

ISSUE BRIEF SERIES

Trauma-Informed Care for Veterans Experiencing Homelessness

An Organization-Wide Framework

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Trauma-Informed Care for Veterans Experiencing Homelessness: An Organization-Wide Framework

Trauma-Informed Care for Women Veterans Experiencing Homelessness, funded by the Bristol-Myers Squibb Foundation from 2012 to 2014 as part of its Mental Health & Well-Being initiative for returning veterans and families, was a multisite demonstration project designed to build the capacity of veteran-serving agencies—particularly those serving women veterans—to adopt a universal, organization-wide approach to understanding and responding to trauma. The National Center on Family Homelessness at American Institutes for Research (AIR/NCFH) partnered with three organizations in Massachusetts—New England Center for Homeless Veterans, Veterans Inc., and Soldier On—that serve homeless veterans and were interested in adopting trauma-informed care. Project activities included (a) introducing an organizational framework for becoming trauma-informed; (b) building the capacity of organizations to integrate trauma-informed care; and (c) evaluating the project’s impact on organizational culture and practice. Project findings suggest that adopting trauma-informed care enhances quality of care for veterans in homeless services and is a promising framework for veteran service systems.

This brief is the first in a three-part series entitled *Trauma-Informed Care for Veterans Experiencing Homelessness*. To access the entire series, visit www.FamilyHomelessness.org.

What Is Trauma-Informed Care?

The term “trauma” is used to describe an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening.² An event becomes traumatic when it overwhelms our ability to cope with the situation and leaves people feeling unsafe, helpless, vulnerable, and out of control.^{3,4} Whether a particular event is experienced as traumatic varies from person to person; what may be traumatic for one person may not be for another. Exposure to violence—particularly violence that is severe, chronic, and interpersonal—can be particularly overwhelming. Without effective supports, combat-related experiences, military sexual trauma, childhood abuse, intimate partner violence, and community violence may have long-lasting effects on a veteran’s physical, mental, and spiritual health.^{2,5}

Trauma-informed care is an organization-wide framework that is “grounded in an understanding of and responsiveness to the impact of trauma; that emphasizes physical, psychological, and emotional safety for both providers and survivors; and that creates opportunities for survivors to rebuild a sense of control and empowerment.”¹

All systems serving veterans play a pivotal role in supporting their recovery from trauma based on their capacity to offer safe, predictable, compassionate, and informed services that buffer the impact of traumatic experiences and support resilience. With a growing awareness of trauma and its impact, organizations across sectors, including those serving veterans, are beginning to adopt an approach to service delivery known as “trauma-informed care.”⁶

Trauma-informed care is a universal framework for addressing trauma that requires changes to the practices, policies, and culture of an entire organization, so all staff have the awareness, knowledge, and skills needed to support trauma survivors. Trauma-informed care is driven by a set of core principles—safety, choice, shared power, cultural awareness, and trauma knowledge—that inform all aspects of service delivery, regardless of the services an agency provides.^{1,7,8}

Why Should Organizations Serving Veterans Adopt Trauma-Informed Care?

Research on the prevalence and impact of trauma, along with findings from *Trauma-Informed Care for Women Veterans Experiencing Homelessness*, AIR/NCFH’s multisite demonstration project, highlight the need for organizations serving homeless veterans to adopt trauma-informed care as an organizational framework for service design and delivery.

1. Rates of trauma in the lives of veterans experiencing homelessness are high.

For male and female veterans, homelessness is yet another traumatic experience layered on what for many is an already complex history of trauma. Rates of posttraumatic stress disorder (PTSD) and homelessness are higher among veterans than in the general population, and PTSD is a risk factor for homelessness among Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans.^{9,10} A study of homeless veterans—primarily male—accessing Department of Veterans Affairs (VA) rehabilitation services in 2001 found that traumatic experiences during and outside of military service were common.¹¹ Women veterans experiencing homelessness also report high rates of trauma: 52% report premilitary adversity; 53% report experiencing military sexual trauma; and 74% screen positively for PTSD compared to 10% of women in the general population.^{12,13,14}

2. Lack of awareness and understanding of trauma increases the risk of doing additional harm.

Veterans who have experienced trauma, be it before, during, or after military service, may exhibit a variety of posttrauma responses in service settings. These behaviors can be best understood as adaptive responses to manage overwhelming stress. However, without

understanding the connection between trauma and current behaviors, providers may mislabel a veteran as “manipulative,” “oppositional,” “lazy,” or “unmotivated.”¹⁵ These types of negative labels impact how providers respond to veterans and the quality of services veterans receive.

Service environments may also inadvertently trigger posttrauma responses in veterans. Common experiences in service settings (e.g., being asked personal questions on assessments, long waits, strict rules) may trigger the activation of a posttraumatic stress response leading to heightened reactions that may be misunderstood by providers as purposefully offensive, rude, or aggressive.^{1,16} Finally, without an understanding of trauma and its impact, service providers run the risk of retraumatizing the veterans they serve. Survivors, veteran or civilian, who are further traumatized within service systems by unrealistic demands and harsh responses by staff become increasingly wary of and triggered by *all* people’s efforts to help and may drop out of VA or community-based services altogether.^{15,17}

Common Posttrauma Responses¹

- Difficulty following through on commitments
- Avoiding meetings and other isolating behaviors
- Frequently engaging in interpersonal conflicts
- Becoming easily agitated and/or aggressive
- Demonstrating a lack of trust and/or feeling targeted by others
- Continued involvement in abusive relationships
- Active substance abuse

3. Mental health interventions for trauma are necessary but not sufficient.

A distinction is increasingly being made between trauma-specific services and trauma-informed care. The former refers to specific clinical interventions that treat posttrauma responses, whereas trauma-informed care refers to practices and policies implemented by entire organizations that involve their structure, culture, values, and operations.^{2,6,18}

Historically, treatment for trauma and PTSD has focused on the individual and been delivered by clinicians in one-on-one therapies, often in the mental health system. Research has demonstrated that various empirically supported treatment interventions are effective in treating PTSD.^{9,19} These clinical services are essential to advance the science and treatment of PTSD and improve outcomes for veterans; however, there are challenges to relying exclusively on mental health interventions to prevent, address, and mitigate the impact of trauma, including treatment limitations and lack of availability or access to quality care.

Despite the critical need for evidence-based treatments for PTSD, some show limited efficacy;¹⁹ drop-out rates for patients with PTSD are as high as 50%.²⁰ In some communities, mental health services and in particular, evidence-based treatments, may not be readily available, and if available, some groups (e.g., homeless veterans) often face barriers to

access. In addition, others may not be properly assessed for PTSD or may not meet the diagnostic threshold, and thus may never be referred for treatment. The VA's Special Committee on PTSD estimates that 15–20% of Iraq and Afghanistan veterans are “at risk for significant symptoms short of full diagnosis but severe enough to cause significant functional impairment.”²¹ Still others who are eligible for individual trauma treatment are hesitant to access that care for a variety of reasons, particularly the fear of stigma associated with accessing mental health services.

Veterans are being served in all service sectors. Integrating a trauma-informed approach in veteran service settings allows providers to meet the needs of all veterans, including those who may not be eligible or ready to access clinical interventions but could benefit from trauma-sensitive environments. Adopting trauma-informed care also places providers in a better position to identify veterans who may require more intensive clinical or “trauma-specific” services and help them access needed supports.

4. Becoming trauma-informed can improve quality of care for veterans.

Results of the current demonstration project suggest that adopting trauma-informed care can lead to shifts in staff perspective and practice that have significant implications for quality of care for veterans.

Reflections From the Field: Staff Reports of Changes in Perspective and Practice

“Before if a client was doing something that was not necessarily positive...the staff...would use language like ‘you are an addict; you are a loser; you are in shelter, get your life together.’ Trauma-informed care stops staff from judging the clients, they are now more understanding where the clients come from, and there is no judgment there with a trauma-informed approach.” —PROGRAM DIRECTOR

“Definitely, I see the change especially in the way our resident advisors treat the clients.... People tolerate more, they show more empathy, and they try to understand why a client is acting that way is because of this instead of seeing them in a more negative way and that comes from our own culture also.” —PROGRAM DIRECTOR

“I think for me, it helps me advocate better.... If there’s an issue, a challenge comes up and having a hard time, I can advocate for them now that I have a better understanding of why that behavior might be happening.... Especially when in the brain they stay in that survival place—I’m able to now recognize that more readily in people.” —CASE MANAGER

“[It has] given me the tools to really start to work on a different level with the women and for the women...now I know where they’re coming from. [It’s] not just mental health, personality or noncompliant—[there are] really reasons why they’re doing what they are doing.” —CASE MANAGER

Across focus groups, staff at the pilot sites reported gaining skills for their work which included

- a. an ability to be proactive rather than reactive because veteran behaviors were better understood and effective interventions could be used sooner;
- b. improved assessment of needs that has changed how veterans are served; and
- c. the ability to recognize how even a seemingly harmless event may be experienced as traumatic by someone who has a history of trauma, and how to respond appropriately.

5. Adopting trauma-informed care benefits service providers.

Service providers who work with trauma survivors are at risk of experiencing posttrauma responses similar to those of the people being served.^{22,23} This phenomenon, known as “secondary traumatic stress,” can have a significant impact on a service provider’s capacity to provide quality care.

A trauma-informed approach acknowledges the impact of this work on service providers and supports practices to build staff resilience in the face of stress. At an organizational level, this means an increased emphasis on provider self-care and building a supportive organizational culture for staff. Agencies that participated in the demonstration project to adopt trauma-informed care reported positive shifts in the work environment including enhanced communication and increased focus on secondary trauma and provider self-care.

Reflections From the Field: Staff Reflections on Changes to Work Environment and Staff Cohesion

“It helps us to understand one another, to be able to work with each other and understand that we all have trauma.” —CASE MANAGER

“Sometimes it can be a little bit challenging. Security might do things certain ways, clinicians might handle the same situation differently, [trauma-informed care] encourages conversation and a mutual understanding of what’s going on and why.” —CLINICAL DIRECTOR

“We have a client that almost died in one of our programs from an overdose and I probably have a dozen staff that came to me as the clinical manager and they were very concerned with what we were doing to support the staff member who came across the client...so I think there is an increased awareness that staff needs to be supported...there is much more of an awareness among the staff that a staff member they like and care about was going to be traumatized from the experience and we as an agency make sure that the staff is adequately supported. There wasn’t a heightened of awareness and concern before we started this process.” —CLINICAL MANAGER

How Do Organizations Become Trauma-Informed?

“As I think about personnel, it’s about shifting our culture—the way we view interacting with each other and veterans. A shift in the way everything is framed for the whole organization.”

—ADMINISTRATOR

In a trauma-informed organization, the entire system is viewed as a vehicle for intervention and all staff has a role to play. This shift in perspective and practice requires system-wide transformation—a collective, sustained effort to embed trauma-informed care across an agency. AIR/NCFH’s model for adopting trauma-informed care involves a series of phases, often overlapping and each building toward a fully trauma-informed organization. Piloted in three organizations serving homeless veterans, the model is flexible and can be applied to other systems of varied size and structure, or at differing starting points in the process. Project findings suggest that AIR/NCFH’s multiphased approach for integrating trauma-informed care is a promising model for systems change in veteran service settings.

Phase One—Awareness, Knowledge-Building, and Buy-In

AIR/NCFH launched *Trauma-Informed Care for Women Veterans Experiencing Homelessness* with introductory training to increase staff awareness and knowledge of the impact of trauma on veterans, and introduced trauma-informed care as an organization-wide response. Across the pilot sites, staff in a variety of roles attended initial trainings (e.g., case managers, supervisors, administrators). Early training with leadership and staff built a common awareness and understanding of trauma with the goal of increasing buy-in to the organizational change process. Over the life of the project, awareness and knowledge-building activities continued, and each site received additional trainings on trauma and trauma-informed care, self-care, crisis intervention, and trauma-informed supervision.

Early in Phase One, the three pilot sites established **multidisciplinary trauma working groups**. Working groups included staff in varied roles across agency departments who were charged with championing the change process and leading the organization in developing its commitment to trauma-informed care. These groups met regularly (at least monthly), identified and monitored short and long-term goals, provided feedback about further changes needed, and identified additional education and training opportunities for the program at large. The composition of the working groups varied depending on the focus of the agency as they began the change process. One site’s working group included approximately five staff, all of whom work directly with their women’s program. Two sites had working groups that included 8–10 staff from a range of departments, some who worked directly with women veterans, and others who work with men and women or mainly male veterans.

Phase One: Strategies for Success

“We tend to be very siloed, we are less siloed as an organization than we were a year ago, but we are not nearly where we want to be. So a working group together thinking of ideas we can do together and the interactions together...has been a big step.” —ADMINISTRATOR

1. **Gaining leadership buy-in.** Ensuring that the leadership of an organization (e.g., President/CEO, Vice President, Director) is fully committed to supporting system-wide transformation is critical to long-term success and sustainability. Actions that reflect true buy-in from leaders include: attending all training events; talking to staff about the agency commitment to trauma-informed care; attending or getting regular reports from the trauma working group; supporting working group members to make programmatic changes; and ensuring that champions and staff are able to fully engage in this process (e.g., providing adequate resources, time, coverage).
2. **Educating leadership.** Educating senior leadership is a critical strategy for establishing buy-in. Initial training sessions for leaders should include information on traumatic stress and its impact, core principles of trauma-informed care, and steps needed to become a trauma-informed organization. This education allows leaders to make an informed decision about how to move forward with the change process.
3. **Establishing and educating the trauma working group.** In addition to leadership buy-in, the trauma working group is a linchpin of organizational change. Establishing the working group represents the first formal, structural change towards becoming trauma-informed and sends the message that becoming trauma-informed is a collective effort. Working group members should represent staff in different roles across an agency who commit to championing this process. Establishing a multidisciplinary working group enhances staff buy-in and ensures all voices and perspectives are represented throughout the change process. Initial training in trauma concepts for the working group ensures leadership and staff are working from a common language and understanding. Like leaders, working group members should make an informed commitment to participating.
4. **Maintaining an agency-wide focus.** As organizations consider becoming trauma-informed, some may start by piloting the process in one program and expand to other programs within the agency over time. Ultimately, becoming trauma-informed is about changing culture and practice, which is most effective and sustainable when done agency-wide. For example, in the current demonstration project, all sites recognized that trauma-informed care would not just benefit women veterans, but male veterans as well, and to really change the culture, trauma-informed practices needed to be applied with all participants, across all programs.

Phase Two—Organizational Assessment and Strategic Planning

Phase Two focuses on assessing the organization to develop a roadmap for change. The AIR/NCFH *Organizational Self-Assessment for Providers Serving Female Veterans* (the *Self-Assessment*) is the only available tool specifically designed to guide organizations serving veterans in becoming trauma-informed. It was used in the demonstration project to guide program assessment and strategic planning during Phase Two of implementation. For this project, AIR/NCFH also developed a consumer version of the *Self-Assessment* used by women veterans at the pilot sites to assess their perception of organizational practices. The *Self-Assessment* includes concrete trauma-informed practices that can be integrated into daily programming across six domains. Each domain contains trauma-informed practices that could be integrated by a range of service settings for all as well as particular practices for serving women veterans.

Domains of the Organizational Self-Assessment:

1. Supporting Staff Development;
2. Creating a Safe and Supportive Environment;
3. Assessing and Planning Services;
4. Involving Consumers;
5. Adapting Policies; and
6. Working with Children.

During Phase Two, a cross-section of staff and women veterans at each site completed an online version of the *Self-Assessment*. AIR/NCFH compiled, summarized, and reviewed assessment results with each site and provided them with a strategic planning template to develop goals. Each site created a strategic plan for the project period that included short- and long-term goals for adopting trauma-informed care agency-wide across all programs serving male and female veterans. Sites targeted their strategic plans toward particular areas of focus based on assessment results.

Phase Two: Strategies for Success

“Part of it, for me, is for this team to not see this as a top-down thing, it should feel empowering to the staff...” —TRAUMA WORKING GROUP MEMBER

- 1. Choose a tool to assess your organization.** There are a number of tools that an organization can choose to assess current practices against core components of trauma-informed care. AIR/NCFH’s *Organizational Self-Assessment for Providers Serving Female Veterans* (the *Self-Assessment*) is a tool designed specifically for organizations serving homeless women veterans and is applicable for agencies that want to adopt trauma-informed care across programs serving men and women. Organizations can access this assessment tool at www.familyhomelessness.org.
- 2. Include staff in all roles in the assessment process.** All staff should be involved in the organizational assessment process. This includes administrative staff, case managers, clinicians, maintenance, direct care staff, and those on day, evening, and overnight shifts. Staff in different roles may have different perspectives on how the agency operates that will help identify areas for communication, clarification, and education moving forward. It should be made clear to staff that they are assessing the organization as a whole and not their individual performance. Staff responses should be anonymous, and staff should be encouraged to answer honestly without fear of reprisal.
- 3. Identify target areas for change and develop an action plan.** Goals should be broken down in a way that makes them achievable and realistic and meets the development needs of all staff in the organization. Short- and long-term goals should be included in action plans so that organizations are able to see progress. Goals should be presented to all staff for feedback and input and finalized by the working group.
- 4. Develop a feedback loop to keep all staff informed.** Organizations should develop a process for keeping the broader agency informed of the working group activities, plans for the agency, and progress toward goals. This may include regular updates in staff meetings, leadership meetings, and in all-staff emails or newsletters. Additional strategies include conducting regular (quarterly or semiannual) staff surveys and focus groups to assess the extent to which changes are reaching all staff and influencing daily practice.

Phase Three—Capacity-Building and Sustainability

During Phase Three, AIR/NCFH provided training and consultation to support sites to achieve identified goals based on the assessment process. Each site chose to focus on particular domains of programming; however, all made staff development the top priority. Sites found their own unique ways to begin a long-term process of ensuring that all staff have at least a basic understanding of traumatic stress and its impact on the veterans in their programs (see the second brief in this series, *Trauma-Informed Care for Veterans Experiencing Homelessness: Building Workforce Capacity* for a specific focus on staff development needs).

The six domains of AIR/NCFH’s trauma-informed care curriculum to target for capacity building and sustainability are presented below, along with concrete examples for implementation.

Activities for Capacity Building and Sustainability	
Domain	Examples
Supporting Staff Development	Provide core training to all staff on trauma and trauma-informed care. Ensure a process for ongoing training for all staff and new hires and ways to practice skills to support trauma-informed responses. Establish organizational processes to address the impact of the work on staff (e.g., secondary traumatic stress) and a supportive culture for staff.
Creating a Safe and Supportive Environment	Establish a safe and welcoming physical space. Establish a supportive environment that includes processes to ensure cultural awareness, privacy and confidentiality, safety and crisis prevention planning, consistency and predictability, and open and respectful communication.
Assessing and Planning Services	Consider what types of questions are included on assessments (e.g., cultural background, strengths, history of trauma) and how assessments are conducted to emphasize safety and compassion. Develop a process for creating goals that is collaborative and ensures that emotional and instrumental supports are considered.
Involving Consumers	Develop a formal process for involving veterans who are currently receiving services in decision making about programming. Include formal ways to gather feedback and include participant voices. Involve veterans with similar lived experiences in program development and support to current participants.
Adapting Policies	Examine all policies to ensure that they align with the principles of trauma-informed care. Create additional policies to support agency commitment to trauma-informed care. Develop a formal process for reviewing policies to identify whether they align with a trauma-informed approach, and include staff and participants in this review process.
Working with Children	Ensure that each child in the program receives a thorough assessment and provide children with access to services and supports that recognize, address, and mitigate the impact of trauma on development.

Phase Three: Strategies for Success

“Staff—all the staff—clinical and operational—are starting to shift their thinking. What’s made the most difference has been for staff to work on concepts...I can see people letting go of their old ways.” –ADMINISTRATOR

1. **Invest in outside consultation.** When an organization is beginning the process of becoming trauma-informed, they often need support from professionals outside the agency who can provide initial training and ongoing consultation early in the process. Over time, the need for outside consultation will lessen as organizations gradually take over more of the education for their staff; however, it is always helpful to maintain ongoing relationships with consultants as needed.
2. **Prioritize Staff Development.** Educating and supporting staff is the first step toward building a trauma-informed organization. Providing all staff with education on trauma and its impact and the principles of trauma-informed care takes time, energy, and resources; however, it is critical to culture change. Managers receive training on trauma-informed supervision to reinforce trauma concepts and model the principles of trauma-informed care in their relationships with their staff. Education about secondary traumatic stress and vicarious trauma helps staff and supervisors recognize trauma responses in themselves and their staff, and focuses on creating work environments that support staff wellness and the delivery of quality care by engaged providers.
3. **Develop mechanisms for sustaining shifts in knowledge and practice.** Organizations should develop mechanisms for providing and reinforcing trauma training. Processes may include: developing a training that is used as a yearly refresher for all and for every new hire and integrating trauma language and applying concepts in some way at all department meetings, all staff meetings, and individual supervision sessions.
4. **Reassess progress regularly.** Review short-term and long-term goals regularly. Programs can do a yearly re-assessment of their program to identify changes. Other assessment tools include staff and consumer surveys, focus groups, and individual interviews that can be done at various times of the year.
5. **Evaluate impact.** Organizations should clearly document changes and evaluate the impact of adopting trauma-informed care. Specific methods of data collection should be formally identified as part of the strategic plan. Quantitative data may be collected through methods such as surveys, record reviews, and analysis of existing program data, or through proxy organizational climate scales. Qualitative information can be collected through focus groups and interviews with consumers and staff, observations, and case studies.
6. **Build communities of practice.** Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly.²⁴ Organizations looking to adopt trauma-informed care can benefit from networking with other agencies that are also committed to becoming trauma-informed. This type of cross-agency collaboration allows people to share new ideas, lessons learned, and strategies for success.
7. **Educate others.** Finally, as organizations become trauma-informed, they often express a desire to share what they have learned with others who work with their population about trauma-informed care. Providing community partners who work with veterans with information about what the agency has done to become trauma-informed and the impact of these efforts can help support organizations new to the process, as well as build cross-system collaboration to best meet the needs of veterans.

Conclusion

Veterans, both male and female, are heroic in their duty to our nation; although many suffer from the impact of traumatic experiences endured before, during, or after military service. Homeless veterans are an especially high-risk group. They not only need support to obtain housing, but services to address the high rates of trauma and help them stabilize in the community. Findings from a recent multisite demonstration project suggest that adopting trauma-informed care has the potential to enhance quality of care for veterans. The model outlined in this brief represents a promising approach to adopting trauma-informed care in homeless service settings and beyond to ensure that all veterans receive the best care possible.

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