# *A Long Journey Home*

## *A Guide for Creating Trauma–Informed Services for Mothers and Children Experiencing Homelessness*

**Laura Prescott**
*Sister Witness International Inc.*

**Phoebe Soares, Kristina Konnath, and Ellen Bassuk**
*The National Center on Family Homelessness*

NCTSN The National Child Traumatic Stress Network
DANIELS FUND
W.K. KELLOGG FOUNDATION
From Vision to Innovative Impact
HRC Homelessness Resource Center

# Table of Contents

**Acknowledgments** **4**

**Introduction and Overview** **5**

**I. Who are Homeless Families? A Brief Portrait**
**II. Why Should Shelter Providers Become Trauma-Informed?**
**III. How to Create an Organizational Philosophy that is Trauma-Informed**

*Exercise 1: The Story of Akasha* **11**

**Strategic Planning** **13**

**I. Create a Trauma-Informed Atmosphere and Environment** **13**
A. Set a Welcoming Tone When Women Arrive
B. Foster an Environment in Which Women Build a Strong Community
C. Establish a Comfortable and Welcoming Physical Environment
D. Tolerate a Range of Emotions
E. Share Power and Control
F. Use Strength-Based, Person-First Language

*Exercise 2 – Say that Again? Watch Words* **19**
*Exercise 3 – Say that Again? Reducing Acronyms* **20**
*Exercise 4 – Develop Low-Cost Ideas and Activities for Changing the Environment* **21**

**II. Develop Trauma-Informed Policies and Procedures** **22**
A. Assume Trauma When Reviewing Policies and Procedures
B. Revisit Narrow Eligibility Criteria
C. Create Partnerships with Women through Informed Consent
D. Adapt Policies to Avoid Retrauma
E. Review Agency Mandates to Maximize Client Autonomy and Choice
F. Interview Women to Improve Procedure
G. Quality Assurance

**III. Establish Trauma-Informed Services and Supports** **26**
A. Ensure Services are Voluntary
B. Support Developing Authentic Relationships
C. Assess Women and Children
D. Create Safety Planning and Crisis Prevention for Women and Children
E. Involve Women in Developing Care Plans
F. Create a Range of Trauma-Informed Services and Trauma-Specific

Clinical Interventions
G. Establish a Place for Ongoing Peer Support
H. Develop Services for Children

*Exercise 5 - Identifying Triggers* **37**

**IV. Support Client Representation and Staff Development** **40**
A. Establish Visible Client Leadership and Representation
B. Foster Staff Development

**V. Provide Training and Supervision** **41**
A. Educate Staff and Clients about Violence and Trauma
B. Provide Ongoing Guidance and Supervision
C. Encourage Staff to Respect their Own Limits and Capacities

**VI. Keep Efforts Sustainable Through Strategic Planning** **43**
A. Establish a Trauma-Informed System through Strategic Planning
B. Generate an Action-Based Research Plan and Document Best Practices

**VII. Other Considerations** **44**
A. Does Your Program or Agency Require Medical Clearance & Screening?
B. Special Considerations When Hiring Male Staff

**Appendices** **46**

A. Individualized Safety Plans
B. Explanation of Selected Exercises
C. Example of a Personal Crisis Prevention Planning Form Adapted for Residential Centers

**References** **56**

## Acknowledgments

This resource guide was co-authored by Laura Prescott of Sister Witness, International and Phoebe Soares, Kristina Konnath and Ellen Bassuk, MD of the National Center on Family Homelessness. The authors would especially like to thank various people from The National Center on Family Homelessness who helped shape *The Long Journey Home,* including Wendy Vaulton, Robin Einzig, Jayne Samuda, Kathleen Guarino and Dawn Jahn Moses. The document was much improved by the insight and ongoing review provided by Lisa Gilbert, MD and the women from Boston area shelters who gave us invaluable input and advice after reviewing the drafts. Finally, *The Long Journey Home* is dedicated to all the mothers and their children who will struggle to find shelter tonight and to those who provide services so they have a tomorrow. We hope this guide will serve as a useful supplement to the important work you already do.

### Disclaimer

Funding for the development of the *Long Journey Home* was provided by the National Child and Traumatic Stress Network; the Daniels Fund; the W.K. Kellogg Foundation; and the Homelessness Resource Center. The Homelessness Resource Center is funded by Contract No. HHSS280200600029C from the Homeless Programs Branch, Division of Services and Systems Improvement, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA), U.S Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

### Public Domain Notice

All material appearing in this report is in the public domain and may be reproduced or copied without permission from SAMHSA. However, citation of the source is appreciated. No fee may be charged for the distribution of this material.

### Recommended Citation:

Prescott, L., Soares, P., Konnath, K., and Bassuk, E. (2008). *A Long Journey Home: A Guide for Creating Trauma-Informed Services for Mothers and Children Experiencing Homelessness.* Rockville, MD: Center for 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

### Originating Office

Homeless Programs Branch, Division of Service and Systems Improvement, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 1 Choke Cherry Road, Room 6-1031, Rockville, MD 20857

Questions or comments related to this document should be directed to Deborah Stone, Federal Project Officer, at 240-276-2411; to the Homelessness Resource Center at 617-467-6014 ext. 200; or e-mailed to generalinquiry@homelessnessandtrauma.com with "Long Journey Home" in the subject line.

### Additional SAMHSA Resources

For more information about SAMHSA resources and programs, contact the SAMHSA Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727).

## Introduction and Overview

*The Long Journey Home* was written as a response to some startling lessons we have learned from the field of homelessness over the last decade. It draws on guidelines from the Substance Abuse and Mental Health Services Administration – who funded the Women, Co-Occurring Disorders and Violence Study to implement trauma-informed mental health, substance abuse and other support services for women (Moses, 2001; Moses, Reed, Mazelis, and D'Ambrosio, 2003). Its contents have been modified and refined to meet the needs of women who are homeless. We know that: (1) family homelessness is increasing; (2) women and children are at risk for becoming a majority of the overall homeless population; (3) homelessness is traumatic and it makes families sick; and (4) violence is a critical ingredient in the recipe for homelessness.

Violence and other traumatic events can be shattering. Their impact permeates all levels of relational development by calling trust into question. What was once assumed safe is no longer that way. A woman's relationship to others, her environment, and herself (body, mind and spirit) is changed. The impact is intergenerational. Given the pervasive level of traumatic stress that results from severe physical and sexual assault, disconnection from relatives and children, and loss of significant supports due to illness, death, and dislocation, it is not surprising that women and children become significantly distressed. Yet, given this knowledge, there still remains a dearth of practical, hands-on guidance about how best to support these families in their healing process.

We would like to acknowledge the pioneering work of Maxine Harris and Roger Fallot (2001a; 2001b) who originally conceptualized the notion of trauma-informed services for survivors of violent victimization. Elliott, Bjelajac, Fallot, Markoff, and Reed (2005) elaborated on their approach by describing ten principles for designing trauma-informed services, particularly for survivors who have alcohol and other drug or mental health problems. They emphasized the importance of creating safe environments in which boundaries are clear, power is shared, consumer choice is ensured and strategies are integrated across all levels of the program. Our work attempts to take additional steps forward on their work by further elaborating on these principles, operationalizing them for ready use, and adapting a trauma-informed approach for specific settings that serve homeless families.

*The Long Journey Home* is intended to serve as a guide to agencies looking for practical ideas about how to create trauma-informed environments. It is best viewed as a template and should be supplemented by your knowledge and expertise regarding the most effective adaptations for working with families in your own program.

## I. Who are Homeless Families? A Brief Portrait

Homeless families are comprised of a caretaker with a child or a pregnant mother. The vast majority of these families are headed by women who are faced with the formidable challenge of filling multiple roles with few resources to buffer the stress of mothering children alone. They are also confronted daily with the chronic pressures associated with severe poverty and must contend with serious adverse life events such as catastrophic illness, family separations and violence on their own (National Center on Family Homelessness [NCFH], 1999).

Typically, a sheltered homeless mother is twenty-seven years old with two or three children, most often of preschool age (NCFH, 1999). She is most likely a woman of color who has been homeless at least once and has less than a high school education. If she can find work, she does not make enough money to keep her from being at risk for homelessness if something goes wrong. Homeless mothers are women who have been subjected to severe physical and sexual abuse in childhood and re-experienced it again in adult relationships (Bassuk, Weinreb, Buckner, Browne, Salomon, and Bassuk, 1996; Browne and Bassuk, 1997). Her children have witnessed violence at home and on the streets (NCFH, 1999). As a result of the onslaught of violence, chronic dislocation and loss, the children exhibit physical and emotional difficulties. Homeless mothers and their children are incredibly resilient given the extraordinarily stressful nature of their day-to-day lives. It is this resilience, tenacity, and courage we hope to honor in producing a document that acknowledges these strengths. At the same time, we hope to encourage agencies to develop trauma-informed programs and policies so that women and children find more places to heal.

**Family homelessness is increasing.**

- *Women and children are the new faces of family homelessness:* In the year 2007, 65% of the sheltered homeless population was women, and families with children comprised 23% of the overall shelter users (U.S. Conference of Mayors, 2007). In homeless families, there are 1.35 million children, 40% of whom are under six years old (Burt et al., 1999).

- *Women and children are at risk for becoming the homeless families of the future*: Women with children who are solely responsible for the economic welfare of their families are one of the fastest growing segments of people experiencing homelessness today (NCFH, 1999). Some project they will become the majority of homeless people in the future (Vladek, 1990).

## II. Why Should Shelter Providers Become Trauma-Informed?

**Homelessness is traumatic (Goodman, Saxe, and Harvey, 1991).**

- *Homelessness leads to a host of compounded and cumulative losses:* Women and children experience dislocation from home and community, and loss of important social roles leading to isolation and feelings of helplessness.

❖ *Shelter living is chaotic:* Families lack privacy. Policies and procedures often accentuate the loss of control over important relational connections and environment.

❖ *Homelessness puts women and children at risk for violence, and violence puts women and children at risk for homelessness.*

**Violence is a critical ingredient in the recipe for homelessness.**

❖ *Violence is normative:* Multiple studies suggest that violence is normative in the lives of homeless women and children with at least half (50% to 60%) experiencing homelessness after fleeing from a violent relationship (Browne and Bassuk, 1997; Goodman, 1991; Bassuk et al., 1996).

❖ *Severe physical and/or sexual assault*: The majority (92%) of homeless mothers have experienced severe physical and/or sexual assault at some point in their lives (Bassuk et al., 1996). Sixty-six percent experienced severe physical abuse and 43% were sexually molested as children (Bassuk et al., 1996; Browne and Bassuk, 1997; Bassuk, Melnick, and Browne, 1998). Sixty-three percent have been subjected to violence by intimate partners (Bassuk et al., 1996; Browne and Bassuk, 1997).

❖ *Sexual and physical violence is intergenerational*: In a national survey of more than 2,000 American families, 50% of the men who frequently assaulted their wives also abused their children (Straus and Gelles, 1990). Sixty-nine percent of sexual assault victims are girls *under the age of six* and 73% are *under the age of twelve* (Snyder, 2000).

❖ *Homeless children are exposed to extremely high rates of violence*: Eighty-three percent of children over the age of 12 years have been exposed to violence and 25% have witnessed violence in their families (Buckner, Beardslee, and Bassuk, 2004).

❖ *Services are not designed to respond to women and children who show symptoms of distress*: Homeless women who present symptoms of post traumatic stress (psychic numbing, rage reactions, re-experiencing painful past episodes, depression, anxiety, endless watchfulness, sleeplessness), may use substances to help them medicate painful trauma-related sequelae. They may have difficulty accessing essential housing, economic, healthcare, educational, childcare and peer support services.

**Homelessness makes families sick.**

❖ *Homeless children are sick four times as often as middle class children* with high rates of acute and chronic illness (Weinreb, Goldberg, Bassuk, and Perloff, 1998). Homeless children have twice as many ear infections, five times more gastrointestinal problems, and are four times more likely to have asthma as other poor children (Weinreb, Goldberg, Bassuk, and Perloff). Forty-seven percent show signs of being anxious, withdrawn, or depressed (Buckner and Bassuk, 1997).

❖ *Chronic stress* associated with homelessness, violence, poverty, isolation, and shame takes its toll on women's physical health. *Poor nutrition* and *lack of nutrition* put women and children at risk for diabetes,

high blood pressure, vitamin deficiencies, anemia, obesity, and high cholesterol (Weinreb, Goldberg, and Perloff, 1998). *Chronic physical problems* such as hypertension, gastrointestinal problems, neurological disorders, arthritis, chronic obstructive pulmonary disease, and peripheral vascular disease are common among women who are homeless (McMurray-Avila, 1997).

❖ *Reproductive health issues* such as complicated pregnancies, poor prenatal care, lack of access to contraceptives, and exposure to violence increase the risk for sexually transmitted diseases (Killion, 1998). HIV and AIDS make these issues potentially life-threatening (The Global Coalition on Women and AIDS, 2004).

❖ *Substance use problems*: In a study of 300 homeless women, one in three had a history of substance abuse, with drug abuse more prevalent than alcoholism (Smith, North, and Spitznagel, 1993). Other studies indicate that 41% of homeless mothers suffer from alcohol and drug dependence, a rate twice as high as the national rate for females in the general population (Weinreb, Goldberg, and Perloff, 1998).

❖ *Major depression*: 45% of homeless mothers have problems with major depression - twice the rate of women in the general population (Bassuk, Buckner, Perloff, and Bassuk, 1998).

❖ *Post Traumatic Stress*: 36% of homeless mothers have Post Traumatic Stress Disorder over the course of their lifetimes, a rate three times higher than women of all ages in the general population (Bassuk, Melnick, and Browne, 1998).

## III. How Do We Create an Organizational Philosophy that is "Trauma-Informed"?

### Begin by defining the term "trauma".

What is trauma? How is it defined? Part of creating an organizational philosophy that is trauma-informed begins with defining trauma itself. Judith Herman, MD, author of *Trauma and Recovery* (1992) provides one definition of trauma that has been used to guide many programs in developing an organizational philosophy. She states that traumatic events:

*(1) render victims helpless by overwhelming force; (2) involve threats to life or bodily integrity, or close personal encounter with violence and death; (3) disrupt a sense of control, connection and meaning; (4) confront human beings with the extremities of helplessness and terror; and (5) evoke the responses of catastrophe*.

Examples of traumatic events include but are not limited to: childhood physical and/or sexual abuse, neglect, adult sexual assault/rape, physical assault, domestic violence, witnessing violence, war-related displacement, internment, such as refugee and concentration camps, being subject to natural disasters, loss, life-threatening medical complications, unexpected death of family, children, friends, comrades, etc.

### Establish a framework for trauma recovery.

The process of recovery is individual and personal in nature so it is important to respond to women in an individualized and flexible way. However, programs focused on trauma-informed approaches to recovery have key ingredients in common. It is helpful to articulate a shared understanding of what

recovery from trauma means so everyone involved - staff and clients - can work together to establish environments that are "safe" and organizationally consistent. The need for organizational consistency lives in necessary dynamic tension with the need to provide individualized and flexible care. The balance between the two is crucial and must be regularly revisited by staff and clients to make sure the organization is not becoming so individualized that it is inconsistent or conversely, so consistent it becomes rigid and punishing. While there are many approaches to recovery from trauma, Herman (1992) outlines three stages of recovering from complex post traumatic stress: establishing safety, remembering and mourning, and reconnecting.

**Define trauma-informed services.**

Trauma-informed services assume that people are doing the best they can at any given time to cope with the life-altering and frequently catastrophic effects of trauma. Because childhood and adult victimization can lead to disconnection with self and isolation from others, the challenge is to develop services and systems that create authentic reconnection, reparation, and healing. In trauma-informed services and systems all staff members - from grounds-keepers, to maintenance staff to administrators - are trained to respond to individuals in distress.

| Traditional<br>Services & Systems | Trauma-informed<br>Services & Systems |
|---|---|
| ❖ Traumatic stress is not viewed as a primary defining event in people's lives. | ❖ Traumatic and violent events are the central, primary events impacting everything else in the lives of women and children. Assumes the impact of trauma is all-encompassing. |
| ❖ Problems/Symptoms are discrete and separate. Each problem (symptom/concern) presented by homeless families requires a separate source of support and /or intervention. For example, when a woman abuses alcohol, the assumption is that she drinks excessively because she is an alcoholic not because she might be trying to deal with sleeplessness, anxiety, intrusive thoughts/memories or other problems associated with trauma. | ❖ Problems/Symptoms are inter-related responses to or coping mechanisms to deal with trauma.<br>Many problems (symptoms) including homelessness, psychological problems, substance use/abuse, dissociation, self-injury, physical problems, and startle responses are attempts to cope with violence/trauma and overwhelming feelings associated with traumatic events or unsafe environments. |

| Traditional<br>Services & Systems | Trauma-informed<br>Services & Systems |
|---|---|
| ❖ ***Hierarchical:*** Clinical staff and administrators are trained to respond to trauma-survivors in a specific way. Clinical personnel are seen as the experts who assign diagnoses in order to treat a condition. The focus is on being "objective" and "distant". This approach is based on power imbalances. | ❖ ***Shares Power/Decreases Hierarchy:*** Everyone is trained to respond to individuals in distress, and about the impact of trauma in the lives of those being served. From grounds-keepers and maintenance staff to accountants, clinicians, administrators, advocates and clients, all are trained to respond to individuals in distress. This approach emphasizes the importance of viewing clients' responses through the lens of trauma and attempts to equalize power imbalances in relationships. |
| ❖ ***People providing shelter and other services are the experts***. Homeless families are seen and treated as *passive* recipients of services provided by people who are more knowledgeable about what is best for families. | ❖ ***Homeless families are active experts & partners with people providing services:*** Women and their children are viewed and treated as the experts in knowing what is best for them and what will help the most. |
| ❖ ***Primary goals are defined by service providers and focus on symptom reduction.*** | ❖ ***Primary goals are defined by homeless families and focus on recovery, self-efficacy and, healing.*** |
| ❖ ***Reactive*:** Services and systems are crisis-driven and focused on minimizing high liability. | ❖ ***Proactive*:** Services and systems for homeless families focus on preventing further crisis and avoiding retraumatization. On an individual level, providers assist families in creating crisis prevention plans and on a systemic level, policies and practices are adjusted to avoid retrauma. |
| ❖ ***Sees clients as broken, vulnerable, damaged and needing protection from themselves.*** Agencies and providers are responsible for "fixing" the "problem." | ❖ ***Understands providing clients with the maximum level of choices, autonomy, self-determination, dignity, and respect is central to healing.*** Philosophy of holistic healing and resilience. Agency responsible for creating an environment conducive to healing and becoming a partner in family-defined process. |

## Exercise 1: The Story of Akasha

**Objective**
Help people identify the difference between a trauma-informed approach and a traditional services approach to working with clients.

**Background**
Akasha, a client, is a new resident of the shelter. She has resided there for a few days and still hardly looks up while her two young children cling to her tightly. She was living in a car for a couple of weeks during the summer after losing her apartment. Akasha and her children were unable to access bathroom and shower facilities and, therefore, arrived at the shelter wearing clothes that were turned inside out and covered in sweat. After three days, she and her children still had not showered or changed. Other residents are beginning to complain to the staff.

One of the shelter workers, Maria, approaches Akasha and in a friendly voice says, "Hi, my name is Maria, what's yours?" while extending her hand. Akasha doesn't look up or make any motion to indicate that she sees Maria standing there. Maria continues, "I know it has been hot out there. Maybe you and the kids would like to use the shower." Akasha becomes immediately angry and starts to raise her voice saying, "I don't need a damn shower and neither do my kids." She gets up off the couch where she was sitting and storms toward her room.

At a staff meeting later that day, staff members Rose, Maria, and Carla disagree about how best to approach Akasha. Rose says the shelter should call the mental health emergency services team to conduct an assessment. Her belief is that Akasha probably has some sort of psychiatric problem. Carla wonders if Akasha was taking medication and has stopped. She also suggests that the new resident is withdrawing from drugs and that is why she is a bit edgy and withdrawn. Maria wants to ask what is making Akasha so angry. Is she frightened? Does she feel unsafe? Did something happen?

Carla and Rose disagree with Maria's approach. They think that only professionals should ask Akasha about her anger. They feel unqualified to ask her in-depth questions about her life. In addition, Carla and Rose are concerned that Akasha will scare the other residents and children. They express uncertainty about whether the shelter should have admitted her at all or if she would be better served by the mental health system.

1a. Who is thinking in a trauma-informed way?

_____

1b. What makes their approach trauma-informed?

_____
_____
_____

2a. Who is approaching Akasha more traditionally?

_____

2b. What makes this approach traditional?

_____
_____
_____

3a. Can you think of other relevant questions to ask Akasha?

- _____
- _____
- _____

3b. What might have been going on that could explain Akasha's response?

_____
_____
_____

3c. What might be some possible remedies or alternative ways of addressing this issue?

_____
_____
_____

*(Answers can be found in Appendix B)*

# Strategic Planning

## I. Create a Trauma-Informed Atmosphere and Environment

Violence and abuse are frequently unpredictable and involve the misuse of power to control an individual. Because of this, women's sense of trust has been shattered, making it difficult to establish relationships. Developing a trauma-informed environment can be the first step to creating a place where families can feel safe enough to heal. Programs and agencies can assist women in their journey by creating an *open*, *predictable, empowering* atmosphere that is *transparent* and committed to transferring power to the families they are serving.

An empowering atmosphere begins with creating a safe and open emotional and physical environment. Emotionally safe environments refer to non-judgmental atmospheres where women have opportunities to gather, express themselves, relate the stories of their lives, and find validation. The kind of experiences women have from the moment they arrive will impact their ability to begin engaging in the healing process. A woman is made to feel comfortable when shelter staff are direct and open from the beginning, which are the building blocks to establishing a trusting relationship. Additionally, expecting and tolerating a range of emotion from the women as well as working to share control with the women will further the relationship and the healing process. Lastly, the use of respectful language both when speaking with and about the women is essential to establishing and maintaining a trusting relationship.

### A. Set a Welcoming Tone When Women Arrive

The emotional atmosphere will likely set the tone for a woman's experience throughout her stay at the shelter. Consider the following to establish a positive beginning:

- ☐ Designate someone to greet new residents/clients and be available to sit/stay/walk with them while they wait to be seen.
- ☐ Familiarize residents/clients with the physical space.
- ☐ Introduce new residents/clients to others.
- ☐ Make sure immediate needs such as food, clothing, and medical attention are addressed upon arrival.
- ☐ Keep extra blankets, clothing, bed linens on hand if possible. People who are having a difficult time reliving previous traumatic experiences often have a physiological response. Frequently they have decreased body temperature and feel cold. Others may experience rapid pulse, increased heart rate and will need to find ways to "cool" their temperature.
- ☐ Create an agency definition of "physical safety" and "emotional safety".
- ☐ Use these definitions to lead group discussions with women about what safety means to them.

As illustrated in the following chart, the definition of safety often creates tension between the people who are providing services and those who are receiving them. Providing opportunities to discuss the term "safety" allows staff and clients to revisit how agency policies are generated, and to assess their flexibility in responding to clients' needs.

| Conflicting Definitions of "Safety" | |
|---|---|
| ***People Receiving Services*** | ***People Providing Services*** |
| Safety = Minimizing Loss of Control Over Their Lives | Safety = Minimizing Loss of Control Over the Environment |
| Safety Means:<br><br>▪ Maximizing Choice<br>▪ Developing Authentic Relationships<br>▪ Exploring Limits<br>▪ Defining Self<br>▪ Defining Experiences without Judgment<br>▪ Receiving Consistent<br>▪ Information Ahead of Time<br>▪ Being free from Force, Coercion, Threats, Punishment & Harm<br>▪ Owning & Expressing Feelings without Fear | Safety Means:<br><br>▪ Maximizing Routine & Predictability<br>▪ Assigning Staff (Based on Availability)<br>▪ Setting Limits<br>▪ Defining Client Problems (Diagnosing)<br>▪ Judging Experiences to Determine Competence and "Appropriateness" of Services<br>▪ Providing Information as Time Allows<br>▪ Threatening Force to De-escalate a Situation (calling police and/or ambulance, to hospitalize or arrest someone). In medical settings, using medication, restraint, seclusion to de-escalate<br>▪ Reducing Expressions of Strong Emotion |

*(Adapted from Prescott, 1998)*

**B. Foster an Environment in Which Women Build a Strong Community**

Betrayal is a central theme in the lives of homeless women and children who have been impacted by trauma. When betrayal happens, trust is undermined and relationships break down. There are a number of ways program personnel can help women re-establish community ties and particularly encourage families to build strong relationships with each other. Fostering strong ties among women contributes to developing an emotionally safe environment where women have an active role in facilitating the process of recovery while being accountable to each other.

- ☐ Encourage women to become interdependent.
- ☐ Support group activities involving all the women. Rent movies together while volunteers watch children. Have a family sharing night during which people prepare their favorite food dishes from their culture and share them with others.
- ☐ Celebrate significant dates in the lives of those coming for services: recovery, anniversaries, birthdays, holidays, etc.
- ☐ Set aside regular time (daily/weekly) in the program for women to talk about what they are learning. Encourage the women to acknowledge something positive they are learning from each other.

- ☐ Encourage peer group discussions so women can share their experiences and expertise regarding ways to live independently, find/access community resources (transportation, child care, subsidies, food, clothing, shelter furnishings, etc.) and save money.
- ☐ Strongly encourage women to resolve conflicts among themselves instead of relying on staff members to intercede.
- ☐ Provide access to an informal, peer-directed, dispute resolution process.
- ☐ Discourage gossip among residents and staff.

**C. Establish a Comfortable and Welcoming Physical Environment**

The way physical space is designed sends messages regarding how agencies feel about the staff and people being served. Projecting a welcoming environment doesn't necessarily require an expensive re-design. It *does* require assessing the features of the current space and adapting them to reflect places that are inviting for those who have been under so much stress. Consider some of the following:

- ☐ Incorporate living, colorful, and beautiful items such as fish tanks and plants.
- ☐ Use plants as a natural barrier to break up small spaces and provide a sense of privacy.
- ☐ Make the space fun and cheerful by using murals, paintings, drawings. Vary the textures in the waiting room. Display artwork, writing and other projects, or photos taken by people in the programs or by formerly homeless people.
- ☐ Provide comfortable chairs rather than folding or hardback chairs.
- ☐ Separate "kid space" from adult space for assessment, play, and privacy.
- ☐ If possible, play-space for children should include a developmental range of toys, low tables and chairs, books, videos, and television.
- ☐ Set up chairs in a semicircle in the corners of a room rather than lined up against a wall. Try not to face chairs directly across from one another unless there is plenty of room between the chairs so people won't feel trapped or claustrophobic.
- ☐ Set up an area of the room to provide beverages, especially water (providing hydration as well as flushing toxins from the system) and small, healthy snacks. Physical health as well as mental health is impacted when a person has experienced one or more traumatic stressors. Providing water and healthy snacks helps to model for women the importance of taking care of their bodies as well as their minds during the healing process.
- ☐ The environment should be well lit inside and out. This includes security lighting on the outside of the building and plenty of light in the common areas of the house. Dark places can remind women of places where assaults took place. Many will need to leave lights on to begin to relax, rest, and/or sleep.
- ☐ Use incandescent rather than pulsing high-intensity office lights (fluorescent lights have a pulse to them and are difficult for people who have head trauma or epilepsy).
- ☐ Show women where light controls are located and ensure they can access them.
- ☐ Bathrooms are traditionally potent places because they have often been sites of vulnerability, intrusion, and attack for women and their children. Bathrooms need to be well-lighted, accessible to people in the shelter, clean and have plenty of paper supplies and soap. Women who need to change their young children will need a place to dispose of diapers and, ideally,

have access to a changing table. Generate an extra supply of diapers, lotion, basic first aid supplies, such as band-aids, tape, smelling salts, anti bacteria ointment, scissors, and women's personal hygiene products.

- ☐ If there is only one bathroom for both men and women, make sure there is a sign on the door that can be turned over by hand to signify when the bathroom is being used.
- ☐ If you have the opportunity to choose material for furniture, consider material that is soft, washable, and durable. Women who have trauma histories will experience a range of emotions and express these emotions often in intense ways. It is helpful to have comfortable furniture that women can use in times of distress.
- ☐ Ensure there are places available for residents/clients to securely store their belongings.
- ☐ If possible, create private retreat spaces, other than bedrooms, for women and their children
- ☐ For privacy reasons, consider installing acoustic tile to help dampen sound.
- ☐ Designate common areas and times in which residents/clients can socialize with each other.
- ☐ Ensure that clients/residents can get to and from the program with ease, so they don't feel isolated and can maintain connections to the community.
- ☐ The building should be accessible for people with hearing, visual, or mobility impairments.

**D. Tolerate a Range of Emotions**

Healing is a complex process, not a linear progression toward an end. Sometimes people will appear to be "getting worse" when, in fact, they are doing important emotional work. Families experience a wide range of responses to the extreme levels of chronic stress and loss they face. Their comfort level in expressing these emotions will depend on their cultural orientation and whether or not these emotions are tolerated in the program setting. Trauma-sensitive environments anticipate these responses and encourage tolerance for emotional intensity as women and children attempt to recover from the impact of trauma in their lives.

Part of becoming trauma-informed involves being very present and genuine with people in distress while containing the desire to "fix" them. It can be challenging to sit with people who are expressing feelings of helplessness, rage, grief, shame and betrayal - or conversely, remaining silent - and not "jump in" and become directive. Yet many women and children going through the process of recovery (uncovering the past and discovering who they are in relationship to what has happened to them) express the need to break the isolation they feel by being in connection with another human being who will validate their pain and not compound it by imposing their own need to "fix" the situation.

- ☐ Validate what people are feeling.
- ☐ Practice being with people in distress without becoming directive.
- ☐ Talk with staff and clients and take an inventory about what emotions are not well tolerated in the environment.
- ☐ Use the above information as an education tool regarding cultural differences in expression.
- ☐ Address the topics of control and power with residents and staff. How does our desire to "fix" interfere with healing? Where does it come from? What ways do we use control when we feel fear? What are some other ways to approach each other when we feel afraid?
- ☐ Brainstorm with staff and clients alternative ways to help support people in distress.

## E. Share Power and Control

Abuse and violence against women often takes place in environments that are private (e.g., bedrooms, bathrooms, basements, etc.). Because violence takes away a sense of control and safety, it is important to assist women in having as much physical and emotional control as possible, particularly in areas that are intimate and private. Sharing power and handing control back to the women coming for services sends vital messages of competency, trust, flexibility, and respect that have been undermined during abusive episodes.

- ☐ If the rules need to be enforced, it is best if the process is as open and transparent as possible rather than covert and secretive.
- ☐ Be open to discussing policies requiring mandatory groups, procedures, screenings, and interventions. Anything mandatory has the potential to devolve into a struggle for power and control. Having a real discussion with residents about the reasons for these policies and procedures can help to generate buy in and avoid a struggle later on. These open discussions provide opportunities for re-evaluating and adapting policies and procedures that may be unnecessarily controlling and restrictive.
- ☐ Plan spaces where staff and clients can mingle.
- ☐ Support women speaking their native language within the program.
- ☐ Include women in discussions regarding designing the space, creating safety, evaluating the effectiveness of service design and delivery, generating ideas for and leading support groups.
- ☐ Titles convey power. Introduce yourself and ask women how they would prefer to be addressed. Always ask permission before using a first name.

## F. Use Strength-Based, Person-First Language

Empowering women to heal from trauma requires building trust and connection. The language we use, the titles we hold, the way we describe others all reflect degrees of power, position and authority. One potent way to share power, foster connection, and celebrate survival is by shifting language from a deficit-based focus to a positive, strength-based focus. By concentrating on strengths rather than deficits, we provide important messages about **hope** and **competence** rather than **defeat** and **despair**. We also provide messages about a willingness to engage in relationships that share power, are respectful and honor survival.

- ☐ Use "person-first" language (e.g., "people *with* disabilities", "women *with* psychiatric problems or substance use problems", "women *who have* trauma histories", etc.).
- ☐ Beware of phrases that generalize about entire groups of people. The words, "**the**" or "**a**" before descriptions of people are red flags that the language is potentially discriminating and/or demeaning (***the*** chronically homeless, ***the*** mentally ill, ***the*** addicts. See more examples below).
- ☐ Use descriptive language rather than characterizing terms.

| Use This | *Not This* |
|---|---|
| ◆ Sandy is a woman ***with*** disabilities.<br>◆ Sandy **"*uses*"** a wheelchair.<br>◆ Sandy is a woman ***diagnosed with*** ……..mental illness, borderline personality disorder, post traumatic stress disorder…..etc.<br>◆ Sandy is a woman ***who has a problem with or who struggles with alcohol/substances***… | ◆ Sandy is a "handicapped-woman".<br>◆ Sandy is "wheelchair-bound". (Brings up images of being tied to a wheelchair.)<br>◆ Sandy is "mentally ill". Sandy is **a** "borderline". Sandy is **a** "cutter".<br>◆ Sandy is **an** "addict", **a** "junkie", **a** "drunk", **a** "coke-head". |

***An example of using words that characterize people***: "Sheila is a chronically homeless alcoholic with children. She has been resistant to treatment in the past and very manipulative while in the shelter program. She has asked for help to get into a treatment program, but will most likely change her mind right before it is time to attend."

***An example of descriptive language***: "Sheila is a mother with two children who had been staying with a friend since she lost her job and apartment two weeks ago. She had started drinking again and taking prescription medications after losing her job, but states she stopped a few days ago. Shelia would like to start treatment for substance use even though she has had trouble completing treatment programs in the past."

| A.<br>Some examples of<br>"Watch Words" that can demean people: | B.<br>An example of another way to<br>describe someone in distress. |
|---|---|
| ◆ "attention-seeking"<br>◆ "manipulative"<br>◆ "chronic"<br>◆ "treatment resistant,"<br>◆ "acting out" | ◆ Donna appears to have a hard time getting what she needs. She often goes to extremes to get someone to talk with her because she has been so neglected in the past. |

It takes practice, but the effort to change how we speak about people helps to facilitate agency sensitivity. You can make a big difference by engaging in deliberate, ongoing discussions about how client experiences and ways of being - their coping mechanisms - are characterized.

## Exercise 2: Say that Again? Watch Words

a) At a staff meeting or other group meeting, list words used to characterize people in Column A (Watch Words).
b) Ask: "What do they mean? What are people really trying to say? Is there another way to write about someone that reflects their life experience?
c) Use Column B to re-write these statements.

| A.<br>Watch Words | B.<br>Say that again?<br>What do we mean? |
|---|---|
| ◆<br>◆<br>◆ | ◆<br>◆<br>◆ |

**Be Aware of Agency/Program Short-Hand and Acronyms**
Every field has its own short-hand, whether mental health, substance use /addictions, homelessness, trauma, and/or public health. While this short-hand creates verbal expediency, the acronyms and shorthand can be hurtful and lead to unintended disconnection rather than building an atmosphere of trust. Note how much less evident judgment becomes as the detail increases.

## Exercise 3: Say That Again? Reducing Acronyms

a) Cover Column B.
b) Now read statements 1 and 2 in column A.
What do you assume about Susan?
What do you assume about Claudia?
c) Now, uncover Column B and read the paragraphs to the right.
Does it make a difference in how you view Susan and Claudia? If yes, why?
d) Make a list of acronyms used in your work.
e) Are there other ways to describe people that might be more trauma-sensitive?

| **A.**<br>**Examples of frequently used short-hand phrases from the field of mental health:** | **B.**<br>**Other ways to say the same thing while creating connection rather than disconnection** |
|---|---|
| 1) CAMI (Chemically addicted and mentally ill)<br><br>Example: "Susan is a CAMI who was recently hospitalized for OCD and PTSD. She was discharged without a place to live and was admitted to this program." | 1) Susan is a 35 year-old woman who was addicted to heroin. She says she stopped using in the last week and reports hearing voices at times but relates that to drug withdrawal and stress. Susan checks door and window locks every fifteen minutes because she is afraid someone will break in and harm her and her children. She was attacked by her former boyfriend who broke down the door of her apartment and strangled her in front of her children until she passed out. She reports having difficulty relaxing enough to sleep, making her edgy and irritable. She was recently discharged from the hospital and admitted to this program. |
| 2) SPMI (Seriously and persistently mentally ill)<br><br>Example: "Claudia is SPMI. She suffers from chronic psychosis with paranoid tendencies and is resistant to treatment." | 2) Claudia reports hearing voices coming from inside the walls and radio planted in her mind. She reports being sexually assaulted by her stepfather and later by men on the streets. She wears hats covering her ears and often sings loudly trying to "block out the noise". She appears very afraid of men and doesn't like to be touched. She says she won't take medication because it makes her too sleepy, gain weight and slur. The last time she was in the hospital, the staff came up behind her and held her down. She has an apartment but is too afraid to stay there because a neighbor called the police when she was up all night making noise. The police broke down her door and put her in hand cuffs, "like a criminal". She is now homeless. |

## Exercise 4: Develop Low-Cost Ideas and Activities for Changing the Environment

- ☐ Ask staff - administrators, direct service, maintneance, groundskeepers - to write down phrases and language they hear that can demean people for a week in their programs/agencies and put those notes in a box. Open the box at staff meetings or community meetings and use the contents for discussion. Be sure comments don't identify particular individuals.
- ☐ Repeat the same exercise with clients in the program.
- ☐ Evaluate all agency generated documents, signs, program postings for exclusionary/ discriminating language. This can be a fun exercise that includes everyone.
- ☐ Generate an ongoing daily and/or weekly activity during which people receiving services and those working in shelters discuss some of the following topics related to "Language and Power":
  - Strengths for surviving.
  - Usefulness of coping mechanisms.
  - Alternatives people have discovered to cope with difficult times.
  - Power of language to both harm and heal.
  - Subtle and obvious ways language conveys power.
  - Body-language and power.
  - Ways people give up their own power when using labels with each other.
  - How can people talk about themselves in a way that correctly contextualizes the experiences of women with children impacted by abuse and violence.

## II. Develop Trauma-Informed Policies and Procedures

### A. Assume Trauma When Reviewing Policies and Procedures

The misuse of power and control to terrorize, silence, control and hurt someone is central to interpersonal violence. Therefore, trauma-informed services and systems should review and adapt policies and practices that might lead to re-stimulating prior traumatic responses, paying particular attention to decreasing the use of force, coercion, intrusion, and decreasing the imbalances between agency personnel and clients. Ensure rules and policies are sensitive to the trauma histories of shelter residents.

### B. Revisit Narrow Eligibility Criteria

Creating a trauma-informed environment means focusing on developing relationships that are honest and trustworthy. While programs can't possibly meet all the needs of women coming for services, eligibility criterion that is too narrow puts women in positions to withhold important information in order to receive services they need. Turning women away for services after they have risked talking about vulnerable information can reinforce the common utterances of abusers - "no one will believe you", "I am the only one who will ever care about you", "you are too fragile, crazy, addicted, stupid, etc., to make it on your own." As shelters are aware, substance abuse, self-injury, depression, dissociation, physical problems, and startle responses are manifestations of prior attempts to cope with intrusive traumatic material. Because these issues are inter-related, separating them from one another is unrealistic. It is important to consider how to expand an agency's program enough, or how to work within a tight referral network, so women don't feel abandoned or punished.

- ☐ Internally review eligibility criteria or other practices that might prevent women from receiving services.
- ☐ Ask women what prevents them from using the services being offered.
- ☐ When program limitations and policy prevent the provision of specific services, assist women in making alternative arrangements to access the services they need.

### C. Create Partnerships with Women through Informed Consent

Providing information is an important part of building trust in relationships. Informed consent is not just an abstract policy, but rather part of an ongoing process that happens throughout the time someone spends at the shelter. Confidentiality practices are an integral part of informed consent. Clients must be aware of how their information is being used, how it will be kept private, who will have access to it, and when there are exceptions to confidentiality. This gives clients the ability to make personal decisions about what they will share and with whom. It is important that women direct the process of their healing rather than being passive recipients. It is vital to avoid surprises that can lead to a sense of betrayal which undermines trust. Giving people information ahead of time and handing as much control over to the women as possible promotes partnership and builds connection. When women are given information in a clear and straightforward manner and when confidentiality is maintained by all staff, trust can be established and clients will be more willing to share important information about their experiences and needs.

- ☐ Obtain informed consent for program requirements.
- ☐ Explain confidentiality policies to all clients.
- ☐ Give copies of confidentiality policies to all clients.
- ☐ Explain the limits of privacy and confidentiality to all clients.
- ☐ Write policies, procedures, and mission statement of the shelter using clear, simple language.
- ☐ Have copies of program rules and mission statement available in the languages of clients coming for services.
- ☐ Explain policies of the program with clients within 24-48 hours of arrival.
- ☐ Be prepared to repeat this information more than once.
- ☐ Give each client a copy of the policies, procedures, and mission statement.
- ☐ Whenever possible, provide information through video and written media.
- ☐ Post program rules in places that are easily accessible.
- ☐ Post a list of client rights and responsibilities.
- ☐ Post a copy of the mission statement in a prominent, visible space.
- ☐ Ask clients about aspects of the policies that may be difficult for them and offer assistance to help navigate within the policies.
- ☐ Create opportunities to meet as a group to discuss information regarding program policies.

## D. Adapt Policies to Avoid Retrauma

### Emergency Procedures

Retrauma often occurs in the midst of an emergency, especially when there are no clear policies or procedures in place to handle safety issues and crises when they arise. The likelihood of retraumatization increases when clients and staff have not had prior discussions about how to best handle crises in ways that avoid re-stimulating traumatic responses. Clients are often reminded of past victimization when staff respond in a panicked way and become over-controlling or police arrive on the scene with uniforms, weapons, handcuffs and restraints. These types of reactive responses can increase client distress, creating an even larger emergency.

- ☐ Work with clients to generate an emergency/crisis plan.
- ☐ Develop an agency-wide emergency response to prevent people who pose a threat to residents and/or their children from accessing the facility.
- ☐ Tell clients about policies/practices governing emergency crisis interventions. (e.g., calling the police if there are threats of violence).
- ☐ Explain and practice emergency protocols with staff and clients.
- ☐ Work with emergency response teams (police, fire, medical) to respond to calls from the program in a way that does not retraumatize clients.

### Night Checks

Checking on people at night is often necessary to ensure clients are physically safe. While this is important, the act of having someone come into a bedroom at night can be terrifying and reminiscent of past sexual attack and intrusion. For some, the use of a flashlight to shine into the room can lead to

increased startle reactions, constant watchfulness and surveillance of the surroundings, and may re-stimulate feelings of being surprised, helpless and out of control. Here are some things to think about:

- ☐ Explain procedures used to check on people at night.
- ☐ Let people know ***who*** will be checking on them, ***how often***, and ***why*** it is important.
- ☐ Ask their opinion about the least intrusive way to enter their sleeping space at night.
- ☐ Record this in notes that are relayed to others.

**Visitation**

The policies of some shelters allow visitation for clients. When visitation is allowed, safety issues need to be taken into consideration in order to avoid situations that may become retraumatizing to any of the clients at the shelter.

- ☐ Carefully consider the safety measures needed if visitation is allowed.
- ☐ Provide a separate space for visitation to take place.
- ☐ If there are restrictions on visitation, inform clients in a clear and concrete manner.

**Toxicology Screening ("Tox Screens")**

Many programs require a client to submit to toxicology testing if she is suspected of using substances. This mandate is a good example of the dilemma many programs encounter when trying to create a trauma-sensitive environment. If women have histories of being assaulted, over-controlled, and violated by voyeuristic perpetrators, particularly in intimate settings such as the shower, bathroom, or bedroom, it is challenging for an agency to meet both the mandate to obtain a "viewed urine sample" (i.e. while a staff member watches) and be trauma-sensitive to the client privacy and trauma history at the same time.

- ☐ Provide information to women about your policy and the exact procedures to obtain a "viewed urine sample" when they first arrive so it is not a surprise. Let clients know who will be informed of the results and review how the test outcomes may impact her options for housing, treatment, subsidies, child custody and legal status.
- ☐ Explain steps the agency will take to preserve dignity whenever a viewed urine sample is requested.
- ☐ If clients are suspected of using substances, approach them in private. Be careful not to shame women by confronting them in front of others.
- ☐ It is *not* a good idea to use staff of the opposite gender to watch women while they provide a urine sample. Staff of the same gender should accompany women during this procedure.
- ☐ Give clients options about who can go with them when they provide the sample.
- ☐ Find a way to reintegrate a person suspected of using substances into the shelter milieu. Often, there is a sense of distrust and anger in the shelter environment after someone has been suspected of using substances. Addressing this directly by creating group activities (fun activities as well as community debriefing exercises) and by supporting individuals within the environment helps to decrease the potential for shame, humiliation, secrecy, and hostility while generating group cohesion and re-building trust.

**E. Review Agency Mandates to Maximize Client Autonomy and Choice**

The point is not necessarily to undo the policies and procedures that may be difficult for women, but to review them in a conscious way with the women's histories in mind. During this review, analyze whether agency policies and procedures are written and delivered in such a way that preserves client trust and diminishes power imbalances, or if the policies need to be refined.

**F. Interview Women to Improve Procedure**

You may decide that a policy is important to the shelter because it improves the overall atmosphere, maximizes the potential for healing among clients, and meets the requirements of the people funding the program. The next step might include interviewing women to determine if there are ways to carry out the policy that could be more sensitive to their needs.

- ☐ How can the policy be refined to be more trauma-sensitive?
- ☐ Can it be improved?
- ☐ What would improvements require and do they still meet the needs of the policy mandate?
- ☐ Who benefits from this policy? Residents? Agency? Funding source? Other?

**G. Quality Assurance**

Strong quality assurance provides organizational consistency in policies and practice when introducing new knowledge. Action-based research allows people to test what works and what doesn't while providing opportunities to make necessary changes for the benefit of individuals and organizations.

***Involve everyone in assessing the organizational atmosphere***.

- ☐ Make quality assurance an ongoing process that involves all levels of agency personnel.
- ☐ Conduct anonymous ongoing satisfaction surveys to assess clients' overall experiences.
- ☐ Form quality assurance teams that consist of individuals with lived experience in addition to interested community members, staff, and board members.
- ☐ Have periodic discussion sessions for staff and clients to focus on improvement.
- ☐ Have a suggestion box for clients and staff to offer feedback.

***Ensure Consistency***

- ☐ Develop a manual for standard operating procedures. This helps to ensure procedures are implemented uniformly across the organization. While consistency is important in creating an environment that is predictable, it is important not to confuse uniformity with rigidity.
- ☐ Build flexibility into the way procedures are implemented to account for individualized approaches and needs.
- ☐ Designate someone to take responsibility for training staff in standard operating procedures and ensure consistent implementation.
- ☐ Develop a mechanism for evaluating whether procedures are followed uniformly across the organization.

***Establish Complaint Processes***

- ☐ Create a complaint review board that consists of the following: at least one board member, one administrator, one member of the advocacy community, four former clients - or fifty-one percent of the total committee - who are not currently receiving services.

- ☐ Ensure that the complaint review board reviews critical incidents, restrictive program practices, and complaints.
- ☐ Define critical incidents, including sexual and/or physical assault, exploitation, sexual harassment, trafficking, death, injury, any restraint and/or force, neglect resulting in injury, threats, etc., that are particular to the setting.
- ☐ Ensure that clients are aware of the complaint review process and how to engage in the process when they have a complaint.
- ☐ Train a pool of people who have received services to assist current clients as peer liaisons/human rights advocates in the complaint/grievance process.
- ☐ Set aside resources for transportation (e.g., subway tokens, bus fare, cab vouchers), outreach, ongoing communication such as phone cards or electronic mail, child care, food, stipends for peer liaisons/advocates who accompany clients to hearings for support and stipends for former clients who sit on the complaint review committee.
- ☐ Develop a procedure to encode information gathered by and submitted to the complaint review board in ways that protect the identities of all involved.

## III. Establish Trauma-Informed Services and Supports

### A. Ensure Services are Voluntary

Because violence is predicated on the use of power to control, force, coerce, and dominate another, it is particularly imperative not to replicate these dynamics through mandatory services. It is much easier to build relationships that are authentic, generate trust, and create an atmosphere that is open if services are voluntary. It is important to give clients complete information in a clear and concrete manner, and provide as many choices as possible to maximize their control and flexibility in the services they receive.

- ☐ Work toward providing a wide range of services to give women as much choice as possible so they are not forced into services they do not want or need.
- ☐ Provide clear, concrete information about available services and any alternatives.
- ☐ Regularly inform residents about any mandatory services or procedures. Post information regarding expected attendance, extent of participation required, and the length of time the service is provided.
- ☐ Review the benefits and limitations of available services.
- ☐ Review consequences of breaking “rules” regarding mandatory services.
- ☐ Meet with clients to generate ideas about the services they desire that might also meet funding requirements.
- ☐ Develop an agency strategic plan to work toward eradicating mandatory services and providing totally voluntary services.

### B. Support Developing Authentic Relationships

Why do we use the term “authentic” rather than “mutual” when thinking about building relationships? While the term “mutuality” has been used to describe relationships in which power is shared, agency personnel generally have paid professional relationships with clients. While paid relationships can be ***authentic***, they are rarely ***mutual*** given the unequal power dynamics created by the limits imposed by agency policies and economics.

***Build authentic relationships between staff and clients***
A part of building authentic relationships between staff and clients has to do with being present, genuine, and honest. Dishonesty or attempts to divert attention away from an issue will probably serve to prove the relationship untrustworthy. Remember that women have survived by being able to scan their environments with impeccable accuracy; otherwise they would probably not be alive. There is a high probability that they will know if you are being dishonest with them. Consider the following when working to build authentic relationships:

- ☐ *Validate what you are hearing*. People with histories of trauma are told they are crazy, threatened about never speaking about the abuse/violence, and encouraged in a variety of ways to remain silent. Validating what you are hearing is a very important step in generating a connection with survivors who have had little reason to trust.
- ☐ *Promise only what you can deliver*. Building trust means following through on promises you make to people who have often been betrayed in their relationships with others.
- ☐ *Educate clients by providing information.* Become allies with clients by providing information about the program, being clear about expectations, and genuinely working toward meeting the goals clients articulate. Educate women about post traumatic stress and the normative nature of what they might be feeling given the high levels of chronic stress they have experienced.
- ☐ *Reflect back what you see, hear, feel* (see Section I: "Tolerate a Range of Emotions").
- ☐ *Be willing to sit with uncomfortable emotion* (see Section I: "Tolerate a Range of Emotions").

**C. Assess Women and Children**

Structured assessments are important in gathering all relevant information uniformly for each woman who is served in the program. Assessments give staff invaluable information about women and children's strengths, needs, goals, and traumatic experiences that will impact the services and interventions they require throughout their time at the program. Additionally, this process serves to validate women and children's traumatic experiences and gives them the message that the program is a place where they can acknowledge what has happened to them. This helps to begin healing and build empowerment.

- ☐ Conduct assessments within the first 24-72 hours of families arriving at the program.
- ☐ Provide staff with training in trauma.
- ☐ Explain the limits of confidentiality to clients prior to assessment. Explain who has access to the assessment information and how the information will be used.
- ☐ Keep assessments confidential and located in locked storage.
- ☐ Conduct assessments in a private area to ensure confidentiality.
- ☐ Consider contracting with a trauma-informed outside agency that is familiar with the population when a more in-depth trauma assessment is necessary for both women and children.
- ☐ Assess women alone rather than in front of others who may accompany her to the program. Asking women personal questions should be done in privacy unless she requests to be accompanied. If a woman's native language is not English use professional interpreters, if possible, rather than family members when asking about domestic assault, incest, traumatic events or private / intimate matters.
- ☐ Culture matters. Race, ethnicity, culture, age, gender and sexual orientation are extremely relevant when assessing women in a trauma-sensitive way. Avoid using male interpreters for women in order to decrease chances of shaming.

- ☐ Determine immediate levels of danger the family might be experiencing. Make sure assessments are comprehensive enough to get a more global picture of past trauma, including any past head injuries.
- ☐ Be consistent by using the same format for each client.
- ☐ Use assessments to inform individualized safety plans and a proactive crisis prevention plan (*see below for more information*) in order to avoid retraumatizing the client.
- ☐ Include the strengths and skills women and children have used to survive.

***Ask Women about Strengths in Addition to Assessing for Trauma***

Women and children often do not survive the violence, chaos, and loss they have experienced. Asking questions about how women and children survive the compounded and cumulative losses in their lives, honors their skills, successful coping mechanisms, and fortitude. Focusing on strengths instead of deficits indicates respect, hopefulness, and a desire to enter into a reciprocal learning relationship/partnership with the person coming for services rather than creating a helping relationship. Focusing on helplessness and deficits often results in the client becoming a passive recipient of services.

***Consider the following when conducting assessments for women:***

- ☐ *Immediate Danger*: Ask women about immediate danger or current violence they may be experiencing or have just escaped.
- ☐ *Past Violence & Trauma*: What types of trauma have women experienced in the past (physical, sexual and emotional)? Have women experienced any past or present head trauma?
- ☐ How did clients survive former and current violence?
- ☐ What are the client's priorities while at the shelter? What issues are most important to her right now?
- ☐ Does the client have any health, mental health, and substance use issues she would like to address?
- ☐ Does the client have any legal issues that need to be resolved (court custody, restraining order, housing eviction, parole, etc.)?
- ☐ Ask about the client's interests, hobbies, and enjoyable activities.
- ☐ How does the client cope and relax?
- ☐ What are the client's goals/ vision for the future?
- ☐ Does the client have a faith that is important to her?
- ☐ Who is the client connected to in the community? Who are the important people in her life who have helped to sustain her?

***Provide In-House Child Assessments***

Children need to be assessed, with parental consent, to determine their exposure to trauma and its impact (e.g. the impact on their achievement of developmental tasks, their attachment to caregivers, and how they cope with overwhelming emotions). This type of assessment provides valuable information that will guide staff and caregivers in providing or identifying services and interventions that will create opportunities for healthier developmental experiences and teaching/modeling healthier coping strategies. While agencies may not initially be able to provide in-depth trauma assessments, it is important to begin to understand the child's experience of the world in order to provide services that are responsive to his or her needs. A long-term goal should be to provide a more in-depth trauma assessment. This can be done by hiring

qualified staff or identifying an agency to contract with who can provide these types of assessments and understand the population of families the program is working with.

*Consider the following when conducting assessments for children:*

- ☐ Ensure the child's safety as a priority. Safety includes helping children be comfortable during the assessment process (e.g., informing caregivers and children about mandated reporting, respecting children's right to not answer any questions they do not want to, allowing caregivers in the room if the child wishes, and referring to an outside agency for further assessment if necessary.)
- ☐ Include a caregiver report asking about the child's strengths, goals, trauma exposures, academics, interests, friends, hobbies, and coping strategies. Include questions about developmental history, current medications, medical history and any previous head injury/trauma.
- ☐ Include the child's view of his/her strengths, goals, interests, friends, hobbies, and coping strategies.
- ☐ Staff completing the assessments should have training in trauma, be familiar with the developmental milestones of children and have knowledge of attachment theory.
- ☐ When necessary, work with caregivers to refer children to a contract agency for a more in-depth trauma assessment when the program is unable to provide such an assessment.
- ☐ Protect the family's right to privacy and confidentiality when referring the child for assessment and when sharing results of that assessment with staff.
- ☐ Provide results of the assessment to caregivers in simple, straight-forward language.
- ☐ After any assessment, develop a plan with parental involvement addressing the needs of the child, including recommended interventions for the child and family.

## D. Create Safety Planning and Crisis Prevention for Women and Children

***Encourage Women to Develop Individualized Safety Plans***

If women have indicated they are in immediate danger or have recently left abusive situations, encourage them to make a safety plan. A safety plan involves problem-solving with a client about how she will respond in the event she is endangered. Once this plan is created it is important to incorporate it into the client's care plan in order for all staff working with the client to know how to respond if safety issues arise. Additionally, it is essential to take into account the need for the safety of the children as well the mother. Working with the woman to include the safety of her children in the plan and working to make it available to those involved with the child's care will serve to further protect the family. A comprehensive example of a safety plan is included in Appendix A of this document.

***Work Proactively: Create a Crisis Prevention Plan***

In order for women to achieve a sense of safety and control while using services, it is important to ask them what particular activities, people, environmental cues, objects, etc. help them when they are having a hard time. This kind of collaborative planning creates an opportunity to begin vital discussions regarding how staff and clients can work together to help women avoid crisis and retraumatization. When crises happen, staff and clients are in positions to react. These reactions can lead to interventions that may or may not be helpful. Even with the best of intentions, standard responses to crises can be retraumatizing because they tend to take away client control. One of the ways to mitigate this is to be proactive. Rather than guessing what helps and what doesn't in the middle of a highly charged situation, it is more helpful if staff work with women when they first arrive to create a crisis prevention plan mapping out what to do if crises occur and incorporating it as part of the client's care plan. This ensures that staff working with the woman are aware of what to do when crises arise.

***Consider the following when creating a crisis prevention plan for women*** *(see Appendix C for further information):*

- ☐ Be proactive: Make the plan ongoing rather than based on a one-time assessment.
- ☐ Modify the plan if circumstances change and more is learned about what might help or hurt.
- ☐ Define the word "safety" by asking what "emotional" and "physical safety" mean to clients. These definitions vary from woman to woman. They need to be accurately recorded in order to create an individualized plan that will avoid further crisis.
- ☐ Define what can be done to help if she finds herself heading toward a crisis. Identify people, places and strategies that have been helpful in the past. Identify potentially harmful responses.
- ☐ Determine potential "triggers" for her and her children.
- ☐ Work with her to develop a proactive plan to care for her children in the event she becomes incapacitated.
- ☐ Staff need to be familiar with the plan. Becoming familiar with it in the middle of a crisis is not helpful. Clients should also have a copy.

***Consider Creating Crisis Plans for Children***

- ☐ Develop child crisis prevention plans with the caregiver and child(ren) to avoid further crisis and retraumatization.
- ☐ Make child crisis prevention plans available to people involved in the child's care.

***Identify and Reduce Potential Reminders of Trauma in the Environment***

Understanding environmental triggers will help avoid crises. Start by asking women what causes their distress to increase. Some common triggers and responses are listed below followed by ideas for assisting families in preventing further retraumatization.

**Some Common Triggers and Responses for Women with Trauma Histories**

| TRIGGERS | TRAUMA RESPONSES |
|---|---|
| ❖ Being blocked or feeling trapped<br>▪ in a room<br>▪ surrounded by people /furniture<br>▪ standing over someone while they sit<br>▪ sitting in a crowded room in a place inaccessible to the door and exit<br>❖ Being in a "no-win" emotional situation<br>❖ Surprises (someone coming up behind)<br>❖ Not being believed<br>❖ Presence of force/ reminders of weapons<br>▪ Uniforms<br>▪ Badges<br>▪ Straps, handcuffs, chains (sound of chains)<br>❖ Being insulted/ put down/ belittled<br>❖ Sexual behavior or comments<br>❖ Loud noises / sudden noises,<br>▪ fire alarms<br>▪ car backfiring (sounds like gunfire) | ❖ Sense of helplessness<br>❖ Rage / anger, edgy<br>❖ Lower frustration tolerance<br>▪ quick to tears,<br>▪ quick to anger,<br>▪ quick to distance, avoid, become numb<br>❖ Sense of despair, depression, tears<br>❖ Numbing,<br>▪ becoming distant,<br>▪ appearing far away or "spaced out", (also known as "dissociation")<br>▪ seeming oblivious to everything and everyone<br>❖ Fear, anxiety,<br>▪ restlessness<br>▪ pacing,<br>▪ difficulty concentrating, easily distracted, difficulty catching breath |

| TRIGGERS | TRAUMA RESPONSES |
|---|---|
| ▪ sirens (police, ambulance)<br>▪ screaming<br>❖ Flashing lights<br>❖ Alcohol/ smell of alcohol<br>❖ Holidays and things associated with families (birthdays, anniversaries, etc.)<br>❖ Times of day | ❖ Desire to use alcohol, illicit or legal prescription medication to calm down to numb intolerable feelings<br>❖ Insomnia<br>❖ Need to leave or escape<br>❖ Overeating or restricting food<br>❖ Self-injury<br>❖ Mental confusion, fogginess |

| SOME PREVENTIVE MEASURES |
|---|
| ☑ Stand to one side<br>☑ Do not block entrances / exits<br>☑ If rooms are crowded, ask women where they would be comfortable sitting or standing<br>☑ If meeting in a private area with limited space, wait until the woman sits down<br>☑ Intimate questions about a client's history need to be asked away from others (including male companions and children). If an interpreter is needed, do not use family members unless it is an emergency.<br>☑ Encourage women to identify objects that are particularly meaningful and to keep small tokens with them.<br>☑ Give clients information about any mandatory reporting requirements so that clients can make informed choices about what they reveal.<br>☑ If police are called ask them to remove badges and guns (or come in plain clothes)<br>☑ If social service personnel are not a regular presence at the shelter, make sure women know who is coming and why they are there.<br>☑ Use carpet or acoustic tile when possible<br>☑ Provide an area where women can congregate without men.<br>☑ Provide a place for self-help and/or peer support that can take place within the program.<br>☑ Establish firm rules regarding sexual behavior while at the shelter<br>☑ Provide education about anger, Post Traumatic Stress Disorder responses<br>☑ Educate about grounding techniques<br>☑ Provide instruction or access to instruction on self defense<br>☑ Do ***not*** decorate all common areas for holidays (only some) |

**Develop Creative "Grounding" Techniques to help Women Become More Unified**

| | Approaches to Helping Individuals and Groups with Grounding |
|---|---|
| **1.** | ***Reflect what you see and ask if your observation is correct***:<br>◆ "You look like you are feeling very sad/ angry/ frustrated at the moment. Is that how you are feeling? I notice your hands are clenched, can you relax them? How about clenching them very tightly and then shaking them out a couple of times."<br>◆ Or something like, "You look pretty scared to me right now. I notice that your arms are crossed over your chest and your legs are crossed as well. Is that how you are feeling? Would you like to stop talking for today?" Before you leave or we shift gears, let's do some grounding exercises. Would you mind uncrossing your arms and maybe putting your feet on the floor? What do you see in the room? On the wall?" |
| **2.** | ***Use imagery that helps decrease emotional intensity***<br>◆ Some people find imagining an "emotional dial" they can "turn down" helpful when there is too much going on in their minds (too many emotions, too many voices, too much thinking/anxiety). Others find using an imaginary lockbox useful when thinking about placing their emotions there until such time when they can be addressed.<br>◆ Guided imagery creating a safe place that the survivor chooses |
| **3.** | ***Focus on external cues and objects to distract from unbearable emotional states***<br>◆ Draw a two foot circle around you and focus on what is in that circle and nothing else. State everything you see in that space, the color, lines, smudges if any, textures/patterns and direction of textures, smell, shapes, etc. If you are outside there can be are more opportunities to describe various environments).<br>◆ Make up a story about the above two foot circle…<br>◆ Focus on something in the distance and do the same as above if people are feeling particularly claustrophobic and need to experience more distance/space.<br>◆ Building a box (any kind of box will do) in which objects are placed that help focus on meaningful events in the woman's life (pictures, stones, jewelry, letters, etc.). Sometime this can shift the energy enough for people to be able to sleep or cry or talk with someone. |
| **4.** | ***Use deep breathing***<br>◆ Inhale through the nose and out through the mouth. Placing hands on stomach and watching the lungs fill with air as the belly distends and contracts.<br>◆ Some people prefer to keep eyes open during this exercise and some find it helpful to close their eyes while doing deep breathing.<br>◆ Dimming lights is helpful as the high pulse lights can feel intrusive.<br>◆ Encouraging people to "be here, now" in a gentle affirming way can also be useful, especially if they can incorporate a similar phrase into the rhythm of their breathing. (Dissociation works to help temporarily alleviate intolerably painful feelings through distancing, so don't be surprised if people cry or have a hard time as a result of being grounded in the present.) |
| **5.** | ***Exercise and focus on the body***<br>◆ Moving the body in a deliberate way (wiggling toes, hands, arms, changing physical position, standing up if you have been sitting a long time or conversely sitting down, walking over to a window if you are in an enclosed space.)<br>◆ Focusing on feeling the body while in motion. Going for a fast walk, jogging, lifting weights (some people use cans for this) or bags filled with sand/water, using a large rubber band for resistance, dancing, yoga, etc. |

| | |
|---|---|
| **6.** | ***Encourage playing music and doing art***<br>◆ Have a variety of music available and headphones for those who wish to create privacy in a public place by shutting out the external cues. Music provides a powerful way of changing mood. For some, loud and repetitive music (preferably with headphones) provides renewed energy and release. For others, soothing instrumental music can facilitate shifting shallow, high anxiety breathing to deeper, more relaxed breath.<br>◆ Some people find group drumming particularly grounding as well.<br>◆ Gathering a group of women together and making sounds to a rhythm (called "sounding" or chanting without words) in unison is powerful and unifying when people in residence have been particularly disconnected from one another.<br>◆ Doing art projects (such as collage or life time lines) as a group or individually can assist women and children in becoming more grounded and unified as a program.<br>◆ Use story sticks (talking about the day, something meaningful, lesson learned, insight gained and then passing the stick to the next person in the circle) to ground and unify a group. |

*(Techniques adapted from Melnick and Bassuk, 1999)*

**E. Involve Women in Developing Care Plans**

When people develop their own goals, it fosters greater motivation and investment in the outcomes. This helps women develop greater self-determination and autonomy in their day to day lives.

- ☐ Involve women in developing their goals and plans with staff members. Move toward having women develop their own plans and present them to staff for review.
- ☐ Ask clients to take the lead in creating a transitional plan from the program.
- ☐ Record client strengths and write individual plans keeping strengths in the forefront.
- ☐ Foster accountability by creating a regular goal review session.
- ☐ Foster peer-run groups where clients can choose to talk about their goals and plans.

**F. Create a Range of Trauma-Informed Services and Trauma-Specific Clinical Interventions**

There are a number of components to providing trauma-informed services. Some of those include creating voluntary services (and eliminating the use of coercion and force), focusing on relationship building, conducting strengths-based assessments, creating safety and crisis intervention plans, the delineation of triggers, and developing overall care plans that foster autonomy. Trauma-informed services are different from trauma-specific clinical interventions. While everyone in trauma-**informed** services and systems is trained to respond to individuals in distress, they are not necessarily providing **specific** interventions designed to directly address the clinical effects of trauma. Trauma-informed services can be provided by various people within the shelter. Trauma-specific clinical interventions are typically provided by someone with an advanced clinical degree and may need to be contracted from outside of the program.

***When creating trauma-informed services or developing access to services/clinical interventions it is important to consider the following:***

- ☐ Build programming and services on client strengths.
- ☐ Provide flexible and individualized services.
- ☐ It is useful to involve former clients in developing programming and services.
- ☐ Make creative and nonverbal (e.g., art, theater, dance, movement, music) programming available.

- ☐ Address issues such as parenting, grief and loss, substance use, interpersonal violence, self-harm, health and social action in groups within the program.
- ☐ Set aside a private, accessible space for women-only, 12-step programming.
- ☐ Offer peer-run support groups within the program or connect clients to peer-run support groups/programs outside the program.
- ☐ Develop relationships with community agencies to fill gaps in trauma-specific programming and services.
- ☐ Set aside resources for community consultation to support trauma-specific programming and services.
- ☐ Generate access to legal advocacy for the women to obtain restraining orders, retain custody of children, accessing entitlement services, etc.
- ☐ Create connections in the community with people concerned with ending violence (through local schools, small businesses, public/private enterprises, etc.) to provide groups, classes and, workshops.
- ☐ Make trauma-specific clinical interventions (e.g., individual therapy, cognitive behavioral therapy, psychodrama, trauma processing, trauma-specific groups) available for women and children. Trauma-specific clinical interventions provided within the program should be provided by those who have been clinically trained to work with clients who have experienced trauma.

**G. Establish a Place for Ongoing Peer Support**

Peer relationships do not share the same power dynamics as do paid relationships. Peers experience dual roles as teacher and student. These relationships can be particularly powerful when women come together with shared experiences. The opportunity to gather, educate and organize for action can decrease isolation, generate accountability among the group, increase self-esteem and awareness about how personal experiences of violence and loss fit within a larger socio-political context. Through this process of education and peer support, many women develop a sense of mission to create a different future for others like themselves and look for occasions to become more socially/politically active.

- ☐ Provide opportunities for former and current clients to educate and support women who are new to the shelter.
- ☐ Develop a range of roles for clients as peer supports based on their interests.
- ☐ Generate roles for peers to act as supportive liaisons in assisting each other in various activities such as going to court, health care visits, accessing entitlements, filling out paperwork, etc.).
- ☐ Support a variety of peer run groups and activities within the agency.

## H. Develop Services for Children

Trauma changes everything for children. It alters the relationships with those around them and compounds losses they have already endured. Families who experience homelessness have often experienced multiple and chronic stressors in their lives, including domestic violence, catastrophic illness, multiple losses and family separations. For children, these stressors often occur within their care-giving system - their primary source of safety and stability. Trauma changes the job of children from playing and exploring to seeking safety and avoiding danger. Children begin to see the world as a scary and dangerous place. This impacts their cognitive, social, emotional, and behavioral functioning both in the present and throughout their lives. Sleeplessness, hypervigilance (constantly scanning the environment for signs of danger), constant clinging or – conversely - recoiling from touch, becoming overwhelmed by feelings, aggression toward themselves, animals or others, staring blankly, minimal expression of feeling, withdrawal from others or playful activities, academic difficulties, and multiple somatic complaints are all examples of traumatic exposure symptoms.

Children's resiliency to traumatic exposure is most often based on the relationship the child has with his/her caregiver. When a caregiver can provide relative safety, structure, and predictability the child can begin to learn to rely on adults for his/her basic survival needs, and can begin to heal from trauma. However, caregivers who have been exposed to chronic trauma themselves often struggle to provide these basic needs as they likely have had few models for healthy caretaking and are often overwhelmed by their own needs. As a result, the shelter must play a role in helping caregivers learn these skills and understand more effective ways to meet children's needs.

***Learn from Caregivers***

- ☐ Explore what caregivers feel are their greatest parenting strengths and needs.
- ☐ Learn the family routine, how they interact, and various roles within the family.

***Enhance Caregiver Skills***

- ☐ Post visuals for both children and caregivers that present emotional expression, coping skills, and the importance of self-expression.
- ☐ Provide charts or handouts that list developmental milestones by age group.
- ☐ Teach and model effective coping strategies for caregivers. Help caregivers practice using these strategies with their children.
- ☐ Assist caregivers in developing routines to increase predictability for children by developing with the caregiver a consistent meal schedule and bedtime routine for their children.
- ☐ When identified as a need, provide caregivers with information about effective behavior management techniques, such as use of timeouts, reinforcing positive behavior, and providing consistent responses to children.

- ☐ Assist caregivers in talking with their children about all the changes they have experienced. Help children process the losses that have occurred and prepare them for anticipated changes in the future.
- ☐ Educate caregivers and staff about child development and trauma.
- ☐ Provide resources to assist staff and caregivers in developing tools to address traumatic symptoms in children.

***Support & Involve Caregivers***

- ☐ Focus on the strengths and accomplishments of families. Include visuals such as posters recognizing special accomplishments.
- ☐ Take time to focus on what caregivers are doing well and verbally acknowledge them (provide positive reinforcement).
- ☐ Work with the caregiver and the relevant school systems to ensure the continuity of education for children in the program.

***Provide Age-Appropriate Programming and Referral***

- ☐ For young children, provide parent-child (dyadic) work on or offsite to address attachment issues with primary caregivers to help foster healthy development.
- ☐ For older children, provide activity-based groups that address topics such as trauma, relationships, communication, and safe expression of feelings.
- ☐ Provide (or provide access to) activity-based programming for children of all age groups. This might include adventure-based groups, drama groups, dance and movement groups, musical groups, etc.
- ☐ Provide or develop access to trauma-specific clinical interventions for children to address trauma symptoms, including individual therapy, group therapy, and early intervention.

***Involve Children***

Children who have been exposed to chronic violence often have not had the opportunity to be playful and have not had normative developmental experiences. It is important to provide children with the opportunity to have "child-like" experiences such as the opportunity to play, have time with friends, go to movies, the zoo, museums, etc.

- ☐ Involve children in programming decisions. Ask children what activities they would like and include them in the development and leadership of these programs.
- ☐ Provide opportunities for children to "teach" adults something about kids.
- ☐ Involve children in creative expression activities such as crafting a book about their feelings or producing a play or a puppet show.

## Exercise 5: Identifying Triggers

**Trying Times at Shirley's Corner Grocery Mart**

Amy Anxious (Ms. A. for short) is in line at the Shirley's Corner Grocery Mart. She spent the better part of the day trying to borrow money to buy cigarettes for herself and diapers for her young daughter, Mariah, who she left in the care of another shelter resident for an hour while she went out. Ms. A. has to get back to the shelter for a mandatory group in thirty minutes but thinks this shouldn't be a problem because the shelter is right around the corner just five minutes away.

However, the line is very long and only one cashier is working. By the time she has been in the line for fifteen minutes, it is twice as long with people lining up in back of her. As Ms. A. moves up slowly in the line, it becomes clear to her that the cashier is probably new and needs assistance from the manager who is called over every few minutes to check on prices, open the register drawer, or punch in an over-ride code to clear mistakes.

The cashier slows down even more, staring out the window as ambulances whiz by the store, followed by fire trucks responding to call nearby. The tension mounts as people in line are growing restless and begin to make nasty comments under their breath, just loud enough for those around them to hear.

When Ms. A. finally arrives at the front of the line, she can feel her heart racing and her head pounding. "Just a few more minutes," she keeps repeating to herself. She puts the diapers and the cigarettes on the conveyor belt and searches for her money but can't find it. "That's just not possible," she says out loud to no one in particular. "I just had it here." A male customer in line says: "Lady, if you can't find your money, could you please move aside, some of us would like to get home today!"

Ms. A. dumps the entire contents of her bag onto the conveyor in front of the cashier. When no money appears she throws it to the floor, swearing. "I'm not going anywhere until I get my _____diapers!

George Imincontrol, the store security guard, has been looking bored for the last twenty-five minutes but becomes more alert when he hears Ms. A. swearing. He walks over and puts his hand on her elbow to guide her away from the line. "Please, step out of line, Miss," he says, staring at her identification card on the counter.

"_____off," Ms. A. quickly replies under her breath while ripping her arm away from his grip.

"What did you say? Amy is it?" George asks, now fully alert, standing in front of her.

"I said, take your damned hands off me, GI Joe," Ms. A. yells defensively.

**Questions and Discussion**

1. How does this scenario most likely end?

2. What are the triggers in this scenario that contributed to Ms. Amy Anxious' heightened response? List all the potential triggers you can find in the above scenario.

   - _____
   - _____
   - _____
   - _____
   - _____
   - _____
   - _____
   - _____

3. Use this list for group discussion about how some of these triggers (no-win situations) might also be generated in the shelter or a program environment.

4. What made the situation worse for Ms. Anxious? Review the scenario again and see if you can identify when certain things took a turn for the worse. What could have been done differently to create a different outcome?

4(a) What could Mr. Imincontrol have done differently?

   - _____
   - _____
   - _____
   - _____
   - _____
   - _____
   - _____
   - _____

4(b) What could the store have done differently?

- _____
- _____
- _____
- _____
- _____
- _____
- _____

4(c) What could the program have done differently?

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

4(d) What could Ms. A. have done differently?

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

## IV. Support Client Representation and Staff Development

### A. Establish Visible Client Leadership and Representation

Trauma-informed programs see women as experts about their own lives and healing process. One way to show that the agency values lived expertise is to hire former clients and others who have received similar services in a broad range of visible leadership and decision-making positions. Having people who have received services (or "walked in the same shoes" as clients) working at multiple levels of the organizational structure ***decreases isolation and stigma by increasing visibility.*** Creating visible leadership positions within the agency conveys an organizational commitment to cultural change and reflects important messages to both clients and staff. For current clients, seeing others who have shared their experiences implies they are not alone and healing is possible. For staff, the implication is that clients are competent people with marketable and valued skills; the current crisis in their lives is only one dimension of what is going on at the present moment.

***Representation and Involvement***

- ☐ Define what proportion or number of former clients reflects a "significant" representation.
- ☐ Develop visible leadership roles for former clients within the program.
- ☐ Hire or involve former clients in a multitude of roles across agency positions, including program development, administration, direct service, and quality assurance/evaluation.
- ☐ Foster mentoring relationships.
- ☐ Create support for staff who are former clients.
- ☐ Develop peer liaison positions to provide mobile outreach to women in need of shelter.
- ☐ Hire former clients to co-facilitate or facilitate support groups.

### B. Foster Staff Development

It is vital that the agency provide ongoing staff development and training. Hire enough staff so coverage is available to clients when needed. This is important in order to avoid high turnover rates, elevated levels of stress, and increasing frustration with co-workers, clients, and the system. Providing an opportunity for staff to give input into programming and policies also helps them feel valued.

- ☐ Make ongoing training, supervision, and consultation available for staff. (*For more information on training and supervision see page* 42).
- ☐ Encourage staff members to support each other through regular team meetings and contact rather than working in isolation.
- ☐ Foster cohesiveness among staff members through activities such as team-building exercises, coaching, retreats, etc.
- ☐ Offer a mechanism for ongoing staff input into programming and policies
- ☐ Create an environment where staff can openly discuss concerns about the program with administrators.

## V. Provide Training and Supervision

### A. Educate Staff and Clients about Violence and Trauma

Training everyone - administrators, staff, clients and anyone else associated with the agency or service - about violence and other traumatic stressors creates an open, informed atmosphere that enables people within the organization to respond to each other in a trauma-sensitive way. Rather than providing training to a few who then become the "experts," systems that are working toward decreasing power imbalances develop plans to train everyone so the whole environment is changed.

The message agencies send when they train everyone is that the impact of violence is central in the lives of women and children, and often those providing services as well. In addition, decreasing power imbalances by sharing information creates a more involved community that supports people, regardless of what position they have within the organization. Trauma often isolates people, making them feel "crazy," "out of control," and acutely alone. Agency-wide educational campaigns can facilitate connection and visibility through increased understanding of how trauma happens, its outcomes, and how best to modify policy and practice to support healing and decrease retraumatization.

- ☐ Provide easily available staff training during work hours along with staff coverage.
- ☐ Create opportunities for staff to attend off-site conferences and trainings.
- ☐ Provide training on such topics as: complex post traumatic stress responses; the impact of past (childhood) trauma on how women experience the present; physical, emotional, psychological, and spiritual impact of trauma.
- ☐ Teach staff and clients how to identify triggers and respond to them in a trauma-sensitive way.
- ☐ Educate staff on such topics as: why assessments are done and how they can be used; developing safety plans and proactive crisis intervention plans; developmental milestones of children, the nature of secure attachments and how both are impacted by trauma.
- ☐ Train staff and clients in understanding the relationship between trauma and substance use, mental health, and health concerns.
- ☐ Educate staff and clients about dissociation and symptoms related to dissociation, including self-injurious behaviors.
- ☐ Provide in-service training for staff conducted by women with lived experiences.
- ☐ Provide training or contract with individuals who can provide training on the impact of vicarious trauma.
- ☐ Educate staff and clients about gender-based violence, human rights, advocacy, and political action. This should address such topics as:
  - Putting violence in a political context: Identifying gender-based violence (sexual assault, rape, trafficking, child prostitution, etc.).
  - Learning ways to protect yourself and your children.
  - Reproductive rights/freedoms, child custody, statute of limitations in reporting.
  - Saying "No" to Violence: Creating an empowered community by advocating for yourself and others. Introducing various projects around the country that address violence against women and children.
- ☐ Provide trauma-specific educational material to both staff and clients.
- ☐ Put trauma-specific educational material in highly visible areas for people to read, such as posters in hallways, bathrooms, bulletin boards, kitchens, etc., in addition to use of multimedia materials (e.g., video, cassettes, etc.).

- ☐ Provide staff access to relevant literature related to trauma (e.g., psychology journals, research publications).
- ☐ Create opportunities for staff to participate in local and national activities related to addressing violence against women and children.
- ☐ Consider membership in organizations concerned with community advocacy.

**B. Provide Ongoing Guidance and Supervision**

Ongoing guidance, supervision, and performance review with feedback creates learning and growth opportunities, provides support, and instills hope.

- ☐ Provide easily accessible supervision on a regular basis for each employee. Even 30 minutes once a month can make a big difference in an employee's ability to cope with work stress. Supervision also provides guidance in responding to clients in situations with a compassionate, authentic response.
- ☐ Provide low cost/free intensive supervision for employees who themselves are struggling with emotional repercussions of their own histories. These supervision sessions are short-tem, full length sessions with a trained therapist or supervisor who is not directly involved as a superior or peer with that particular staff member. To address the cost of providing this service:
  1) Contract with a local therapist outside the agency to provide four low-cost, reduced-rate sessions. After four sessions, the staff member could decide to continue on her/his own.
  2) Identify and contract with another local trauma-informed agency to provide reciprocal supervision for employees needing a greater degree of privacy.
- ☐ Group supervision can be beneficial. Occasionally bringing in an outside facilitator to run group supervision and discuss trauma-related situations in the workplace can be stimulating. These group sessions are not to be confused with therapy with the same facilitator running the sessions. Rather, these groups are supervised by different leaders from inside or outside the agency who are responsible for facilitating a session monthly or every other month. The goals are to generate discussion, engage in creative problem solving, and encourage healthy trauma-informed responses to workplace situations. Here again, a reciprocal relationship with another trauma-informed agency to provide facilitators can be enormously beneficial and low in cost.

**C. Encourage Staff to Respect Their Own Limits and Capacities**

Being present with clients and engaging in deep and meaningful ways with women and children who have been impacted by trauma can be painful, exhausting, and reactivating for providers who have experienced prior losses and trauma themselves. Staff members need to be encouraged to understand their own stress reactions and to take appropriate steps to develop their own self-care plan. Things to consider include:

- ☐ Do staff members maintain connection with a community of friends, family, spiritual support?
- ☐ Are there ways staff have developed to deal with expressing their stress?
- ☐ Do staff members have a regular exercise routine or other physical activity?
- ☐ Is there adequate separation between work life and personal time?
- ☐ Are staff members getting enough sleep or are they experiencing intrusive dreams interrupting sleep cycles?
- ☐ Are they receiving adequate outside support to address material that may be coming up as a result of the work?

- ☐ Are there mechanisms in place at work to support staff cohesiveness, such as team meetings, outings, retreats, etc., to allow staff to feel comfortable receiving feedback from one another about work-related stress?

## VI. Keep Efforts Sustainable Through Strategic Planning

Most organizations serving homeless families do not have the opportunity to routinely evaluate their work to refine their programs and policies and to ensure they reflect the complex needs of the mothers and children they serve. Successful alignment of resources to become trauma-informed requires commitment from all levels of the staff and program as well as careful planning and designated resources. Strategic planning is one way to construct a record of your efforts and to keep the momentum sustainable over time.

### A. Establish a Trauma-Informed System through Strategic Planning

There are a variety of ways to do strategic planning. The following provides an outline of ideas to guide the process.

- ☐ Meet with board members, administrators, staff, clients and, community members to generate broad support and "buy-in" for developing a trauma-informed system.
- ☐ Hire someone or have someone in a leadership position agree to become the point person in pulling people together to create a written strategic plan for becoming trauma-informed.
- ☐ Identify community experts and other pro bono resources to assist in plan development and implementation.
- ☐ Develop goals with clear objectives and a timeline for meeting each objective.
- ☐ Assign personnel responsible for ensuring each milestone is met in a timely manner.
- ☐ Determine the cost associated with developing and implementing the plan.
- ☐ Decide who will be responsible (depending on the size of your program you may want to identify more than one person) for identifying sources for needed funds.
- ☐ Communicate the plan to your funders and solicit their support.
- ☐ Clearly demonstrate how becoming trauma-informed will lead to better outcomes for the families in your program and will result in a better return on their investment.
- ☐ Include hiring strategies in the plan. Define what proportion or number of former clients reflects "substantial" representation. When developing the strategic plan, use that number as the gold standard so you can measure your success and improve representation.
- ☐ Develop relationships with community-based organizations to fill service gaps.
- ☐ Develop a plan for sustaining trauma-informed changes.

### B. Generate an Action-Based Research Plan and Document Best Practices

It is important to research and document what works, for whom and why. Gathering information from all levels of agency personnel and clients will provide a richer picture of agency operations. This learning could be used to help instruct others in the field about the efficacy of becoming trauma-informed, understanding the process by which it is achieved, and identifying the challenges inherent in making such changes. By documenting your work, the process becomes part of a living history that is stored and passed on to others when new knowledge is generated. This ongoing learning process can be documented

using multimedia such as video cassettes, focus groups, etc. In addition, the generation of new knowledge can lead to increased funding opportunities for agencies with promising/best practices.

- ☐ Develop an evaluation and research agenda to document your strategies and impact.
- ☐ Write up your theory of change and the process used.
- ☐ Determine areas where you need more information and develop mechanism to collect information.
- ☐ Develop a plan for implementing your agenda.

## VII. Other Considerations

Shelters vary widely across regions and service provision. While the following topics will not be relevant for some, other shelter providers requested guidance in these areas. They have been included here in response to those requests and to offer a template for agencies to adapt when attempting to meet the needs of people in their specific programs.

***Policies and Procedures***

**A. Does Your Program or Agency Require Medical Clearance & Screening?**

Many women and children who have experienced homelessness and violence have not had medical care in a long time. They suffer from a host of physical problems related to poverty, substance use, and repeated exposure to violence. With this knowledge, many programs and agencies require medical clearance or screening to determine a medical baseline for women prior to entering the program. Even though mandatory medical screening policies may exist for the best of reasons, they pose particular dilemmas.

Many medical environments and exams of any kind are difficult for most people, but particularly for those with histories of trauma. Such environments are loaded with potential reminders - or triggers - of prior abuse and traumatic experiences. Medical implements themselves, such as needles, hoses, clamps, scissors, gurneys with straps, etc., can remind people of prior weapons, leading to anxiety, panic, anger, edginess, tearfulness, and other post traumatic stress responses. In addition, the way medical exams are conducted, particularly in a crisis or emergency exam, are infamous for taking control away from patients. This happens in various ways, including when women are: (1) unable to choose physicians and are often assigned a male; (2) asked to remove clothes; (3) left alone in a room which can be reminiscent of being attacked in private; (4) left behind a curtain while wearing a jonnie; and (5) left alone for hours without receiving information about what is going on, and provided no food, water, access to a bathroom or human contact. People may feel particularly vulnerable late at night in emergency rooms.

If your program or agency requires medical examinations or physicals for medical clearance, you may want to consider the following ways to help reduce the possibility of retraumatizing clients:

***Empowering Women to Avoid Retraumatization***

- ☐ Contract with: (1) community nurses willing to perform medical clearance exams at your agency or program rather than having women go off-site; (2) contract with medical providers who understand the need for female nurses, nurse practitioners, physicians, and physician assistants to perform exams.

- ☐ Identify former recipients of services willing to accompany women to exams.
- ☐ Find out if women are required to remove any of their clothing for the exam or if exams can be performed without removing clothes.
- ☐ Find out what alternatives are available to removing clothing during exams and convey this to the women beforehand.
- ☐ Defer the exam until a later date if a woman has flashbacks or a difficult time unless an imminent medical emergency exists.
- ☐ Have child care provided while women are examined.
- ☐ Provide debriefing for women after their exam by shelter staff or peers.

***Supporting Children***

- ☐ Talk with children in a way they understand about what to expect in the exam room.
- ☐ Use multi-media to explain exams to children (e.g., pictures, drawing, music, etc.).
- ☐ Find providers that allow mothers to accompany children into exam rooms.
- ☐ Find out if there are alternative ways to examine children who don't want to remove their clothes.
- ☐ Debrief children after exams.
- ☐ Ask children if ***they*** would like to explain exams to ***other*** children.

**B. Special Considerations When Hiring Male Staff**

Homeless mothers experience extraordinarily high rates of violence by intimate male partners. A study by The National Center on Family Homelessness found that sixty percent of sheltered homeless and poor housed mothers had experienced severe physical abuse, and nearly one-third had been severely assaulted by a current or most recent partner. Because so many women have been assaulted by men, programs need to take certain precautions when considering hiring male staff to work in a family shelter environment. The following considerations can help keep residents safe from potential exploitation in addition to protecting staff and agencies from legal liabilities.

- ☐ Men should not be in a position to work overnight alone or enter private spaces (e.g., women's bedrooms, bathrooms, showers, etc) without a female staff member.
- ☐ Male staff should not be put in the position to be solely responsible for children.
- ☐ Staff should make their presence known when entering private spaces (All staff, but particularly men: e.g., van drivers, maintenance personnel, ground-keepers, kitchen personnel, direct service staff, administrators).
- ☐ Background checks should be performed before hiring all staff members. Prior acts of violence, including sexual assault against women and children, should eliminate candidacy.
- ☐ A clear policy should be developed that precludes romantic involvement, including: dating; "joking" about romance, sex, physique; or flirting and; engaging in sexual contact between any staff and residents.
- ☐ Optimally, men should have their own lavatory. If this is not possible due to space considerations, develop a procedure for making sure residents know when men are using the bathroom. Signs on the door or other creative indicators are helpful.

## Appendix A: Individualized Safety Plans

**Identification**
___ Divers License and registration or other identification
___ Your birth certificate
___ Children's birth certificates
___ Social security cards
___ Public assistance identification
___ Work permits, green cards, passport, visa

**Legal**
___ Your protective order
___ Lease or rental agreement
___ Insurance papers: Health, car, life insurance papers
___ Medical records for self and children
___ School and vaccination records for children
___ Divorce papers
___ Custody papers
___ Copies of any bank accounts, loan papers, past tax returns, paycheck stubs,

**Financial**
___ Checkbook and passbooks
___ ATM cards

**Other items**
___ Keys: Apartment and car keys
___ Pictures of yourself, children and abuser
___ Medications
___ Jewelry and other small items of value
___ Address book
___ Phone card
___ Change of clothing for self and children
___ Children's favorite toy/blanket

**CHECKLIST - WHAT YOU NEED TO TAKE WHEN YOU LEAVE:**

**IDENTIFICATION**

____ Driver's license
____ Children's birth certificates
____ Your birth certificate
____ Social security card
____ Welfare identification

**FINANCIAL**

____ Money and/or credit cards
____ Bank books
____ Checkbooks

**LEGAL PAPERS**

____ YOUR RESTRAINING ORDER
____ Lease, rental agreement, house deed
____ Car registration & insurance papers
____ Health and Life Insurance papers
____ Medical records for you and children
____ School records
____ Work permits/Green card/VISA
____ Passport
____ Divorce papers
____ Custody papers

**OTHER**

____ House and car keys
____ Medications
____ Small saleable objects
____ Jewelry
____ Address book
____ Phone card
____ Pictures of you, children & your abuser
____ Children's small toys
____ Toiletries/diapers
____ Change of clothes for you and your kids

**FOR MORE INFORMATION ABOUT YOUR LEGAL RIGHTS AND OPTIONS,** contact an advocate at your local court or shelter or one of the following numbers:

**BATTERED WOMEN'S SHELTERS:**

| | |
|---|---|
| Casa Myrna Vasquez (24 hour) | 800/992-2600 |
| Transition House (24 hour) | 661-7203 |
| Renewal House | 566-6881 |
| Elizabeth Stone House | 522-3417 |
| Respond | 623-5900 |

**POLICE:**

| | |
|---|---|
| EMERGENCY | 911 |
| Cambridge Domestic Violence Unit | 349-3370 |
| Somerville Police | 625-1600 |
| Watertown Police | 972-6500 |
| Belmont Police | 484-1212 |
| Arlington Police | 646-1000 |

**MIDDLESEX COUNTY D.A.'S OFFICE:**

| | |
|---|---|
| Domestic Violence Unit (MAPP) | 617/629-0222 |
| *Victim Witness Advocates* | |
| Cambridge Division | 617/494-4430 |
| Malden Division | 617/322-2020 |
| Natick Division | 508/875-4141 |
| Newton Division | 617/964-6640 |
| Somerville Division | 617/625-2521 |
| Waltham Division | 617/893-7140 |
| Woburn Division | 617/933-9586 |

**OTHER IMPORTANT NUMBERS:**

| | |
|---|---|
| Dating Viol. Intervention Project | 868-8328 |
| Camb. & Somerville Legal Services | 494-1800 |
| Community Legal Svs & Counseling Ctr | 661-1010 |
| Fenway Community Health Center | 267-0900 |
| Network for Battered Lesbians | 424-8611 |
| Immigrant & Refugee Coalition | 357-6000 |
| Disabled Abuse Hotline | 800/426-9009 |
| Elder Abuse Hotline | 800/922-2275 |
| National Domestic Violence Hotline | 800/799-SAFE |

# PERSONAL SAFETY PLAN

**YOU HAVE A RIGHT TO BE SAFE!**

**CITY OF CAMBRIDGE**
**POLICE DEPARTMENT**

## I. SAFETY DURING AN EXPLOSIVE INCIDENT

A. If an argument seems unavoidable, try to have it in a room or area where you have access to an exit. Try to stay away from the bathroom, kitchen, bedroom or anywhere else where weapons might be available.

B. Practice how to get out of your home safely. Identify which doors, windows, elevator, or stairwell would be best.

C. Have a packed bag ready and keep it at a relatives or friends home in order to leave quickly.

D. Identify one or more neighbors you can tell about the violence and ask that they call the police if they hear a disturbance coming from your home.

E. Devise a code word to use with your children, family, friends, and neighbors when you need the police.

F. Decide and plan for where you will go if you have to leave home (even if you don't think you will need to).

G. Use your own instincts and judgement. If the situation is very dangerous, consider giving the abuser what he wants to calm him down. You have the right to protect yourself until you are out of danger.

H. Always remember - *YOU DON'T DESERVE TO BE HIT OR THREATENED!*

## II. SAFETY WHEN PREPARING TO LEAVE

A. Open a savings account and/or a credit card in your own name to start to establish or increase your independence. Think of other ways in which you can increase your independence.

B. Leave money, an extra set of keys, copies of important documents, extra medicines and clothes with someone you trust so you can leave quickly.

C. Determine who would be able to let you stay with them or lend you some money.

D. Keep the shelter or hotline phone number close at hand and keep some change or a calling card on you at all times for emergency phone calls.

E. Review your safety plan as often as possible in order to plan the safest way to leave your batterer. *REMEMBER - LEAVING YOUR BATTERER IS THE MOST DANGEROUS TIME.*

## III. SAFETY IN YOUR OWN HOME

A. Change the locks on your doors as soon as possible. Buy additional locks and safety devices to secure your windows.

B. Discuss a safety plan with your children for when you are not with them.

C. Inform your children's school, day care, etc., about who has permission to pick up your children.

D. Inform neighbors and landlord that your partner no longer lives with you and that they should call the police if they seem him near your home.

## IV. SAFETY WITH A PROTECTIVE ORDER

A. Keep your protective order on you at all times. (When you change your purse, that should be the first thing that goes in it.) Give a copy to a trusted neighbor or family member.

B. Call the police if your partner breaks the protective order.

C. Think of alternative ways to keep safe if the police do not respond right away.

D. Inform family, friends, neighbors and your physician or health care provider that you have a protective order in effect.

## V. SAFETY ON THE JOB AND IN PUBLIC

A. Decide who at work you will inform of your situation. This should include office or building security. Provide a picture of your batterer if possible.

B. Arrange to have an answering machine, caller ID, or a trusted friend or relative screen your telephone calls if possible.

C. Devise a safety plan for when you leave work. Have someone escort you to your car, bus, or train and wait with you until you are safely en route. Use a variety of routes to go home by if possible. Think about what you would do if something happened while going home (i.e., in your car, on the bus, etc.).

## VI. YOUR SAFETY & EMOTIONAL HEALTH

A. If you are thinking of returning to a potentially abusive situation, discuss an alternative plan with someone you trust.

B. If you have to communicate with your partner, determine the safest way to do so.

C. Have positive thoughts about yourself and be assertive with others about your needs. Read books, articles, and poems to help you feel stronger.

D. Decide who you can call to talk freely and openly to give you the support you need.

E. Plan to attend a women's or victim's support group for at least 2 weeks to gain support from others and learn more about yourself and the relationship.

## VII. FOR TEENS IN A VIOLENT DATING RELATIONSHIP

A. Decide which friend, teacher, relative or police officer you can tell.

B. Contact an advocate at the court to decide how to obtain a restraining order and make a safety plan.

# Appendix B: Explanation of Selected Exercises

## Exercise 1: The Story of Akasha

1a. Maria

1b. Because of the high rates of trauma experienced by the women coming for services, Maria assumed that Akasha's anger was probably a reaction to some prior traumatic event, even if it was not obvious in the moment. She was open to asking questions in a non-judgmental, respectful way in order to find out more information from Akasha about why she responded so strongly. By asking if something happened to make Akasha so angry, Maria is creating an opening for dialogue to take place. In addition, she is taking the first step in developing a partnership with the new resident by treating her as the expert from whom she is learning.

2a. Rose and Carla

2b. Rose and Carla concluded that Akasha was exhibiting psychiatric symptoms because she became angry so quickly and because it appeared to them to come out of nowhere. They couldn't understand why something as soothing as a hot shower could lead to a rage response. Akasha's resistance might be seen as oppositional or defiant or as the result of a specific psychiatric condition. It is important to view Akasha's anger within a trauma-informed context so we do not miss an important opportunity to help her heal and risk the possibility of potentially retraumatizing her and her children by referring them to a mental health system that would most certainly separate the family.

3a. Is the shower the problem or is it something else?
How has Akasha dealt with this problem before? (example of strength-based questioning)
What helped?
What makes the problem worse?
Is there a way to work together to make things easier?
Is there something that Maria or anyone else can do to help?

3b.As it turns out, Akasha had been assaulted by her live-in boyfriend in the bathroom while she was taking a shower a couple of months ago. He choked her until she passed out and the last thing she remembers is his voice telling her she was going to die. She didn't dare leave him until recently when she became afraid he would assault her children. Since then, she has not let the children out of her sight. She is very frightened of taking off her clothes. In addition, she avoids bathrooms and showers that have windows, are poorly lighted, and can not be locked for privacy.

3c. Tour the facility during the day.
Make sure the shower is well lighted and clean.
Make sure the door and window can be locked, and the space is otherwise private. (e.g. there are no gaps in or around the doorframe, there is a curtain or shade or other window covering to prevent people from seeing inside or gaining entry).
Offer to remain near the shower or outside the bathroom door for safety and assistance.

***Conclusion***
Akasha no longer needed assistance once she grew comfortable with her surroundings and found that no one would enter the bathroom while it was occupied.

## Exercise 5: Identifying Triggers: Trying Times at Shirley's Corner Grocery Mart

**Questions and Discussion**

1. How does this scenario most likely end?
   While there are many possible endings to our story, the following are fairly predictable given the multiple triggers in the environment and interactions. Look over the endings below and discuss them with the group. Are these plausible? Are they likely? Are they familiar? If so, why? What leads to the crises? Are the crises she endures necessary? What other endings can you come up with?

*Possibility A*:
The store security guard probably escorts Ms. A. to the door and tells her to leave. Ms. A. feels controlled, frustrated and furious because she has not been able to get her needs met (buying diapers and cigarettes in time to make it back to the house for the meeting). She storms out of the store, shaking violently and swearing loudly at George Imincontrol (the security guard). She walks back to the residence with her fists balled up, talking to herself the whole time. Ms. A. is met at the door by a staff person who asks her to step into the office. The staff person is just about to give Ms. A. a warning when she explodes with anger, throwing everything in sight. The police are called and she is escorted off the property in handcuffs.

*Possibility B*:
Ms. A. refuses to get out of line until she finds her money. She stays where she is franticly searching for the money she knows she had in her bag. The people in line behind her get louder and the security guard repeats his request more sternly for her to step out of line so others can pay for their items. Ms. A. is visibly shaking and dropping everything she picks up, making the whole process longer. "Just back up and give me a minute," she yells without looking at anyone. "Madam, I'm not going to ask you again. Please step to one side." Mr. Imincontrol gets on the radio and calls for backup.

What else?

2. What are the triggers in this scenario that contributed to Ms. A. heightened response? Take a pen and highlight all the potential triggers you can find or make a list below.

Amy Anxious (Ms. A. for short) is in line at the Shirley's Corner Grocery Mart. She spent the <u>better part of the day trying to borrow money (1)</u> to buy some cigarettes for herself and diapers for her young daughter, Mariah, who she <u>left in the care of shelter resident for an hour (2)</u> while she went out. Ms. A. <u>has to get back to the shelter for a mandatory group in thirty minutes (3)</u> but thinks this shouldn't be a problem, because the shelter is right around the corner just five minutes away.

The <u>line (4)</u>, however, is <u>very long (5)</u> and there is only <u>one cashier working in the whole</u> <u>store. (6)</u> She has been in <u>line fifteen minutes and it is already twice as long as when she started (7)</u> with <u>people lining up in back of her.(8)</u> As Ms. A. moves up slowly in the line, it becomes clear that the cashier is probably new and needs a lot of assistance from the manager, who is called over every few minutes to check on prices, open the register drawer, or punch in an over-ride code to clear mistakes.

The <u>cashier slows down (9)</u> even more as she hears <u>multiple sirens (10)</u> as <u>ambulances</u> whiz by the store, followed by <u>fire trucks responding to a call nearby.(11)</u> The tension mounts as <u>people in line are growing restless and beginning to make nasty comments under their breath, (12)</u> just loud enough for those around them to hear.

When Ms. A. finally arrives at the front of the line, she can feel her heart racing and her head pounding. "Just a few more minutes," she keeps repeating to herself. She puts the diapers and the cigarettes on the conveyor belt and searches for her money but can't find it. (13) "That's just not possible," she says out loud to no one in particular. "I just had it here."

Male customer (14) behind her (15) in line: "Lady, if you can't find your money, could you please move aside, some of us would like to get home today!"

Ms. A. dumps the entire contents of her bag onto the conveyor in front of the cashier. When no money appears, she throws it to the floor, swearing. "I'm not going anywhere until I get my _____diapers!"

George Imincontrol (16) the store security guard (17) has been looking bored for the last twenty-five minutes but becomes more alert when he hears Ms. A. swearing. He walks over and puts his hand on her elbow (18) to guide her away from the line. "Please, step out of line, Miss," he says, staring at her identification card on the counter.

"_____off," Ms. A. quickly replies under her breath while ripping her arm away from his grip.

"What did you say?" Amy, is it?" (19) George asks, now fully alert, standing in front of her. (20)

"I said, take your damned hands off me, GI Joe," Ms. A. yells defensively.

---

Most of this scenario has to do with feeling trapped in a no-win situation for which there could be large consequences.

| | |
|---|---|
| 1. | Feeling humiliated (trapped), stressed: spending all day trying to borrow enough money to get what she needs. |
| 2. | Pressure, fear: She has to get back within an hour because someone is watching her daughter and she has a mandatory group in 30 minutes. |
| 3. | Trapped: Lines are easy places to be triggered because there is someone in back and someone in front. |
| 4. & 5. | Potentially a no-win situation: The line is *long*, so there was already tension about time. Would she be able to make it or not? Other concerns might be: a) the store might close; b) she needed to get her stuff and c) she had to get back to the shelter. |
| 6. & 7. | Frustration and helplessness |
| 8. | Threat of being trapped: people are lining up in back of her |
| 9. | Frustration, anger, helplessness, trapped |
| 10. & 11. | *Fear*: Are the fire trucks and ambulances going to the shelter where someone is taking care of her daughter? Is her daughter in danger? Has she been in a fire before? What might the sirens be reminding her about? |
| 12. | Helplessness: mounting tension in the environment (spoken but in a whisper that could be denied), |
| 13. | Feeling crazy, frustrated, embarrassed, afraid of not being believed, trapped, helpless when she finally gets to the front of line after spending most of the day getting the money, waiting in that long line, jeopardizing her standing in the shelter to buy |

| | |
|---|---|
| | diapers and she ***still*** can't buy the products she needs. |
| 14. | Fear: male hostility |
| 15. | Threat of being hurt/danger: someone behind her is angry |
| 16. & 17. | Authority, badges, guns, weapons, men |
| 19. | Intrusion: Familiar reference to her first name without permission. |
| 18. & 20. | Physically trapped: Mr. Imincontrol physically traps Ms. A. by putting his hand on her elbow(18), and standing in front of her (19) effectively blocking her way. |

3. Use this list for group discussion about how some of these triggers might also be generated in the shelter or program environment?

☐ Fear
☐ Threatened
☐ Trapped
☐ Intrusion
☐ Helplessness
☐ No-Win situations
☐ Authority/Power Imbalances
☐ Presence of Men
☐ Symbols of Power

4. What are the things that made the situation worse for Ms. A.?
Review the scenario again and see if you can identify where certain things took a turn for the worse. What could have been done differently to create a different outcome?

*4a) What Mr. Imincontrol could have done differently*:

- Instead of standing in front of Ms A., it would have been much more beneficial if Mr. Imincontrol stood to one side. This is a much less threatening and confrontational stance.
- Instead of touching Ms. A., Mr. Imincontrol could have asked her to please step to one side while assuring her she would be able to get back in line.
- Acknowledge that Ms. A, was upset (believing her).
- Asking Ms. A. if he could help her look for something she lost. (aligning himself with her).
- Addressing Ms. A. by her formal name as a sign of respect.
- Looking at her directly rather than looking at her identification card.
- Mr. Imincontrol could have addressed the man behind Ms. A. by asking him to be patient for a few more minutes while Ms. A. looked for her money, assuring him that everyone would like to be on their way.

*4b) What the store could have done*:

- The store manager could have added more cashiers to address the tension of the growing line.
- The store personnel could have assisted the cashier in getting her job done.
- Since post traumatic stress symptoms are not uncommon, the store would do well to consider adjusting their policies limiting the wait times for customers in line by increasing the number of cashiers on the floor.

*4c) What the program could have done*:

- Staff members could have asked Ms. A. why she was late before giving her a warning for missing group. They could used the scenario as a learning opportunity to help her learn about various triggers and how to anticipate and handle them.

- Reassessed whether their no tolerance for lateness policy regarding mandatory groups was flexible enough to account for individual situations.
- Helped Ms. A. with her anxiety, frustration and anger regarding her day.

*4d) What Ms. A. could have done:*

If Ms. A. had understood more about what situations make her anxiety worse, she would have been in a much better position to have taken steps to prevent the situation from escalating.

- Stepped out of line slightly so she could see the people in back of her.
- Had she been aware that lines (waiting, being surrounded, stress, etc.) are difficult for her, she could have brought something to distract her while she waited (object to hold onto, book, magazine, etc).
- Ms. A. could have asked the people in front of her if they minded her checking out before them because she was going to be late for a meeting.
- When Ms. A. noticed the line was getting long, she could have asked the person in front to save her place while she made a phone call to the program to let them know where she was and what was going on.

## Appendix C: Example of a Personal Crisis Prevention Planning Form Adapted for Residential Centers

*(Adapted from Carmen et al., 1996)*

This form is a guide to gathering information with clients for the development of strategies to de-escalate agitation and distress so that emergency interventions such as calling the police, crisis referral, use of force, restriction, and restraint can be averted. It should be used in conjunction with a trauma assessment evaluation. After review, the information obtained should be incorporated into a plan developed with and signed by the client.

1. It is helpful to be aware of the things that make you feel better when you're having a hard time. Have any of the following ever worked for you? We may not be able to offer all these alternatives, but I'd like us to work together to figure out how we can best help you while you're here.

| | | | |
|---|---|---|---|
| *Spending alone time in your room* | | *Yoga* | |
| *Spending time with others* | | *Reading a newspaper/book* | |
| *Talking with another client* | | *Watching TV* | |
| *Talking with staff* | | *Pacing the halls* | |
| *Listening to music* | | *Calling a friend* | |
| *Drinking something warm* | | *Calling support people* | |
| *Eating something* | | *Doing artwork, pounding some clay* | |
| *Punching a pillow* | | *Exercising* | |
| *Writing a journal* | | *Using ice on your body* | |
| *Deep breathing exercises* | | *Putting hands under cold water* | |
| *Going for a walk* | | *Lying down with cold face cloth* | |
| *Taking a hot shower* | | *PRN medication* | |
| *Wrapping in a blanket* | | *Other?* | |
| | | | |
| | | | |

2. Is there a person who has been helpful to you when you're upset? **(Y/N)** Would you like them to visit you? **(Y/N)** Can we assist in this process? **(Y/N )** If you are in a position when you are having a hard time and unable to give us information about how to help, do we have your permission to call and speak to:

_____ (Name) _____ (Phone)

If you agree that we can call and speak to someone you designate, please sign below:

Client signature _____ Witness _____

Date: _____

3. What are some of the things that make it more difficult for you when you're already upset? Are there particular "triggers" that you know will cause you to escalate?

| | | | |
|---|---|---|---|
| *Being touched* | | *Being isolated* | |
| *Bedroom door open* | | *People in uniform* | |
| *Time of the year (when.?)* | | *Particular time of day (when.?)* | |
| *Yelling* | | *Loud noise* | |
| *Not having control/input (explain)* | | *Other (please list)* | |
| | | | |

4. Do you have a preference regarding the gender of staff assigned to you during and immediately after an emergency?

**Women Staff _____Men Staff _____No Preference_____**

5. Is there anything that would be helpful to you during an emergency that is not covered above? Please describe.

_____

_____

_____

6. In order to keep everyone safe in the residence, women are not allowed to use substances, carry weapons or other objects that can be used to hurt themselves or others. Therefore, if we suspect you have been using, carrying drug paraphernalia, alcohol, weapons, razors, etc. we may have to search your room, body, and/or personal items. This is a routine practice and can be frightening to some women. Are there ways that we can work together to decrease your fear and help you feel in control while this is going on?

| | | | |
|---|---|---|---|
| Females present during body searches | | Privacy while undressing (one female present) | |
| Inform me what you are doing at each step | | Allow me to help in room search | |
| Ask me more than once if you suspect I am using drugs/alcohol, carrying paraphernalia, weapons, razors or other objects | | Other (*Please List*) | |

7. We do room checks here to make sure you are okay at night. We are trying to make these room checks as non intrusive as possible. Is there anything that would make room checks more comfortable for you?

_____

_____

**Please incorporate the information obtained in the Crisis Prevention Plan Form into the client plan**

## References


Bassuk, E.L., Buckner, J.C., Perloff, J.N., & Bassuk, S.S. (1998). Prevalence of mental health and substance abuse disorders among homeless and low-income housed mothers. *American Journal of Psychiatry*, *155*(1), 1561-1564.

Bassuk, E.L., Melnick, S, & Browne, A. (1998). Responding to the needs of low income and homeless women who are survivors of family violence. *Journal of the American Medical Women's Association*, *53*(2), 57-64.

Bassuk, E.L., Weinreb, L.F., Buckner, J.C., Browne, A., Salomon, A., & Bassuk, S.S. (1996). The characteristics and needs of sheltered homeless and low-income housed mothers. *Journal of the American Medical Association*, *276*(8), 640-646.

Browne, A., & Bassuk, S.S. (1997). Intimate violence in the lives of homeless and poor housed women: prevalence and patterns in an ethnically diverse sample. *American Journal of Orthopsychiatry*, *72(*2), 261-277.

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

Burt, M., Aron, L., Douglas, T., Valente, J., Lee, E. & Iwen, B. (1999). *Homelessness: Programs and the People They Serve: Summary Report - Findings of the National Survey of Homeless Assistance Providers and Clients* (Washington, DC: The Urban Institute).

Carmen, E., et al. (1996). *Task Force Report Concerned with Restraint/Seclusion of Persons who have been Physically and/or Sexually Abused*. Boston, MA: Department of Mental Health, Appendix 4.

Elliott, D. E., Bjelajac, P., Fallot, R.D., Markoff, L.S., & Reed, B.G. (2005). Trauma-informed or trauma-denied: Principles, competencies, and implementation of trauma-informed services for women. *Journal of Community Psychology*, *33*(4), 461-475.

Goodman, L. (1991). The prevalence of abuse among homeless and housed poor mothers: A comparison study. *American Orthopsychiatric Association, 61*(4), 489-500.

Goodman, L., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma. *American Psychologist, 46* (11), 1219-1225.

Harris, M., & Fallot, R. (2001a). Envisioning a trauma-informed service system: A vital paradigm shift. In M. Harris and R.D. Fallot (eds.), *Using Trauma Theory to Design Service Systems*. New Directions for Mental Health Services, Number 89, San Francisco: Jossey-Bass.

Harris, M., & Fallot, R. (2001b). Designing trauma-informed addictions services. In M. Harris and R.D. Fallot (eds.), *Using Trauma Theory to Design Service Systems.*New Directions for Mental Health Services, Number 89, San Francisco: Jossey-Bass.


,

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

Institute for Health and Recovery. (2002). *Developing trauma-informed organizations: A tool kit.* 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.

Moses, D.J. (2001). *Innovations from the sites: The Women's Support and Empowerment Center: A drop-in center for women living with substance abuse, mental illness, and trauma.* Delmar, NY: Policy Research Associates, Women and Violence Coordinating Center.

Moses, D.J., Reed, B.G., Mazelis, R., & D'Ambrosio, B. (2003). *Creating trauma services for women with co-occuring disorders: Experiences from the SAMHSA women with alcohol, drug abuse and mental health disorders who have histories of violence study.* Delmar, NY: Policy Research Associates, Women and Violence Coordinating Center.

Killion, C.M. (1998). Poverty and procreation among women. An anthropologic study with implications for health care providers. *Journal of Nursing Midwifery*, *43(4)*, 273-9. as quoted in Silver, G., & Panares, R. (2000). *The Health of Homeless Women: Information for State Maternal and Child Health Programs.* Washington DC: US DHHS, HRSA, Maternal Health Bureau.

McMurray-Avila, M. (1997). Organizing Health Services for Homeless People: A Practical Guide. Nashville, TN: National Health Care for the Homeless Inc. as quoted in Silver, G., & Panares, R. (2000) *The Health of Homeless Women: Information for State Maternal and Child Health Programs.* Washington DC: US DHHS, HRSA, Maternal Health Bureau.

Melnick, S.M., & Bassuk, E. (1999). *Table 6: Grounding Techniques.* In *Identifying and Responding to Violence Among Poor and Homeless Women*. Boston, MA: Better Homes Fund.

National Center on Family Homelessness. (1999). *Homeless Children: America's New Outcasts*. Newton, MA: Better Homes Fund.

Prescott, L., (1998). Safety in Conflict Table: A Life of My Own Training Curriculum. In A. Blanch & L. Prescott, (December 2002) *Managing Conflict Cooperatively: Making a Commitment to Nonviolence and Recovery in Mental Health Treatment Settings*. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC), p. 12.

Smith, E.M., North, C.S., & Spitznagel, E.L. (1993). Alcohol, drugs, and psychiatric comorbidity among homeless women: an epidemiologic study. *Journal of Clinical Psychology*, *54*(3*)*, 82-7.

Snyder, HN. (2000). *Sexual Assault of Young Children as Reported to Law Enforcement: Victim, Incident, and Offender Characteristics*. Washington, DC: National Center for Juvenile Justice (NCJ 182990), US Department of Justice and the Bureau of Justice Statistics.

Straus, M., & Gelles, R, (Eds.) (1990). *Physical Violence in American Families*. New Brunswick, N.J.: Transaction Books.

The Global Coalition on Women and AIDS. Intimate Partner Violence and HIV/AIDS. Violence Against Women and HIV/AIDS: Critical Intersections. (2004). *Informational Bulletin Series*, Number 1, Washington DC: World Health Organization.

US Conference of Mayors, (2007). *Hunger and Homelessness Survey: A Status Report on Hunger and Homelessness in America's Cities*. Washington, DC: U.S. Conference of Mayors. Retrieved April 1, 2008, from http://www.usmayors.org/uscm/hungersurvey/2004/onlinereport/HungerAndHomelessnessReport2004.pdf

Vladek, B.C. (1990). Health care and the homeless: A political parable for our time. *Journal of Health Politics, Policy and Law*, *15*, 305-317.

Weinreb, L., Goldberg, R., & Perloff, J.N. (1998). The health characteristics and service use patterns of sheltered homeless and low-income housed mothers. *Journal of General Internal Medicine, 13*(1), 389-397.

Weinreb, L., Goldberg, R., Bassuk, E., & Perloff, J.N. (1998). Determinants of health and service use patterns in homeless and low-income housed children. *Pediatrics, 102*(3), 554-562