-date at which point programs are "trauma-informed" and therefore, "finished" with the process. The *Trauma-Informed Organizational Self-Assessment, User's Guide* and *How To Manual* represent one set of tools that programs can use to become more trauma-informed. As programs begin to incorporate *Self-Assessment* practices, the hope is that they will also begin to generate additional ideas for creating trauma-informed programming that go beyond what is outlined in the *Self-Assessment.* As programs implement the *Self-Assessment* practices, they would benefit from learning about other models of trauma-informed organizational change as well as trauma-specific services that may be offered to meet individual consumer needs.

Additional Tools and Resources:

The following are additional tools and resources that programs may use to gain ideas and build supplemental skills that will aid in the trauma-informed organizational change process:

» ***Shelter from the Storm: Creating Trauma-Informed Homeless Services***. This report outlines current trends and promising models for developing trauma-informed homeless service systems and organizations. The report includes additional tools for creating organizational change, as well as preliminary research findings that identify the positive outcomes associated with a trauma-informed approach to service provision. This report includes specific programs around the country that have incorporated trauma-informed service models. These are places and people that program leaders may want to contact to get more information about what different programs are doing and share successes and challenges. Shelter from the Storm can be accessed electronically at **www.homeless.samhsa.gov**.

» ***Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services: A 2007 Update***. Created by the Center for Mental Health Services' National Center for Trauma-Informed Care, this document includes a thorough list of models for developing trauma-informed service systems and organizations, as well as trauma-specific service models for adults, children and parents. Programs may want to learn about and consider integrating these types of trauma-specific, therapeutic services into an organization that is also making the broader changes that are designed to support this type of individualized trauma work. The report includes brief descriptions of each model, as well as contact information. Though many of these models have not been adapted for use in homeless service settings, they may provide programs with additional ideas for how to continue to evolve in the process of becoming trauma-informed. This document can be accessed electronically at **www.mentalhealth.samhsa.gov/nctic/**.

» ***A Long Journey Home: A Guide for Creating Trauma-Informed Services***. This document offers concrete practices that programs can incorporate in order to become trauma-informed. Many of these practices correspond to the areas covered in the *Self-Assessment*. *A Long Journey Home* also provides programs with suggestions for how to shift their culture, attitudes and responses to those they serve. This guide offers side-by-side comparisons of trauma-informed vs. traditional approaches to providing care that serve as helpful educational tools for staff who are learning how "trauma-informed" care differs from "business as usual". Also included in the guide are sample practice scenarios and techniques that can be used to help staff understand how to be "trauma-informed" in their responses to consumers in the moment. *A Long Journey Home* can be accessed electronically at **www.homeless.samhsa.gov**.

» ***What About You? A Workbook for Those Who Work with Others.*** This workbook includes education about burn-out and secondary trauma, along with activities to address the self-care needs of individuals and organizations. Activities may be incorporated into programming within an organization, whether on staff retreats or in regular staff meetings, in an effort to create a culture where staff support and self-care is valued. *What About You?* can be accessed electronically at **www.familyhomelessness.org**.

Step 14:

As programs begin to achieve their initial goals and modify their strategic plans to include new ideas for trauma-informed practices, it is helpful to begin to brainstorm ways to document the impact that this type of trauma-informed change is having in the program, specifically as it relates to consumer feedback and outcomes. This may include the use of staff and consumer focus groups, questionnaires, and documentation of information such as number of terminations from the program, number of consumer crises, and rates of staff turn-over. Documenting how becoming trauma-informed impacts consumer and staff experiences may be a helpful way for programs to advocate for additional resources and changes in broader systemic policies that may conflict with a trauma-informed approach.

II. What Does Becoming "Trauma-Informed" Look Like?

Becoming trauma-informed is a process that involves striving towards a new way of understanding people and providing services and supports. This process involves a gradual integration of trauma concepts and trauma sensitive responses into daily practice. What it looks like to become "trauma-informed" can vary from program to program. The programs that were involved in the piloting of the *Trauma-Informed Organizational Self-Assessment* identified specific changes in attitudes and practices as a result of the trauma training, assessment process, implementation of *Self-Assessment* items, and on-going consultation on trauma-related issues. These concrete changes are outlined on the following pages.

The following are examples of changes that programs have identified as reflective of becoming more "trauma-informed":

- Staff recognizes homelessness is a trauma.
- Staff is better able to recognize that the people they serve have experienced trauma and are reacting in the present based on these past experiences.
- Trauma-related language (e.g., discussions about triggers, re-traumatization, and trauma impact) is used more frequently in general discussions, staff meetings, and supervision.
- Changes in attitude among staff since learning about traumatic stress and its impact on consumers. Staff responds differently to consumers based on their knowledge of trauma (e.g., more flexible, non-judgmental, more patient).
- Staff is more engaged and excited about making changes.
- Staff is asking for more trauma training.
- In supervision, there are more conversations about consumers' pasts and relating their current situations to past trauma.
- The program finds ways to train new staff in trauma to get them on the same page with others who have already begun this process.

- The program finds ways to provide on-going trauma education, whether in the form of in-person or on-line trainings or case discussions with outside consultants.

- The program has more formal ways to support staff (e.g., discussions about self-care in supervision and staff meetings, staff retreats, education about vicarious trauma and burn-out, procedures for debriefing from crises, an acknowledgement by all staff that self-care is important and necessary).

- People are thinking about the environment more (e.g. asking where people feel comfortable and thinking about trauma while they are doing this, posting consumer rights).

- The program has a self-care or crisis prevention plan for each adult and child in the program. These plans are part of the intake process.

- The program uses more strengths-based language when explaining the rules and policies (e.g. telling consumer what they can do instead of what they cannot do).

- The program has consumers on the board of directors.

- The program asks consumers for input about group meetings.

- The program surveys consumers about their ideas for and experiences in the program.

III. Sustaining Trauma-Informed Change

The following are suggested "next steps" for sustaining trauma-informed changes:

- On-going review: Review of short-term and long-term goals related to becoming trauma-informed. Programs can do a yearly re-assessment of their program, using the *Self-Assessment* to identify changes. Other assessment tools include staff and consumer surveys, focus groups, and individual interviews. Have these strategies built-in to your long-term plan.

- On-going trauma training: Trauma training as part of the new hire process and refresher trainings on trauma and trauma-related topics for all staff.

> *"We must become the change we want to see."*
>
> – Mahatma Gandhi

- Making connections: Finding ways to connect with experts in various areas, such as trauma, cultural competence and child development. These agencies can provide on-going support and consultation. Networking with other programs who are integrating trauma-informed organizational models and finding ways to share information and experiences (resources for this are discussed in Step 13).

- Bringing trauma-informed concepts to the broader system: Program staff can bring their understanding of trauma and trauma-informed care to the broader service system. This means educating other service systems and providers working with families on the impact of trauma and trauma sensitive responses.

IV. Conclusion

In an effort to help others toward the goal of recovery and healing, providers are called on to modify existing attitudes, practices, and procedures to best meet the needs of all who walk through their doors. Throughout this *Manual* we have identified concrete steps that an organization can take to become "trauma-informed". Becoming trauma-informed involves a gradual transformation in the way that an organization provides for and meets the needs of those they serve. This type of organizational change requires the support and guidance of many, both within and outside of an organization. Change happens slowly and in communion with others who are also committed to this type of service provision and care. As change takes hold in an organization and staff members become "champions" of trauma-informed care, there is a hope that individuals and agencies can carry this knowledge and passion beyond their program walls. Ultimately, becoming trauma-informed is about creating a web of integrated service systems that are united in the goal of providing comprehensive, quality care that seeks to uplift and empower both the provider and the consumer.

V. Next Steps

For additional information about training and consultation around trauma and homelessness, providing trauma-informed care, and beginning the organizational change process, contact the National Center on Family Homelessness at 617-964-3834 or e-mail kathleen.guarino@familyhomelessness.org or info@familyhomelessness.org.

Trauma-Informed Organizational Self-Assessment: Consumer Version

Instructions:

Your program is looking to provide the best services possible. In order to do this, they need your feedback and opinions about your experiences in the program. This *Organizational Assessment* includes a list of items that programs could be doing on a daily basis. You are asked to rate how much you agree that the program is doing each of the items on the list using the following scale:

Strongly Disagree
Disagree
Agree
Strongly Agree
Do not know
Not applicable to my role

Example Item:
"Staff members talk to you in a respectful way."

You respond *"Strongly Disagree, Disagree, Agree, Strongly Agree, or Do not know."*

The *Assessment* can be completed in one sitting or in sections. It takes approximately 20-30 minutes to complete the entire *Assessment* at once. When responding to *Assessment* items, please answer based on your experience in the program over the past 6 months or since your arrival if you are new to the program.

Your responses are anonymous and will not affect your stay in the program. Please answer as honestly and accurately as possible. If you have questions or are confused about the items, instructions, etc., please contact the person or persons that your organization has identified to help with the completion of the *Assessment*. Please return your copy of the *Assessment* to the drop-off location.

I. Supporting Staff Development

A. Staff Education	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know
Staff have discussed the following information with you:					
1. What traumatic stress is.					
2. How traumatic stress affects the brain and body.					
3. The relationship between mental health and trauma.					
4. The relationship between substance use and trauma.					
5. The relationship between homelessness and trauma.					
6. How trauma affects a child's development.					
7. How trauma affects a child's attachment to his/her caregivers.					
8. Cultural differences in how people understand and respond to trauma.					
9. What triggers are and how to identify them.					
10. How to develop safety and crisis prevention plans.					

II. Creating a Safe and Supportive Environment

A. Establishing a Safe Physical Environment	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know
1. The program facility has a security system (i.e., alarm system).					
2. Program staff monitors who is coming in and out of the program.					
3. Staff members ask you how they can keep you physically safe.					
4. The environment outside the program is well lit.					
5. The common areas within the program are well lit.					
6. Bathrooms are well lit.					
7. You can lock bathroom doors.					
8. You have access to private, locked spaces for your belongings.					
9. The program incorporates child-friendly decorations and materials.					
10. The program provides a space for children to play.					
11. The program provides you with opportunities to make suggestions about ways to improve/change the physical space.					

B. Establishing a Supportive Environment	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know
Information Sharing					
12. The program reviews rules, rights and grievance procedures with you regularly.					
13. You are informed about how the program responds to personal crises (e.g., suicidal statements, violent behavior).					
14. You are informed about who will be checking on you and your spaces (e.g., how often and why it is important).					
15. Expectations about room/apartment checks are clearly written and verbalized to you.					
16. Your rights as a consumer in the program are posted in places that are visible.					
17. Material is posted about traumatic stress (e.g., what it is, how it impacts people, and available trauma-specific resources).					
Cultural Competence					
18. Program information is available in different languages.					
19. You are allowed to speak your native language within the program.					
20. You are allowed to prepare or have ethnic-specific foods.					
21. Staff shows acceptance for personal religious or spiritual practices.					
22. The program provides on-going opportunities for you to share your culture with others (e.g., potlucks, culture nights, incorporating different types of art and music, etc.).					

Privacy and Confidentiality	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know
23. The program informs you about the extent and limits of privacy and confidentiality (e.g., the kinds of records that are kept, where they are kept, who has access to this information, and when the program is obligated to report information to child welfare or police).					
24. You are asked about the least intrusive ways for staff to check on you and your spaces.					
25. The program gives notice prior to doing room/apartment checks.					
26. The program gets permission from you prior to giving a tour of your room/apartment.					
27. If permission is given, you are notified of the date, time and who will see your room/apartment.					
28. Staff does not talk about you or other consumers in common spaces.					
29. Staff does not discuss your personal issues with another consumer.					
30. If you have violated the rules, you are approached in private.					
31. There are private spaces for you and staff to discuss personal issues.					
Safety and Crisis Prevention Planning					
For the following items, the term "safety plan" is defined as a plan for what you and staff members will do if you feel threatened by another person outside of the program.					
32. You work with staff to create written, individualized safety plans for your family.					
33. Written safety plans are incorporated into your individual goals and plans.					

Safety and Crisis Prevention Planning, cont...	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know
34. You have a written plan that is designed to help you when you are feeling stressed-out or overwhelmed.					
35. Your child has a written plan that is designed to help him/her when he/she is feeling upset or overwhelmed.					
Written plans include the following:					
36. A list of situations that are stressful or overwhelming and may remind you of negative experiences from the past.					
37. A list of ways that you show others that you are stressed or overwhelmed (e.g., types of behaviors, ways of responding, etc.).					
38. Specific responses from others that are **helpful** when you are feeling upset or overwhelmed.					
39. Specific responses from others that are **not helpful** when you are feeling upset or overwhelmed.					
40. A list of people that you feel safe around and can go to for support.					

Open and Respectful Communication	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know
41. Staff members ask you what you need to feel emotionally safe in the program.					
42. Staff members are good listeners.					
43. Staff members talk to you in a respectful way.					
44. Staff members make an effort to acknowledge good things about you.					
Consistency and Predictability					
45. The program has regularly scheduled community meetings for consumers.					
46. The program provides advanced notice of any changes in the daily or weekly schedule.					
47. Program staff responds consistently to you and others (e.g., consistency across shifts and roles).					
48. The program is flexible with rules if needed, based on individual circumstances.					

III. Assessing and Planning Services

A. Conducting Intake Assessments	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know
During your initial intake assessment you are asked questions about:					
1. Personal strengths.					
2. Cultural background.					
3. Strengths that you draw from your culture.					
4. Social supports in the family and the community.					
5. Current level of danger from other people (e.g., restraining orders, history of domestic violence, threats from others).					
6. History of trauma (e.g., physical, emotional or sexual abuse, neglect, loss, domestic/community violence, combat, past homelessness).					
7. Previous head injury.					
8. What your relationship is like with child or children.					
9. Any trauma that your child/children may have experienced.					
10. Your child/children's achievement of developmental tasks.					
11. Your child/children's history of mental health issues.					
12. Your child/children's history of physical health issues.					
13. Your child/children's history of prior experiences of homelessness.					

Intake Assessment Process	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know
14. There are private, confidential spaces available to do intake assessments.					
15. The program informs you about why questions are being asked.					
16. The program informs you about what will be shared with others and why.					
17. Throughout the assessment process, the program checks in with you about how you are doing (e.g., asking if you would like a break, water, etc.).					
18. The program provides an adult translator (not another consumer in the program) for the assessment process if needed.					
Intake Assessment Follow-up					
19. Based on the intake assessment, you are referred for specific services as necessary.					
20. Based on the intake assessment, your child/children are referred for further assessment and services as needed.					
21. Your intake assessment is updated on an on-going basis.					
22. The program updates releases and consent forms with you whenever it is necessary to speak with a new provider.					
B. Developing Goals and Plans					
23. Staff supports you in setting your own goals.					
24. Your goals are reviewed and updated regularly.					
25. You work with staff to identify a plan to address your child/children's needs.					

Developing Goals and Plans, cont...	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know
26. Before leaving the program, you and staff develop a plan to address potential safety issues.					
27. Before leaving the program, you and staff develop a plan to address future service needs related to trauma.					
28. Before leaving the program, you and staff develop a plan that addresses your child/children's service needs related to trauma.					
C. Offering Services and Trauma-Specific Interventions					
29. The program provides opportunities for you to receive a variety of services (e.g., housing, employment, legal and educational advocacy, and health, mental health and substance abuse services).					
30. When mental health services are needed (e.g., individual therapy, group therapy and/or family therapy), the program refers **adults** to counseling.					
31. When mental health services are needed (e.g., individual therapy, group therapy and/or family therapy), the program refers **children** to counseling.					
32. The program provides opportunities for you to express yourself in creative and nonverbal ways (e.g., art, theater, dance, movement, music).					

IV. Involving Consumers

A. Involving Current and Former Consumers	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know
Current Consumers					
1. Your needs and concerns are addressed in community meetings.					
2. The program provides opportunities for you to lead community meetings if interested.					
3. You are involved in the development of program activities.					
4. You are given opportunities to evaluate the program and offer your suggestions for improvement in anonymous and/or confidential ways (e.g., suggestion boxes, regular satisfaction surveys, meetings focused on necessary improvements, etc.).					
Former Consumers (refers to anyone who has experienced homelessness)					
5. Former consumers are involved in providing services (e.g., peer-run support groups, educational, and therapeutic groups.).					
6. Former consumers are invited to share their thoughts, ideas, and experiences with the program.					
7. After a period of time, there are opportunities for former consumers to come back and work in the program in some way.					

V. Adapting Policies

A. Creating Written Policies	Strongly Disagree	Disagree	Agree	Strongly Agree	Do not know
1. The program provides you with a copy of the policies.					
2. The program has a written commitment to demonstrating respect for cultural differences and practices.					
3. The program has a written commitment to hire staff who have experienced homelessness.					
4. The program has a written policy to address potential threats to consumers from persons outside of the program.					
5. The program has a written policy outlining program responses to consumer crises (e.g., self-harm, suicidal thinking, aggression towards others).					
6. The program has written policies outlining professional conduct for staff (e.g., boundaries, responses to consumers, etc.).					
B. Reviewing Policies					
7. The program involves you in its review of policies.					

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