TRAUMA-INFORMED CARE

for Women Veterans Experiencing Homelessness

A GUIDE FOR SERVICE PROVIDERS

WOMEN'S BUREAU
U.S. DEPARTMENT OF LABOR

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ACKNOWLEDGEMENTS

Trauma-Informed Care for Women Veterans Experiencing Homelessness was commissioned by the U.S. Department of Labor (DOL) Women's Bureau (WB) as one of its many efforts to help women veterans who are experiencing homelessness find jobs and successfully reintegrate back to civilian life. This document is an outcome of a two-phase Women's Bureau project that included coordination of listening sessions with women veterans experiencing homelessness and the subsequent development of quality resources for the community-based organizations that serve them. In addition to this document, the Women's Bureau has prepared fact sheets on the subject, conducted a "Woman-to-Woman Stand Down" for female veterans and is developing case studies to further shed light on the important issues affecting homeless women veterans.

Over the past several years, the federal government has made great strides in addressing the issue of homelessness among women veterans. The U.S. Department of Veterans Affairs (VA) has greatly expanded services for women veterans at medical centers and community-based outpatient clinics. The VA has teamed with the U.S. Department of Housing and Urban Development (HUD) in providing the HUD-VASH supportive housing voucher program and, under the leadership of Secretary of Labor Hilda L. Solis, the U.S. Department of Labor's Veterans' Employment and Training Service has initiated a separate Homeless Women Veterans and Homeless Veterans with Families program that awarded 26 employment assistance grants in fiscal year 2010.

Pursuant to a contract with the Women's Bureau, *Trauma-Informed Care for Women Veterans Experiencing Homelessness* was developed and written by The National Center on Family Homelessness (Kathleen Guarino, LMHC). Contributions were also made by community partners who participated in the pilot project: Interfaith Community Services, Oceanside, CA; St. Vincent De Paul Village, San Diego, CA; and Westcare's San Joaquin Valley Veterans, Fresno, CA. A number of individuals – including Suzanne Zerger, Dawn Jahn Moses, and Risa Greendlinger – provided feedback that greatly improved the quality and relevance of these materials.

For more information about this guide, or additional Women's Bureau projects for women veterans experiencing homelessness, please contact the U.S. Department of Labor Women's Bureau at (202) 693-6710 or visit the WB website at www.dol.gov/wb.

The Women's Bureau would like to acknowledge the tremendous effort and teamwork of its staff in making this project a success.

Special thanks to the women veterans who have served our country with distinction and who shared their experiences that greatly contributed to *Trauma-Informed Care for Women Veterans Experiencing Homelessness.*

Trauma-Informed Care for Women Veterans Experiencing Homelessness was adapted from the *Trauma-Informed Organizational Toolkit* that was developed by The National Center on Family Homelessness.

Dear Service Providers:

The number of women veterans serving our country has grown significantly over the last several years. Women are estimated to comprise 20 percent of new recruits, 14 percent of the current military, and approximately eight percent of the entire veteran population.

While the transition from military to civilian life is challenging for both male and female veterans, the trauma experienced by women veterans during military service often makes the transition more difficult for women and contributes to an increased risk of homelessness. Women veterans are more likely to end up homeless than women who have not served in the military. Over the last decade, the number of homeless women veterans has nearly doubled.

As Secretary of Labor, I am very concerned about this increase in homelessness and other challenges our women veterans face as they reintegrate back to their families, communities, and civilian workplaces. Too often women veterans are neither aware of the available services nor comfortable accessing them. Something must be done.

I am committed to addressing the issues that lead to increasing rates of homelessness among veterans, to shedding light on the challenges of homelessness, and to helping create solutions that bring about positive changes. The Labor Department's own Women's Bureau and Veterans' Employment and Training Service are part of this effort to ensure that women successfully transition back into the working world.

Last year, the Women's Bureau hosted a series of listening sessions with homeless female veterans and service providers across the country to gain further insight into reintegration challenges specific to our women veterans. As a result of these sessions, *Trauma-Informed Care for Women Veterans Experiencing Homelessness* was developed by the Women's Bureau to equip service providers with a deeper understanding of the unique experiences and needs of women veterans.

Members of our armed forces make enormous sacrifices for this nation. The least we owe them when they return to civilian life is a chance to earn a living, support their families, and have a stable place to rest their heads each night. This resource is an important tool for building capacity among providers to better serve our courageous women veterans.

HILDA L. SOLIS
Secretary
U.S. Department of Labor

WOMEN'S BUREAU
U.S. DEPARTMENT OF LABOR
90 YEARS: STILL WORKING

Greetings:

In 1920, two months before women were granted the right to vote, Congress created the Women's Bureau, an agency charged with safeguarding the interests of working women and advocating for their equality and economic security. After 90 years, the Women's Bureau continues to advance its mission, thus our anniversary theme: "90 Years: Still Working."

Today, the vision of the Women's Bureau is to empower all working women to achieve economic security by preparing them for higher-paying jobs, ensuring fair compensation, promoting workplace flexibility, and helping homeless women veterans reintegrate into the workforce.

At this time in our Nation's history, we have more women serving in the military than ever. The number of women serving in our Armed Forces is steadily rising. Currently, there are 1.8 million women veterans.

The Women's Bureau recently hosted a series of listening sessions with homeless women veterans and service providers across the country. The primary objective was to gain further insight into the factors that lead to homelessness among women veterans, as well as how to improve services and resources for this population.

The sessions revealed that the experience of multiple traumas severely impacts the woman veteran's ability to readjust to civilian life. The most vulnerable women veterans informed us that their needs are not being met. Their stories made clear that these multiple traumas increase the risk factors for homelessness.

Consequently, the Women's Bureau commissioned *Trauma-Informed Care for Women Veterans Experiencing Homelessness*. This guide seeks to share the unique experiences and needs of women veterans, while providing organizational self-assessment tools to service providers on how to appropriately treat this population. The guide underscores the need for organizations to recognize how trauma from military experiences impacts the reintegration process for women veterans and offers a comprehensive approach to help organizations create effective trauma-informed care environments.

The Women's Bureau proudly salutes our women veterans for serving our country with honor and distinction.

SARA MANZANO-DIAZ
Director
Women's Bureau, U.S. Department of Labor

DEDICATION

Trauma-Informed Care for Women Veterans Experiencing Homelessness is dedicated to the female veterans who shared their experiences and insights throughout the project and to all of the women who have served our country.

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INTRODUCTION

The number of women in the military – both active duty and veteran populations – is growing rapidly. They face unusual challenges because of their military experiences and for many, multiple roles as breadwinner, parent, and spouse. Often their return to civilian life is difficult. An estimated 75,609 veterans are homeless, sheltered or unsheltered, on any given night. Women were 10,214 (7.5%) of the 136,334 homeless veterans who were sheltered sometime between October 1, 2008 and September 30, 2009 (U.S. Department of Housing and Urban Development and U.S. Department of Veterans Affairs). Female veterans have a greater risk of homelessness compared to their civilian counterparts. Risk of homelessness for recent veterans, particularly women who served in Iraq and/or Afghanistan, is increasing.

The experience of trauma prior to enlistment coupled with trauma experienced while in uniform is a common denominator among homeless female veterans. Research suggests that 81-93% of female veterans have been exposed to some type of trauma, significantly higher rates than the civilian population (Zinzow et al., 2007). Traumatic experiences include childhood abuse and neglect, domestic violence, military sexual trauma, and combat-related stress. These experiences have a significant impact on mental and physical health, family relationships, and housing and job stability.

Trauma Informed Care for Women Veterans Experiencing Homelessness is designed to be used by community-based service agencies that work with homeless female veterans in a variety of settings (e.g., emergency shelters, domestic violence shelters, transitional and supportive housing programs, outpatient settings). Leaders within these organizations who are looking to improve their effectiveness in engaging the female veterans they serve can use this guide to begin the process of becoming trauma-informed. *Trauma-Informed Care for Women Veterans Experiencing Homelessness* includes:

1. A user's guide that offers organizations:
    - Information on the experiences and needs of female veterans, what it means to provide trauma-informed care to this population, and resources for staff training and education.
    - Background information on the *Organizational Self-Assessment for Providers Serving Female Veterans* (the *Self-Assessment*).
    - A step-by-step process for using the *Self-Assessment* to incorporate new practices and institute change.
2. The *Organizational Self-Assessment for Providers Serving Female Veterans*. The *Self-Assessment* consists of concrete trauma-informed practices that can be integrated into daily programming within organizations serving female veterans who are homeless.
3. Resource Lists consisting of printed materials, videos, and websites on the following topics: Female Veterans, General Trauma Information, Homelessness and Trauma, Cultural Competence, Trauma-Informed Services, Consumer Involvement, and Self-Care for Service Providers.

Community-based organizations can achieve the goal of effectively delivering trauma-informed services if they combine the process and information contained in *Trauma-Informed Care for Women Veterans Experiencing Homelessness* with training and knowledge of the unique needs of the populations they serve.

SECTION 1

UNDERSTANDING THE EXPERIENCES AND NEEDS OF FEMALE VETERANS

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UNDERSTANDING THE EXPERIENCES AND NEEDS OF FEMALE VETERANS

I. Background

The percentage of women in the military and among the ranks of veterans is growing dramatically. Female deployment has increased exponentially from 41,000 in the Gulf War to more than 200,000 in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) (Women in Military Service for America Memorial Foundation, Inc., 2009). Women serve in all branches of the military, but are most likely to serve in the Army and least likely to serve in the Coast Guard (Women in Military Service for America Memorial Foundation, Inc., 2009). Throughout U.S. military history, various rules and regulations have limited official involvement, rank attainment, and role within the services (Murdoch et al., 2006). However, this is changing, and in OEF/OIF more women have been in combat-related roles (Alvarez, 2009; LaBash et al., 2009). In addition, assignment to supply operations in the OEF/OIF theatres means female service members frequently fight alongside their male counterparts in stark contrast to the back line historic role of supply operations (Alvarez, 2009).

FEMALE VETERANS

According to U.S. Department of Veterans Affairs (VA) estimates, the number of female veterans will grow from 1.8 million (8.2% of all veterans) in 2010 to 2.1 million (15.2%) in 2036. At the same time, the number of male veterans is expected to decline. Women veterans are up to four times more likely to: 1) be younger than their male counterparts, with a median age of 47 for female veterans versus 61 for male veterans; 2) identify themselves as a racial minority; 3) have lower incomes than male veterans; and 4) be unemployed (U.S. Department of Veterans Affairs, 2006). Prior to the recent recession, female veterans ages 18-24 had an unemployment rate of 16% – double that of their non-veteran counterparts and higher than male veterans in the same age group (Foster & Vince, 2009).

Female Service Members:

- 14% of Active Duty force
- 18% of National Guard and Reserve
- 20% are new recruits
- 11% are single parents, compared to 4% of military males

Increased Female Deployment:

- 41,000 in Gulf War
- About 200,000 in OEF/OIF

(Foster & Vince, 2009)

SERVICE NEEDS AND UTILIZATION

Increasing numbers of women in the military and the expanding role of women in theatre reinforces the need

VA has taken some steps to improve the availability of services for women veterans, including requiring that all VA medical facilities make the Women Veterans Program Manager – an advocate for the needs of women veterans – a full-time position and providing funding for equipment to help VA medical facilities improve health care services for women veterans. Additionally, in November 2008, VA began a system-wide initiative to make comprehensive primary care for women veterans available at all VA medical centers and community-based outpatient clinics. In announcing this initiative, VA established a policy defining comprehensive primary care for women veterans as the availability of complete primary care – including routine detection and management of acute and chronic illness, preventative care, gender-specific care, and mental health care – from one primary care provider at one site. (U.S. Government Accountability Office, 2010)

MILITARY SEXUAL TRAUMA

The VA defines Military Sexual Trauma (MST) as "sexual harassment that is threatening in character or physical assault of a sexual nature that occurred while the victim was in the military, regardless of geographic location of the trauma, gender of victim, or the relationship to the perpetrator."

for physical and psychological services for returning women veterans. In 2003, experts forecasted that the percentage of female veterans seeking services at the VA would double in the next 10 years because of women's increased presence in the military and the high costs of alternative medical care (Gamache et al., 2003). The increase in female veterans has caused demand for women's health care in the VA to steadily increase (Kelly et al., 2008). Women's health care in the VA has significantly expanded in response and now includes, for example, prenatal care, maternity services, and fertility treatments (Washington, Caffrey, Goldzweig, Simon & Yano, 2003). Female veterans may also receive care in separate women's health clinics, which have increased in number in the past several years (Yano, Goldzweig, Canelo & Washington, 2006). In these clinics, which tend to have more female providers than do traditional VA centers, there is a focus on women's health. (Yano, Washington, Goldzweig, Caffrey & Turner, 2003). In addition, recent legislation known as the Caregivers and Veterans Omnibus Health Services Act adds VA funds to expand health care for female veterans.

Despite these efforts to improve women's health services, there is evidence that female veterans are less likely to choose the VA as a care provider than male veterans (Perl, 2009, Williamson, 2009). In fiscal year 2007, 15% of women veterans used VA's health care services, compared to 22% of male veterans (U.S. Government Accountability Office, 2010). Women who had experienced combat were more likely to feel that services provided at the Veterans Health Administration (VHA) were too male-centered (Kelly et al., 2008). A study found that, while providers at VHA centers were knowledgeable and supportive of female patients, many providers lacked a complete understanding of the increased likelihood of a female patient being in a caregiver role and its implications for her health (Vogt et al., 2001). Female survivors of military sexual trauma do not always feel comfortable using the VHA (Kelly et al., 2008). Women who use VA services at higher rates have certain characteristics, including being older, unmarried, not having children, and having lower socioeconomic status than less frequent users (Ouimette, Wolfe, Daley & Gima, 2003). Please see Appendix 2 (p. 81) for information about services provided by Women Veterans Health Strategic Health Care Group.

EXPERIENCES OF TRAUMA

Research suggests that 81-93% of female veterans have been exposed to some type of trauma (Zinzow et al., 2007). Rates of trauma for female veterans are significantly higher than those of the civilian population. Often these experiences begin prior to military service. Researchers have found that more than half of female veterans experienced some type of trauma or abuse before joining the military. Twenty-seven to 49% of women veterans experienced childhood sexual abuse and 35% have experienced childhood physical abuse (Zinzow et al., 2007). Traumatic experiences continue in adulthood with 29-40% of female veterans experiencing sexual assault and about half experiencing physical assault. Domestic violence is a significant issue for this population, as 18-19% of female veterans have experienced it (Zinzow et al., 2007). In a 2002 survey of active duty military women, more than one out of every five reported physical and/or sexual assault by intimate partners, often partners who were active duty or retired military.

Military Sexual Trauma (MST) in the form of sexual harassment and assault remains a significant concern for female soldiers. Twenty percent of female veterans who served in Iraq and Afghanistan have been identified as having experienced MST (U.S. Department of Veterans Affairs, 2010). According to the Department of Defense, approximately one in three military women has been sexually assaulted compared to one in six civilians (Foster & Vince, 2009).

Prevalence of military sexual assault among female veterans ranges from 20-48%, and 80% of female veterans have reported being sexually harassed (Foster & Vince, 2009). Despite the implementation of prevention programs and improved reporting mechanisms, female soldiers continue to experience sexual harassment and assault and are reluctant to report incidences. Of significant concern is this under-reporting of MST and a lack of

information about services for survivors of MST.

In addition to the high rates of MST, women in the military face challenges that may differ from their male colleagues. According to a report by Iraq and Afghanistan Veterans of America, more than 40% have children and approximately 30,000 single mothers have been deployed. Women report higher levels of stress over the impact of their deployment on family and relationships (Vogt, Pless, King & King, 2005). Due to these factors, women are less likely to feel prepared for deployment than men (Carney et al., 2003) and are often highly stressed (Vogt et al., 2005). Women are in the minority when serving in the military and have fewer opportunities for peer support, which may lead to feelings of isolation (Myers, 2009; Vogt et al., 2005).

Traumatic experiences can have a significant impact on a person's overall health and well-being. The effects of multiple experiences of trauma, such as those that are statistically common among female veterans, may include: difficulties trusting others and forming and maintaining healthy relationships; struggles understanding, talking about and managing feelings; adopting high-risk behaviors as coping mechanisms (e.g., eating disorders, substance abuse, self-harm, sexual promiscuity, violence); and developing severe and persistent physical and mental health issues such as post-traumatic stress disorder (PTSD). The impact of military sexual trauma on female veterans is especially pronounced. Female veterans assaulted in the military are nine times more likely to exhibit PTSD symptoms; are more likely to have problems with alcohol or drugs; have lower economic and educational outcomes; and experience difficulty maintaining relationships as well as stable housing and employment.

HOMELESSNESS

Experiences of trauma and the subsequent impact on daily functioning can present a significant challenge as women veterans readjust to civilian life, and can be a risk factor for homelessness (Perl, 2009). Research indicates that female veterans who experience MST, for example, are at a higher risk for a variety of problems, from PTSD to homelessness (Gamache, Rosenheck, & Tessler, 2003). Indeed, rates of homelessness among female veterans are of growing concern. Female veterans are at four times greater risk of homelessness than their civilian counterparts (Foster, 2010).

Female veterans who are homeless or at risk of homelessness have tremendous service needs, many of which are going unmet. Needs include therapy to address the impact of trauma; supportive services that create community among veterans, such as linkages to faith-based communities; transitional employment and job training; safe living environments; and options for substance abuse treatment (The National Center on Family Homelessness, 2009). Since mixed-gender living arrangements and therapy groups can present risks for sexual harassment and assault and can invite interactions that are reminiscent of perpetrator–victim relationships, separate female veteran homelessness transitional housing programs that are not co-located with programs/housing for male veterans are recommended (The National Center on Family Homelessness, 2009).

The VA has enhanced current programs and implemented new initiatives to address homelessness among veterans. Many of these programs have the capacity to serve women, including women with children. However, this subsection of the

Symptoms of Post-Traumatic Stress Disorder

Avoidance – Avoiding situations or experiences that remind the person of a past traumatic experience.

Hyperarousal – A persistent feeling of heightened anxiety that includes being constantly on alert for danger and focused on survival.

Re-experiencing – Re-experiencing the traumatic event in the form of flashbacks, nightmares, intrusive thoughts, images, etc.

Emotional Numbing – Disconnecting or "dissociating" from overwhelming feelings associated with the traumatic experience. This disconnection can lead to difficulties feeling and expressing a range of positive and negative emotions.

(Monson et al., 2009)

female veteran population is expected to increase and additional special services will be needed.

II. U.S. Department of Labor Women's Bureau Demonstration Project: Women Veterans Who Are Homeless

The U.S. Department of Labor Women's Bureau's mission is to improve the status of wage-earning women, improve their working conditions, increase their efficiency, and advance their opportunities for profitable employment. This mission encompasses helping women veterans who are homeless to find gainful employment, thereby restoring them to financial stability. In the summer of 2009, to address the growing issue of homelessness among female veterans and the need for clarity regarding the service needs of this population, the Bureau designed the Women Veterans Who Are Homeless Demonstration Project. This project funded pilot programs in the seven states with the highest concentrations of homeless female veterans (California, Kansas, New York, Oregon, Pennsylvania, Texas and Washington) to gain a better understanding of the needs of this population and to inform the competitive solicitation process for new Homeless Female Veterans and Homeless Veterans with Families Program grants that were issued in the spring of 2010 by the U.S. Department of Labor Veterans' Employment and Training Service. Twenty-six grants in 14 states and the District of Columbia will provide job training, counseling, and placement services (including job readiness, and literacy and skills training) to expedite the reintegration of homeless female veterans into the labor force. The program will provide services to more than 2,300 female veterans who are homeless and is being carried out in coordination with the Women's Bureau.

The National Center partnered with the Women's Bureau, Region IX (San Francisco) to conduct a two-phase pilot program to listen to California's homeless female veterans and service providers and design a strategy for meeting the needs of this population. During Phase One, The National Center conducted listening sessions with homeless female veterans and community-based service providers in San Diego County. These sessions focused on: women's experiences in the military and as veterans; factors that lead to homelessness; challenges in overcoming homelessness; services available to women veterans; and barriers to accessing services. These listening sessions were part of a broader series of sessions with female homeless veterans that were sponsored by the Women's Bureau in the other six states with the highest concentration of homeless female veterans. Towards the conclusion of the project, the Women's Bureau decided to augment the project and include a series of listening sessions in Florida (Tampa Bay area) because of the recorded large total number of homeless veterans, male and female. Information from these multi-site listening sessions was synthesized into a national report for the Veterans' Employment and Training Service. The information that follows captures the main findings from the listening sessions with female veterans and represents anecdotal experiences that were voiced by these women.

FINDINGS FROM THE CALIFORNIA WOMEN VETERANS WHO ARE HOMELESS LISTENING SESSIONS

The findings from the listening sessions echo much of the current literature on the experiences and service needs of homeless female veterans. Themes of violence and trauma in childhood and adulthood were pronounced, as was expressed frustration concerning the paucity of services for female veterans and more specifically, homeless female veterans. The National Center incorporated the listening session information into the development of *Trauma-Informed Care for Women Veterans Experiencing Homelessness* during Phase Two of the pilot program. The following is a summary of the key findings from the Region IX Phase One listening sessions:

Female veterans who are homeless have significant histories of trauma.

The female veterans who participated in the listening sessions had experienced multiple layers of trauma, both systemic and interpersonal, that contributed to their current experience of homelessness. Traumatic experiences included: childhood abuse; intimate partner violence; combat-related stress; military sexual trauma; and the loss of social supports and stable housing.

A common theme across listening sessions involved the stress associated with being a female service member in a predominately male-oriented military culture where power imbalances, harassment, and sexual assault were prevalent. The women used phrases such as "*the boy's network*" and a "*male-dominated world*" to describe the military culture. Most of the women felt that in the military there is "*a lot more pressure on women*" and women have to work "*twice as hard as men.*" Experiences

of sexual harassment and sexual assault while in the military were also common. As one woman explains, "*I heard that they want to say PTSD is only combat-related. What about those raped in the military? . . . Trauma is trauma. Some women come into the military with stuff from their childhood and that exacerbates, especially when you have to prove yourself equal to the guys. You think you're fine, and then something comes up. We have been shoved off to the side for so long, and given so much less than the men, it's time for the women to start fighting back.*" Though some women had positive experiences while in the military (e.g., having access to additional educational opportunities or career advancement), being a female service member has unique stressors apart from combat-related experiences. As one participant expressed, "*The stress of surviving as a woman in the military is its own type of trauma.*" Whether surviving military sexual trauma or surviving in a male-dominated culture, these experiences have a significant adverse long-term impact.

In addition to military trauma, listening session participants struggled with their own experiences of violence and trauma in childhood and adulthood. As one participant explained, "*We all joined the military to get away from our families.*" Another stated, "*I joined the military to get away from abuse as a child,*" and another shared, "*I grew up with low self-esteem and depression.*" Many of the participants were also survivors of domestic violence. One woman commented, "*DV starts the downward spiral . . . You end up homeless and afraid.*" Similar comments were echoed by others in the sessions. "*When I got into domestic violence – brutal from the very beginning – I didn't know how to deal with it, get out of it, or handle it at all.*"

Exposure to trauma impacts all aspects of daily functioning.

The impact of the traumas described by participants was overlapping and devastating. Repeated experiences of trauma both within and outside of the military environment contributed to a high prevalence of substance abuse, mental health issues, difficulty accessing and maintaining employment, and difficulty accessing services and supports. This section includes examples shared by some of the women veterans about how these factors contributed to their homelessness.

Experiences in the military had a profound impact on these participants. One woman explained, "*When I was in the Navy in 1979, I was raped. I was never treated by the military for anything*" and suggested "*Maybe I have problems now because I didn't address the issue originally.*" Several of these women linked their military service to subsequent struggles with substance abuse. They described the frequent use of alcohol while in the military. One woman shared, "*I didn't drink a lot before, but within a few months [of joining the military] I went to mandatory rehab.*" Military sexual trauma was another source of stress connected to substance use: "*There was a lot of sexual harassment and sexual assault that probably factored into my drinking more. I think my homelessness came from my poor choices because of my drinking.*"

The demand for self-reliance among women in the military and the pressure to prove that one is strong and capable creates a culture where seeking services is seen as a sign of weakness, further contributing to the risk of homelessness. As one participant said, "*The veterans are probably the last ones to go and ask for help.*" Providers agreed that women veterans are "*socialized not to seek help.*" They commented that reporting military sexual trauma is "*particularly difficult to reach out and get help for. You don't tell.*"

For most of the women in the listening sessions, the combination of violence in adulthood and childhood trauma resulted in struggles with addiction that contributed to their homelessness. One woman shared, "*[I had] PTSD through circumstances in the military. [The] last few years of my marriage were very mentally abusing . . . left me with scars, depression. I grew up with low self-esteem and depression. Mental abuse was like a hole that I couldn't get out of. On the outside it looked like I could do the part. Could get a good job but couldn't maintain it. Physical heals, the mental does not.*" Another woman explained, "*I filled my pockets in the drug world, trying to get out of this relationship I was in.*" The presence of mental health issues prior to entering the military adds another layer of trauma that further complicates the current situation. One participant identified untreated mental illness as a factor in her homelessness. "*I used and numbed, became suicidal [and] did not know where to go or how to get help.*" Another shared, "*I fight addiction, I'm on psych meds – so mine has been a combination of things.*" Service providers agree that past traumatic experiences contribute to the current difficulties that many homeless women veterans experience interacting with others and maintaining stable employment and housing.

Female veterans do not always self-identify.

Many of the women who participated in the listening sessions did not self-identify as veterans, and felt society in general did not readily acknowledge female veterans or their needs. A few of the comments we heard included:

"When you think veterans – you don't think of women. As much as society is trying to change, it's still a man's world."
—Female Veteran

"I thought veteran meant you had been in combat. If in church, on Veteran's Day, I don't want to stand up. I don't want to raise my hand. It just doesn't seem right to me."
—Female Veteran

"I never thought of myself as a veteran even though I served. I didn't think those words applied to me."
—Female Veteran

This lack of identification with veteran status is a barrier to seeking veteran-specific services. Service providers also noted that many women did not identify their military experiences as sources of potential trauma for which they could receive supportive services. One homeless program director put it this way, "*The segment of the population we serve is so focused on their day to day survival that being a veteran may not be part of their identity but it is part of their history.*"

Women saw themselves as wives, mothers, and survivors of addiction and violence. However, their lack of connection to their veteran status meant that they were less likely to be aware of and access the benefits and resources that they earned based on their time in the military.

Female veterans often find themselves without a support network.

Isolation and a lack of social supports was also a common factor contributing to homelessness. One woman reflected, "*Things began to spiral down after a while. I became subservient in marriage, lost female friendships, felt isolated.*"

Another woman explained, "*A lot of women join the services to get away from what you had. [You] get out of the service, don't want to go back, have no connections, [you are in a] strange place, don't have anybody. People will party with you before they will feed you. You don't know how you crossed the line; you don't know how to get back. You're just lost, not having any resources and anyone you can trust.*" Others talked about the military as being their only family. Once discharged, many of the women stayed in the same geographical area where they were stationed, though they had no connections outside of the military.

"Some women come into the military with stuff from their childhood and that exacerbates, especially when you have to prove yourself equal to the guys."
—Female Veteran

Services that are trauma-informed and tailored to female veterans are minimal.

Participants in all listening sessions agreed that there are very few services available for women veterans in general and even fewer for women veterans experiencing homelessness. As one woman expressed, "*We're the forgotten veterans.*" One participant noted, "*There seems to be so much more out there in the way of programs, shelters, sobriety homes – so much more for men,*" and another expressed, "*A Vet's a Vet – they should have things for everyone.*" The range of services is also limited, so if a group setting or type of group or treatment does not work, few other services are available. Women specifically expressed frustration at the lack of services for survivors of intimate partner violence.

The women expressed an overall need for more services and programs for women and more spaces for women within existing programs. In general, the women who participated in the listening sessions seemed less likely to participate in programs that were perceived as mainly designed for men. Women were looking for programs that offered "culturally competent" service provision (e.g., services designed with an understanding of and an ability to meet the unique needs of women who are also veterans and experiencing homelessness). Some women described positive experiences with individual service providers who were "*thoughtful about the situation,*" provided support for a range of issues, helped women access services, and served as advocates. As one participant summarized, "*We need networking groups and safe places with the right people to direct us down the pathways we want to go.*"

Participants also agreed that there is little outreach and communication about the few available services and programs. Many women veterans found the transition out of the military into civilian life difficult and that resources to assist them were inadequate or non-existent. As one participant said, "*There's a big gap when you're leaving the military. They keep secrets. It's like they keep all the resources tight and close, if you're special enough maybe they'll tell you.*"

Across sessions, women said that they were unaware of available services for women veterans and/or confused regarding their eligibility for services. Regardless of age or time served in the military, these women were confused about benefits and the purpose of the VA.

Community-based service providers also expressed confusion regarding how to best support women veterans within their programs. They acknowledged that many programs are designed for men, and there is a limited understanding of how to change both the physical environment and the culture of an organization once women are admitted. There is a lack of communication between community-based and veteran-specific service providers such as the VA or Vet Centers regarding available services.

"We need networking groups and safe places with the right people to direct us down the pathways we want to go."
—Female Veteran

Service provider working with female veterans seeking assistance.

Based on the results of the listening sessions, The National Center designed a strategy during Phase Two of the pilot program to address the following key issues:

- **Homeless female veterans have experienced traumatic stress.** Research and conversations with homeless female veterans suggest that most of these women have experienced some form of trauma (Zinzow et al., 2007). Many female veterans have experienced multiple traumas before, during, and after military service. Traumatic experiences include childhood abuse, violent relationships, and military sexual trauma. In addition, the experience of being homeless is, in and of itself, traumatic (Goodman and Harvey, 1991).
- **Responses to traumatic stress are adaptive.** In the face of traumatic experiences, people learn to adapt to keep themselves safe. Responses to traumatic stress may include withdrawing from others, becoming aggressive, dissociating ("spacing out" or disconnecting from certain thoughts, feelings, or memories associated with traumatic experiences), engaging in self-injurious behaviors such as cutting, or abusing substances in an effort to manage overwhelming feelings. The National Center found that many of the homeless female veterans who participated in the listening sessions struggled with mental health issues and substance abuse that had a significant impact on their ability to manage day to day. While these behaviors may appear to be unhealthy or ineffective to providers, they should be understood as coping skills that were once useful in the past, and which can slowly be replaced with healthier alternatives.
- **Trauma impacts how female veterans access services.** People who have experienced ongoing trauma may view the world and other people as unsafe. Those who have repeatedly been hurt by others may come to believe that people cannot be trusted. This lack of trust and a need to be constantly on guard for danger makes it difficult for people to ask for help, trust providers, or form relationships. For homeless female veterans, these challenges are compounded by the absence of services for women veterans and the perceived lack of acknowledgement of and respect for their service.
- **Homeless female veterans require specific, tailored interventions.** Healing for trauma survivors, specifically female veterans, is not supported by "one size fits all" services that fail to consider trauma and its impact. In addition to addressing the impact of trauma, female veterans require services that are specifically tailored to their experiences as military service members. How an organization responds to the needs of female veterans who have experienced trauma has a significant impact on their process of recovery. Currently, there are no clearly defined guidelines or strategies for providing trauma-informed care to female veterans who are homeless. There is a growing need for trauma-informed tools and program models for serving homeless female veterans that can be implemented and evaluated in an effort to garner a set of best practices for working with this population.

SECTION 2

PROVIDING TRAUMA-INFORMED CARE IN HOMELESS SERVICE SETTINGS

SECTION 2 PROVIDING TRAUMA-INFORMED CARE IN HOMELESS SERVICE SETTINGS

I. Defining Trauma-Informed Care

Some people experience very few traumatic events over the course of a lifetime, while others are chronically exposed to traumatic experiences. Research and first-hand knowledge tells us that the rate of trauma is extraordinarily high for those who are homeless. In the case of homeless female veterans, traumatic experiences often include childhood abuse, domestic violence, and experiences in the military (including combat-related trauma and military sexual trauma). In addition, the loss of place, safety, stability, and community associated with homelessness is, in and of itself, traumatic. These experiences have a significant impact on how people understand themselves, the world and others. As traumatic experiences accumulate, responses become more intense and have a greater impact on functioning. Ongoing exposure to traumatic stress can impact all areas of people's lives, including biological, cognitive, and emotional functioning; social interactions/relationships; and identity formation.

"The veterans are probably the last ones to go and ask for help."
—Female Veteran

Because people who have experienced multiple traumas do not relate to the world in the same way as those who have not had these experiences, they require services and responses that are tailored to their needs. In response to the impact of trauma on people experiencing homelessness, the homelessness field is moving toward a new way of providing care. People can and do recover from trauma, and it is imperative to design services and service environments that best support healing. Meeting the needs of trauma survivors requires that organizations become "trauma-informed" (Harris & Fallot, 2001). Providing "trauma-informed" care involves using what we know about trauma and its impact to respond differently. Maxine Harris (2004) describes a trauma-informed service system as "a human services or health care system whose primary mission is altered by virtue of knowledge about trauma and the impact it has on the lives of consumers receiving services." This means looking at all aspects of programming through a trauma lens, constantly keeping in mind how traumatic experiences impact consumers. Organizations that are informed by an understanding of trauma respond best to consumer needs and avoid engaging in practices that may cause additional harm. This type of change requires providers at all levels and in all roles and organizations as a whole to modify what they do based on an understanding of the impact of trauma and the specific needs of trauma survivors.

What makes an experience traumatic?

- The experience involves a threat to one's physical or emotional well-being.
- It is overwhelming.
- It results in intense feelings of fear and lack of control.
- It leaves people feeling helpless.
- It changes the way a person understands themselves, the world, and others.

(American Psychiatric Association, 2000)

FOUNDATIONAL PRINCIPLES

The National Center has identified eight foundational principles that represent the core values of trauma-informed care. These principles were identified on the basis of knowledge about trauma and its impact, findings of the Co-Occurring Disorders and Violence Project (Moses, Reed, Mazelis, & D'Ambrosio, 2003), literature on therapeutic communities (Campling, 2001), and the work of Maxine Harris and Roger Fallot (Harris & Fallot, 2001; Fallot & Harris, 2002) and Sandra Bloom (Bloom, 2008). Principles of trauma-informed care include:

- **Understanding Trauma and its Impact.** Understanding traumatic stress and how it impacts people and recognizing that many behaviors and responses that may seem ineffective and unhealthy in the present, represent adaptive responses to past traumatic experiences.
- **Promoting Safety.** Establishing a safe physical and emotional environment where basic needs are met, safety measures are in place, and provider responses are consistent, predictable, and respectful.
- **Ensuring Cultural Competence.** Understanding how cultural context influences one's perception of and response to traumatic events and the recovery process; respecting diversity within the program, providing opportunities for consumers to engage in cultural rituals, and using interventions respectful of and specific to cultural backgrounds. When working with female veterans, this requires that programs ensure "military cultural competence," which includes knowledge of military language, acronyms, paperwork, service delivery systems, culture, and experiences of female military service members and veterans.
- **Supporting Consumer Control, Choice and Autonomy.** Helping consumers regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy; keeping consumers well-informed about all aspects of the system, outlining clear expectations, providing opportunities for consumers to make daily decisions and participate in the creation of personal goals, and maintaining awareness and respect for basic human rights and freedoms.
- **Sharing Power and Governance.** Promoting democracy and equalization of the power differentials across the agency; sharing power and decision-making across all levels of an organization, whether related to daily decisions or in the review and creation of policies and procedures.
- **Integrating Care.** Maintaining a holistic view of consumers and their process of healing and facilitating communication within and among service providers and systems.
- **Healing Happens in Relationship.** Believing that establishing safe, authentic, and positive relationships can be corrective and restorative to survivors of trauma.
- **Recovery is Possible.** Understanding that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for consumer and former consumer involvement at all levels of the system, facilitating peer support, focusing on strength and resiliency, and establishing future-oriented goals.

*Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings, (*Hopper et al., 2010) puts forth the following "consensus-based definition" of trauma-informed care based on principles identified by organizations including the National Child Traumatic Stress Network, The National Center on Family Homelessness, The National Association of State Mental Health Program Directors, and various workgroups, researchers, and expert panels: *Trauma-Informed Care is a strengths-based 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.* This definition reflects a set of core beliefs (e.g., trauma-awareness, safety, control, and strengths-based care) that should inform service provision for trauma survivors across service settings. Whether providing shelter and housing services, medical or mental health care, education or employment services, providers can adopt these trauma-informed principles to assist consumers in reaching goals and achieving success.

Shelter from the Storm identifies the following key components to providing trauma-informed care in homeless settings, for example: 1) staff training on trauma and its impact; 2) ongoing supervision and consultation to reinforce trauma-based concepts; 3) assessment and screening that include trauma history; and 4) trauma-informed services for children that include specialized programming, assessments, and resource coordination.

OUTCOMES OF TRAUMA-INFORMED SERVICE PROVISION

Shelter from the Storm identifies preliminary outcomes of trauma-informed care, such as:

- Improved functioning and a decrease in psychiatric symptoms and substance use in adults
- Increased housing stability
- A decrease in intensive services such as hospitalization and crisis intervention
- Enhanced self-identity and coping skills among children

Further research is needed to define and evaluate trauma-informed programming, particularly in homeless service settings and with special populations such as veterans.

II. Accessing Related Resources for Transforming Principles into Practice

In 2009, The National Center published the *Trauma-Informed Organizational Toolkit* (the *Toolkit*) to provide homeless service organizations with a roadmap for becoming trauma-informed. Developed over several years, the *Toolkit* served as the baseline for *Trauma-Informed Care for Women Veterans Experiencing Homelessness.* The information from the Phase One Listening Sessions, site visits, and input from veterans service providers participating in the Phase Two pilot program combined to adapt this baseline to address the specific needs of female veterans experiencing homelessness.

In addition to the foundational principles, community service providers should collaborate with the U.S. Department of Labor's One-Stop Career Centers, Job Corps, Office of National Response (dislocated workers' programs), Office of Unemployment Insurance, Office of Apprenticeship, and Veterans' Employment and Training Service. Community service providers should work with other Federal agencies as well, including the U.S. Department of Education's Rehabilitation Services Administration, and Office of Vocational and Adult Education; the U.S. Department of Housing and Urban Develpment's Office of Community Planning and Development (Community Development Block Grants and economic development programs); the U.S. Department of Health and Human Services' Administration for Children and Families (Temporary Assistance for Needy Families), Health Resources and Service Administration (Community Health Centers), and Center for Medicare and Medicaid Services (Medicaid); and the U.S. Department of Agriculture's Food and Nutrition Service (Supplemental Nutrition Assistance Program and Special Supplemental Nutrition Program for Women, Infants and Children).

SECTION 3

DEVELOPING AND PILOTING THE ORGANIZATIONAL SELF-ASSESSMENT FOR PROVIDERS SERVING FEMALE VETERANS

SECTION 3 SECTION THREE: DEVELOPING AND PILOTING THE ORGANIZATIONAL SELF-ASSESSMENT FOR PROVIDERS SERVING FEMALE VETERANS

I. U.S. Department of Labor Homeless Women Veterans Project: Phase Two

The *Organizational Self-Assessment for Providers Serving Female Veterans* (see Self-Assessment on p. 48) consists of concrete, "trauma-informed" practices that reflect the needs and ideas shared by women veterans and service providers during Phase One, as well as the areas of need identified in the literature (see The National Center on Family Homelessness Military Literature and Resource Review at www.familyhomelessness.org/media/100.pdf). Phase Two of the Homeless Women Veterans Project involved developing and piloting the *Self-Assessment* in three homeless service organizations in California and included the following key activities:

1. OUTREACH AND RECRUITMENT OF PILOT SITES

The National Center utilized relationships developed during Phase One of the U.S. Department of Labor Women's Bureau's Women Veterans Who Are Homeless Demonstration Project to recruit organizations from the San Diego provider network as well as the Central Valley (which includes the San Joaquin Valley) provider network to pilot the *Self-Assessment*. The National Center also reached out to organizations such as the Corporation for Supportive Housing for additional feedback. The following organizations agreed to participate in the pilot project: Interfaith Community Services, Oceanside, CA; St. Vincent De Paul Village, San Diego, CA; and Westcare's San Joaquin Valley Veterans, Fresno, CA.

2. CONDUCTING ADDITIONAL LISTENING SESSIONS AND DEVELOPING A DRAFT OF THE SELF-ASSESSMENT

The National Center conducted additional listening sessions with providers and women veterans at the pilot sites to obtain their feedback and ideas regarding the service needs of female veterans and the specific practices that should be included in the *Self-Assessment*. The National Center modified the previous *Trauma-Informed Organizational Self-Assessment* based on feedback from female veterans and service providers to create an initial draft of the current version of the *Self-Assessment* for homeless service providers working with female veterans.

3. IMPLEMENTING AND EVALUATING THE SELF-ASSESSMENT

The National Center provided each organization with foundational training on trauma and its impact, the needs and experiences of women veterans, and what it means to be trauma-informed, along with instructions for using the *Self-Assessment*. Staff at each site evaluated the extent to which they currently incorporated each of the practices set out in the *Self-Assessment*. Based on this assessment of their programming, agencies identified goals for more fully incorporating these trauma-informed practices. The National Center's evaluators conducted interviews with program staff to: 1) document the process by which organizations used the *Self-Assessment,* including challenges, barriers, and facilitators in its implementation; 2) collect information necessary to refine the tool for future replication; and 3) identify changes in operations, culture, policies, or other outcomes associated with the implementation of the *Self-Assessment*.

4. FINALIZING THE SELF-ASSESSMENT

The National Center made further refinements to the *Self-Assessment* based on implementation, evaluation activities,

and feedback, and created a final version of the tool.

II. Understanding the Domains of the Self-Assessment

The National Center created the *Self-Assessment* to offer service providers guidelines on how to provide trauma-informed care in general and trauma-informed care to female veterans more specifically. Some trauma-informed strategies and practices are essential regardless of the type of population being served, while others are implemented in response to the unique needs of female veterans.

This section explores the six domains or areas of programming within the *Self-Assessment* offering:

- **An explanation of each domain –** A review of the six domains to explain why they were chosen as the primary areas of focus
- **Essentials for providing quality programming to homeless female veterans –** This section offers summary guidelines for providing quality care to female veterans experiencing homelessness
- **Additional tips for creating trauma-informed settings –**These tips supplement the *Self-Assessment* items, and provide organizations with additional ideas about how to further incorporate trauma-informed practices

DOMAIN 1: SUPPORTING STAFF DEVELOPMENT

Trauma can impact every aspect of a survivor's life, and its effects can appear in areas directly related to the trauma as well as those that initially seem unrelated.

Coping strategies used to survive and manage traumatic experiences may be seen by others as inappropriate or "maladaptive." A lack of awareness of trauma and its impact on adults and children often leads to misunderstandings between staff and consumers that can re-traumatize consumers and cause them to disengage from services.

Creating trauma-informed services and settings requires organizations to expand on basic, traditional staff development efforts to include a range of trauma-related training and support activities. Training and education on trauma, supervision that includes discussions about trauma, and a focus on self-care for the provider are all key components of a trauma-informed organization. Providing trauma-informed care to female veterans adds an additional layer of staff development activities to meet the needs of this special population.

Training and Education

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

"Training is helpful in its focus on women veterans . . . planting seeds that it's different."

California multi-service agency program director

Agencies may begin with basic training about traumatic stress and its impact on the brain and the body and move on to offer more specific information on various types of trauma common among female veterans (e.g., military sexual trauma, combat-related trauma, intimate partner violence, homelessness). To understand the impact of the early trauma that is often reported by female veterans, it is important for staff to learn about how trauma impacts child development and attachment to caregivers. Staff education should also include a focus on how working with trauma survivors can impact staff (e.g., vicarious traumatization or "compassion fatigue") to raise staff awareness about their own triggers and level of burnout, and how these issues can impact their work with consumers.

Experiences of trauma can lead to a variety of mental health and substance abuse issues and more severe responses that include suicidal behaviors. Given the high rates of mental health issues and substance abuse among homeless female veterans, it is important for service providers to receive basic education on common mental health and substance abuse disorders that may impact their work with this group.

Becoming trauma-informed also involves incorporating education about the cultural backgrounds of consumers being served, including how individuals from different cultures understand and respond to trauma. When working with female veterans, it is essential for providers to understand not only the personal culture of each individual being served, but also the military culture and how that impacts a female veteran's experience. This type of education is essential to doing outreach and providing services to homeless female veterans, particularly for community-based providers who do not have a depth of military expertise. Military-specific staff education includes the following: general military knowledge (e.g., structure, branches, terms, and acronyms); military culture (e.g., philosophy, norms, rules of conduct, experiences of military service members); specific experiences of female service members; types of discharges; benefits and forms; eligibility criteria for various services and benefits; and specific resources for female veterans.

Once staff members are educated on topics including trauma and its impact and military-related topics, they require additional training on how to apply this information to their daily work. Skills and strategies for working with trauma survivors may include: using motivational interviewing techniques; providing staff trainings on crisis management (e.g., how to help consumers identify triggers, express their feelings safely, and use healthy coping skills); learning how to develop safety and crisis-prevention plans; learning how to support female veterans by providing services; and creating connections with veteran-specific service providers.

Large group trainings are helpful forums for initial staff education about trauma, but these trainings alone are insufficient. Supervision and team meetings offer smaller settings in which to convey and clarify information. Smaller team meetings are a forum for open communication, peer support, and additional training and education (see Figure 1 on p. 26).

Staff Supervision, Support and Self-Care

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

One-on-one supervision offers service providers an opportunity to think about their work and how they understand and respond to consumers. It is also an avenue for monitoring job frustration or burnout. Individual supervision by someone who is trained in understanding trauma is an essential follow-up strategy to trauma training. Having opportunities for supervision or consultation from someone with military expertise is also a key component to working with the veteran population.

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

Figure 1: Tips for Sustaining Education and Awareness

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

- Creating a "trauma workgroup" — A core group of staff members from all levels of the organization, sanctioned by management, who come together to take what they have learned about trauma and strategize about how to apply this knowledge to daily program practices, and facilitate continued education about trauma for all staff. Workgroup activities may include examining the environment and program practices for potential triggers, arranging for further staff training and consultation by outside agencies, and identifying and taking advantage of smaller opportunities such as supervision and staff meetings to provide further education about trauma and how these concepts can be applied in real world situations. The trauma workgroup would be responsible for incorporating additional practices that might be needed to meet the unique needs of female veterans.
- Incorporating trauma language — Using the term "trauma" in program mission statements and handbooks, and incorporating questions about a potential employee's understanding of trauma concepts into the interview process represents another way to integrate trauma into daily practice and convey the message that understanding trauma and providing trauma-sensitive care is a priority.
- Maintaining military-specific knowledge — Enhancing and maintaining organizational knowledge of military structure, protocol, and culture; maintaining staff knowledge of benefits, service needs, and resources for veterans (specifically female veterans).
- Establishing external networks of support — Organizations can sustain trauma-awareness by establishing regular contact with outside agencies with expertise in trauma, including the use of outside consultants to provide ongoing education and case consultation. Organizations can also make connections to agencies with expertise in serving veterans (e.g., VA, Vet Centers, veteran-specific service agencies) to stay current on new information, avoid isolation, and focus on areas where the program is most in need of guidance.

(Harris & Fallot, 2001; Harris, 2004)

DOMAIN 2: CREATING A SAFE AND SUPPORTIVE ENVIRONMENT

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

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

Establishing a Safe Physical Environment

Creating a safe physical environment is one of the primary components of a trauma-informed organization. Specific areas within the building, such as bathrooms and bedrooms, can be particularly triggering for those who have abuse histories. Poor lighting or building security and a lack of control over personal space and belongings can also trigger past feelings of fear and helplessness. Key safety features include providing adequate lighting inside and outside of the program, making sure consumers can lock bathroom doors and have locked spaces for their belongings when applicable, and having a program securing system (see Figure 2).

For female veterans, creating a safe and welcoming physical space includes offering spaces just for women and incorporating military-related decorations and materials that include and are relatable to women veterans.

Establishing a Supportive Environment

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

Figure 2: Tips for Enhancing the Physical Environment

- Put up colorful, culturally diverse artwork.
- Incorporate military-related decorations that include female veterans.
- Incorporate living items into the decorating such as plants and fish tanks.
- Integrate child-friendly areas, decorations, and engaging play materials when appropriate.
- Provide calming music.
- Have comfortable, soft seating.
- Offer quiet rooms or spaces and places to exercise.
- Have rocking chairs/gliders.
- Involve consumers in designing and decorating the space.
- Set up an "environment" committee where consumers can determine ways in which they would like to improve/change the physical space.

Information Sharing

Experiences of trauma leave people feeling helpless and powerless. To avoid recreating these same feelings, providers must be conscious of sharing detailed information about program rules, expectations, schedules, etc. Providing consumers with information enhances their sense of safety and control. Traumatic experiences can have a significant impact on people's ability to integrate information, particularly under stressful circumstances. This potential difficulty in assimilating information requires providers to be ready to review agency information on a continual basis. Information about rules and consumer rights needs to be given to consumers verbally and in written form, and posted throughout the building. Programs should also post information about trauma, how it impacts people, and available trauma-specific resources. For organizations that serve female veterans, information sharing should be tailored to address the experiences and needs of this group. Topics should include information about different types of trauma, including military sexual trauma, information on community- and Web-based resources for female veterans, and local VA resources. As female veterans sometimes do not self-identify, it may also be helpful to change intake procedures to not ask for veteran status, but rather any military service experience, and to provide information that government and community-based services are available to those without combat experience or physical injuries.

Cultural Competence

While traumatic events happen to people from all racial and ethnic backgrounds, culture plays a significant role in the types of trauma that may be experienced, the risk for continued trauma, how survivors manage and express their experiences, and which supports and interventions are most effective. Violence and trauma have different meanings across cultures, and healing takes place within one's own cultural system. For the female veteran population, cultural awareness includes developing "military cultural competence" or an understanding of the military culture and how that impacts a service member's world view (see Figure 3). Military cultural competence includes understanding the spoken and unspoken "rules" within the military culture; the fundamental attitudes, values, and beliefs that drive the military system; and the unique experiences of female veterans. For example, talking about trauma that occurred while serving may be viewed as disloyal or taboo for many female veterans based on their experiences within the military system. The military's culture of independence and self-sufficiency may impact a veteran's desire to ask for and accept help from others, particularly service providers with a limited understanding of the military.

"I learned in the military to take care of my own business. If I go report this, it will be public knowledge. We're taught to do our own thing, not ask for help."
—Female Veteran

Cultural awareness may also include offering people opportunities to engage in various cultural rituals or religious services, cook specific foods, speak in their language of origin, and access peer supports. A culturally competent approach helps to create a respectful environment in which survivors can begin to rebuild a sense of self and a connection to their communities.

Figure 3: Components of Military Cultural Competence

- General military knowledge (e.g., language, acronyms, branches of service, rules/regulations, processes)
- Ongoing information-gathering regarding the experiences of military service members (in-person interviews and focus groups; and online tools and resources offering a perspective on military service, combat and the experiences of specific populations, including female veterans)
- An understanding of the military culture among and across branches of service
- An understanding of the VA system (processes, benefits, services, eligibility)
- Knowledge of how the military culture impacts a veteran's world view

(Greendlinger & Spadoni, 2010)

Privacy and Confidentiality

Often, trauma survivors (in this case female veterans who have experienced trauma) have had their privacy violated and their dignity taken away. Respecting privacy and confidentiality includes: asking permission and outlining clear boundaries before entering consumers' spaces; providing private, confidential spaces to conduct assessments and have conversations with consumers; addressing individual issues in private; avoiding having discussions about consumers in public places; and clearly explaining the limits of privacy and confidentiality.

Safety and Crisis Prevention Planning

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

Open and Respectful Communication

Trauma survivors often enter service settings with past experiences that include being mistreated, ignored, and silenced. For female veterans who have experienced trauma while in the military, there is often a sense of secrecy and a feeling that it is unacceptable to report incidences of harassment or violence for fear of the personal and professional ramifications. Providers are faced with the challenge of encouraging honest communication with consumers and demonstrating an ability to listen to and accept the range of thoughts and feelings that consumers may share. Open communication with consumers involves using active listening skills such as open-ended questions, affirmations, and reflective listening (see Miller and Rollnick on p. 82). These techniques are designed to demonstrate respect and empathy for the consumer experience at any given moment.

Respectful communication also involves an awareness of the language used to talk to or about consumers. This includes using "people first language" such as "people experiencing homelessness" rather than "homeless people" and avoiding negative and derogatory labels that foster disrespect (e.g., referring to the consumer as "manipulative" or "lazy"). This type of communication also focuses on a person's strengths and capabilities as opposed to her deficiencies. Female veterans take pride in their military service and the skills that they have developed. These unique qualities and strengths should be acknowledged as part of establishing respectful dialogue.

Figure 4: Creating Consumer Crisis Prevention Plans

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

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

(Guarino et al., 2009)

"We're strong. I walked miles and miles for over three months straight. I had to prove myself every day. There should be just a little bit more respect than what we get."

—Female Veteran

Consistency and Predictability

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

DOMAIN 3: ASSESSING AND PLANNING SERVICES

In all service settings, completing a thorough intake assessment and referring consumers to appropriate services is essential to providing quality care. Considering traumatic experiences and the impact of these experiences on female veterans should be a routine part of the assessment and service planning process. In addition, when serving female veterans, their veteran status and related service needs must be a routine part of the intake process (see Figure 6 on p. 31).

Conducting Intake Assessments

People who have experienced trauma have specific needs that may remain mislabeled or misinterpreted if their history of trauma is not addressed as part of the intake process. Research indicates that female veterans who are homeless have suffered high rates of trauma in childhood and adulthood, within and outside of their military service. Therefore, the intake assessment process should include questions regarding emotional, physical, and sexual abuse and other types of trauma (e.g., military sexual trauma, combat-related stressors). Given the high rate of domestic violence within the female veteran population, it is important to include questions about current levels of danger from other people (e.g., restraining orders, history of domestic violence, and threats from others). In light of the increase in women serving in combat roles, it is also important to ask about previous head injuries. Given the risk for post-traumatic stress disorder and traumatic brain injury among female veterans, screening tools should be used to diagnose these issues.

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

Intake assessments are only the first step in a process of linking people with appropriate services. Consumers should be referred for more in-depth assessments when there is a need for further intervention and more specific types of services that require outside professionals. For programs serving female veterans, this means determining eligibility for VA and non-VA benefits and services and helping women connect to these resources.

Figure 5: Important Services to Consider

For Homeless Female Veterans

- Individual and group therapies to address the impact of trauma
- Substance abuse treatment options
- Gender-specific services and service providers
- Peer-to-peer supports
- Job programs and skills-training
- Legal assistance that includes, but is not limited to, child support
- Housing programs/vouchers for Veterans
- Child care options

Developing Goals and Plans

For trauma survivors, developing goals and plans for obtaining housing, employment, and other types of services may seem intimidating and overwhelming. In these situations, it is easy for the consumer to "freeze" and for providers to take over. This pattern only serves to recreate past traumatic experiences and dynamics, and leaves consumers feeling helpless and powerless. Encouraging and helping consumers to create their own goals allows them to take control of their lives and futures. Trauma-informed goal planning is individualized; goals and plans are reviewed on a regular basis and updated as needed.

Offering Services and Supports to Female Veterans Experiencing Homelessness

Female veterans often require a number of services and supports, both emotional and instrumental. A community-based organization may provide many of these services in-house, or it may make referrals to other agencies, including the VA when applicable. A trauma-informed agency makes it a priority to facilitate communication among different service providers. Making referrals to agencies that have expertise in working with trauma survivors is a good first step towards assuring that female veterans receive adequate mental health services. Female veterans have also voiced their desire for all-female therapy and support groups, including groups that address the impact of trauma. Opportunities for peer-to-peer support are important to female veterans who are looking to connect with and learn from others with similar experiences (see Figure 5 on p. 30).

Figure 6: Essentials for Assessing and Planning Services with Female Veterans Who Are Homeless

Intake Assessments

Intake assessments include questions about:

- Personal strengths.
- Current level of danger from other people (e.g., restraining orders, history of intimate partner violence, threats from others).
- Suicidal thoughts and behaviors.
- Military service (branch, rank, job in the military).
- Experiences in the military.
- History of trauma (e.g., physical, emotional, or sexual abuse; neglect; loss; intimate partner violence; community violence; combat-related experiences; military sexual trauma; past homelessness).
- Head injury.
- Past experiences with VA/Vet Center-based services.

Intake assessment tools include:

- A screening for post-traumatic stress disorder.
- A screening for traumatic brain injury.

Based on intake assessments:

- Program staff determines female veterans' eligibility for VA and non-VA benefits and services.

Developing Goals and Plans

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

- Goals are generated by the female veterans themselves.
- Goals are recorded in written, individualized plans.
- Goals are reviewed and updated regularly.

The impact of trauma is often felt at the body level. It may be extremely difficult for trauma survivors to verbalize their thoughts, feelings, and memories related to their trauma. It is helpful for organizations to provide opportunities for consumers to express themselves using alternate strategies (e.g., art, theater, dance, movement, and music).

In addition to emotional supports, female veterans who are homeless identify a number of practical or instrumental supports that are necessary to achieve stability. These include legal services, educational advocacy, job skills-building, housing services, transportation, and child care. While an organization may not offer all of these services, it is important that providers increase their rolodex of possible services for homeless female veterans based on an understanding of eligibility rules and available benefits. There is also a need for female veterans to have access to gender-specific care when possible.

For community-based service agencies, a significant aspect of serving homeless female veterans involves outreach to Vet Centers and the VA, including identifying and connecting with the state VA designated Women Veterans Coordinator. It is also helpful for organizations that are educated about needs of homeless female veterans to provide outreach to other community providers as they learn about available resources (e.g., through fliers, workshops, stand-downs). According to homeless female veterans and service providers, this type of community outreach is lacking. As a result, many women do not access the services that they have earned.

Staffing and Hours

Throughout the listening sessions, female veterans expressed concern about their lack of access to female service providers. For women who have a history of abuse by men, working with men can be very "triggering," reminding them of past trauma and impacting their ability to build a relationship with a male service provider. Some women had positive experiences with male providers; however, there was an overall preference for female service providers. In addition to female service providers, female veterans preferred providers who were veterans themselves or had a military affiliation, such as the parent of a military member. Service providers also expressed that it is easier to work with veterans if you are a veteran yourself. If a provider is not a veteran, she can be successful, but it may take longer to build rapport, and building military knowledge is a key component to making these connections and providing support.

Female veterans who are homeless often struggle to manage all of the requirements necessary to maintain housing, employment, mental health, etc. Consistent across listening sessions with female veterans was the need for organizations to have more flexible hours, particularly for women who work day and evening shifts.

DOMAIN 4: INVOLVING CONSUMERS

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

Recovery and success for trauma survivors is largely based on their ability to regain control of their lives. Female veterans who are homeless have experienced many events, both interpersonal and economic, that have resulted in a loss of control over their lives. Organizations can facilitate empowerment by giving all consumers, including female veterans, a voice in what happens on a daily basis in the program. Giving consumers a voice can begin by facilitating regular meetings where consumers can address questions, concerns, and ideas about the program. Involving consumers also means providing opportunities for them to be directly involved in developing program activities and evaluating program practices. In the case of female veterans, this may include having veterans involved in developing programming for other veterans. Involving consumers in program development enhances the quality of the services provided and affirms the belief that consumers are the experts in what works best for them (see Figure 7 on p. 33).

Former consumers have a unique and invaluable perspective. People who have experienced homelessness in the past know first-hand what was helpful and what was not along their road to recovery. veterans have a unique perspective that offers an advantage when providing services to other veterans. It is important

Figure 7: Tips and Strategies for Involving Consumers

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

to involve formerly homeless staff and women veterans in program development and service provision (e.g., peer-run support groups, question and answer sessions, educational and therapeutic groups). Organizations can make a broader commitment to involving former consumers by recruiting people to their board who have similar experiences to those being served in the program (e.g., veterans, formerly homeless men and women) and hiring them as paid program and operations staff.

DOMAIN 5: ADAPTING POLICIES

Establishing Written Policies

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

Trauma-informed policies include a formal acknowledgement that consumers have experienced trauma and a commitment to understand trauma and its impact and engage in trauma-sensitive practices. As part of this commitment, programs establish written policies based on an understanding of the impact of trauma on consumers. Agencies focus first on creating policies that address issues of safety, including the program's response to threats made to consumers by others outside of the program. A policy outlining the program's response to a consumer crisis is also important when serving trauma survivors who may frequently feel unsafe within their own bodies. Organizations who serve female veterans should also have a written commitment to understanding the needs of this population and tailoring services to meet these needs. Within a trauma-informed agency, there is a formal commitment to hire staff with similar life experiences to those being served. In organizations serving homeless female veterans this includes hiring staff who have experienced homelessness and providers who are veterans themselves (see Figure 8).

Reviewing Policies

Creating trauma-informed organizations requires continual review of policies to see what works and what may be re-traumatizing to trauma survivors. For policies to be effective, they must be enforced properly, considered helpful, and not be re-traumatizing. The more an organization's staff learns about trauma, the more modifications it may need to make to their policies and services. A regular review of policies will be required to update practices and guidelines to make them as relevant as possible to the people being served. The effectiveness of policies and the impact of enforced policies on consumers can be accurately assessed only when staff and consumers are part of the policy review process (see Figure 9 on p. 34).

Figure 8: Essential Policies for Serving Female Veterans Who Are Homeless

- The program has a written statement that includes a commitment to understanding trauma and engaging in trauma-sensitive practices.
- The program has a written statement that includes a commitment to understanding the needs of female veterans and tailoring services to meet those needs.
- The program has a written commitment to hire female veterans and formerly homeless female veterans.

Figure 9: Tips and Strategies for Reviewing Policies

When evaluating policies or rules, here are some helpful criteria:

- Is this policy or rule necessary?
- What purpose does it serve?
- Who does it help? Who does it hurt?
- Does the policy facilitate/hinder consumer inclusion and control?
- Were consumers included in its development?
- Could this policy or rule re-traumatize the consumer (e.g., limit consumer control and power or lead to fear and confusion)?
- Does this policy require additional tailoring to meet the needs of female veterans?

DOMAIN 6: WORKING WITH CHILDREN

Children of military families face unique challenges. Children have to cope with the stress of moving periodically to new bases; having a parent deploy, be absent, and reintegrate; and potentially managing a parent's death or injury. For some children, these experiences may be overwhelming or even traumatic. Becoming homeless adds an additional layer of stress that can have a significant impact on a child's health and well-being. As more female veterans with children are returning to unstable living conditions and limited employment opportunities, the number of homeless veteran families is likely to increase.

The homeless service system is focused on meeting the needs of adults. Obtaining and maintaining housing and employment are among the first steps towards stability and success for the family as a whole. However, this focus on adults means that children's needs are often overlooked. The impact of trauma on child development and the parent/child relationship is profound, and it is essential that children receive services as soon as possible to lessen the negative impact of these experiences on their emotional, physical, cognitive, and social development. To meet children's needs, questions about their exposure to trauma must be included in the intake assessment. In addition to questions about traumatic experiences, it is important to ask about children's achievement of developmental tasks, and the quality of the parent/child relationship. Providing thorough intake assessments often results in a need for access to child-specific services. Organizations serving homeless women and their children should be prepared to make referrals to agencies that provide the following services: early intervention, mental health, physical health, and education. For children of veterans, it is important to ask about the children's experiences during a parent's deployment and upon their return. It is helpful for organizations serving female veterans to make connections with agencies that offer child-specific services that are also specific to children of veterans, and familiarize themselves with printed materials and online resources for this population. In smaller ways, programs can focus on children's needs by incorporating child-friendly materials and providing a space for children to play (see Figure 10 on p. 35).

A word about children . . .

Traumatized children may behave in ways that are consistent with a diagnosis of attention deficit hyperactivity disorder, bi-polar disorder, oppositional-defiant disorder, or reactive-attachment disorder (Cook et al., 2005). Without a thorough assessment that includes a history of trauma, providers are likely to make a diagnosis or label a child based on presenting behaviors and miss the traumatic experiences that may be the source of the symptoms and the necessary focus of treatment.

Figure 10: Tips for Supporting Children

- Provide child-friendly spaces in your facility. Child-friendly spaces include developmentally appropriate toys, chairs, and books; colorful pictures and paintings; and learning materials and posters with "feelings faces" and "feelings thermometers" to foster skill-building.
- Identify "safe spaces" for children to go when they are feeling overwhelmed. These safe places may include: 1) a reading corner in a classroom; 2) the guidance counselor's office or an area of the playroom separate from the main activities; 3) a particular chair in an office; and 4) a "calming room" where children can draw, listen to music, rock in a chair, or take a nap.
- Create child-specific crisis prevention plans that include: 1) a list of triggers; 2) a list of "warning signs" that a child is escalating or becoming overwhelmed; 3) responses that are helpful when a child is in distress (e.g., physical touch, space away from the group, offering him or her a specific toy or stuffed animal); 4) responses that are not helpful when a child is in distress (e.g., physical touch, multiple adults attempting to help, offering to call a child's parent); and 5) safe people and places for a child when he or she needs to calm down.

SECTION 4

IMPLEMENTING THE SELF-ASSESSMENT

SECTION 4

IMPLEMENTING THE SELF-ASSESSMENT

I. Becoming Trauma-Informed

Creating a trauma-informed organization requires system-wide transformation. This type of change is not found just at the direct care level or only in the administrative arena. Becoming trauma-informed requires a commitment to changing the practices, policies, and culture of the entire organization. This type of change requires staff at all levels and in all roles to modify what they do based on an understanding of the impact of trauma and the specific needs of trauma survivors. This section outlines the steps to begin the process of becoming trauma-informed and implementing specialized practices to meet the needs of homeless female veterans. These steps are based on The National Center's experiences and lessons learned while working with community-based organizations as they moved through the assessment process and worked to create changes in both individual behaviors and organizational processes. An organization's ability to move through this step-by-step process will depend on several factors including staffing, resources, and time.

BUILDING KNOWLEDGE AND GAINING BUY-IN

Becoming trauma-informed is an ongoing process that begins by raising awareness through education and training about trauma and its impact and gaining buy-in from staff across an agency to make changes based on this knowledge.

Step 1:

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

Tips and Strategies:

- It is helpful to have co-leaders to facilitate the change process so that one person is not the sole champion of this cause.
- Try to choose trauma-informed leaders who represent different roles in the organization (e.g., the program director and a case manager). This increases buy-in across the organization and assures that many different voices are heard.
- Program leaders must have the authority to institute programmatic change and the support of the broader agency to implement these changes. Program leaders who are dedicated to the change process but have no real authority to make programmatic changes will have a difficult time implementing new practices and creating a new culture. Program leaders also need to be given the time in their work life to devote to the change process. Without the time to devote to the process, change efforts are likely to fall by the wayside.

Step 2:

In order to "set the stage" for trauma-informed organizational change, program leaders introduce the concept of becoming trauma-informed and the need for organizational change (see Resource Lists on p. 73). Education and discussions about these concepts can be done in all-staff meetings, in smaller lunch meetings or shift change meetings, or in whatever ways work best in your program to include everyone in the conversation.

Tips and Strategies:

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

Step 3:

The concept of being trauma-informed involves educating all staff on how to respond in a safe and sensitive manner. Before an organization uses the *Self-Assessment* to develop goals and plans, it is important that all staff receive basic training and education on the following: 1) what trauma is and how it impacts people; 2) the relationship between homelessness and trauma; 3) traumatic stress and its impact on the lives of homeless female veterans; 4) information about what it means to provide trauma-informed care; and 5) education on the unique needs of female veterans who are homeless. Training recipients include everyone from the executive director to administrative assistants and maintenance staff. This type of foundational education ensures that everyone is using the same language and working from a similar level of understanding. The National Center has included a list of resources on page 73 that offers programs a variety of possibilities for educating staff on these topics, particularly when more formal in-person trainings by outside experts are not an option.

Tips and Strategies:

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

Step 4:

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

Tips and Strategies:

- It is important to read and acknowledge staff frustrations or confusion about the need for change early in the process. Use initial meetings to gauge readiness. If there is an overarching negativity about change, program leaders may want to think about how to begin the process more slowly and on a smaller scale. (For example, start with additional training and conversations before beginning to talk about evaluating and changing program practices.)
- In order to gain buy-in, the process has to identify "hooks" for all participants, addressing the benefits of becoming "trauma-informed." For some staff, the "hook" may be improved safety due to a reduction in patterns of interaction that are more likely to lead to escalation and crises. For others, directly addressing the emotional impact of this work on the provider, via discussions of secondary trauma, is immensely relieving and worthwhile. For some, gaining insight into the effective treatment strategies and approaches for consumers previously thought to be "untreatable" is the value. The possibility of improved outcomes as a result of trauma-informed programming provides administrators with the potential for new funding opportunities or evidence that this type of work has benefits for the broader system.
- Communication is an important key to success. If communication between staff is strong, it is easier to lay out a plan and assess people's interest, understanding and readiness. If communication between staff members in various roles is a challenge, it is essential that these issues be resolved before attempting to make system-wide changes that will require ongoing dialogue and peer support.

Step 5:

Program leaders introduce the *Self-Assessment* (see Self-Assessment on p. 50) as a tool to help the organization become trauma-informed and, more specifically, to better meet the needs of homeless female veterans. Leaders explain that the *Self-Assessment* includes a list of concrete practices that should be incorporated into daily programming in a "trauma-informed" organization that serves homeless female veterans. Leaders inform staff members that they will begin by evaluating the extent to which the program currently incorporates the practices outlined in the *Self-Assessment* and, based on the results, develop an action plan for implementing those practices that are not currently being used. Organizations may choose to have their staff complete the entire *Self-Assessment* at once, or complete it one category at a time (e.g., start with "Supporting Staff Development" or "Creating a Safe and Supportive Environment" and move on to additional categories later).

COMPLETING THE SELF-ASSESSMENT

Step 6:

Agency leaders provide each staff member with a copy of the *Self-Assessment*, review instructions for completion, and set a deadline for when the completed *Self-Assessment* should be returned. Instructions are provided in ways that everyone can understand. Confidentiality of answers is reinforced to ensure that staff members are able to answer freely and with no repercussions for honesty. Information from this assessment process is an essential component of goal-setting moving forward.

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

Example: "*Material is posted about available benefits for women veterans.*" Staff respond "*Strongly Disagree, Disagree, Agree, Strongly Agree, Do Not Know, or Not Applicable to My Program.*"

Staff responses should remain anonymous, and staff should be encouraged to answer as honestly and accurately as possible. Staff members are not evaluating their individual performance, but rather the practices of the organization as a whole. Staff should complete the *Self-Assessment* when they have time to consider the items carefully. The *Self-Assessment* may be completed in one sitting or it may be filled out section by section.

Tips and Strategies:

- It is recommended that programs give staff a period of time, whether at a staff meeting or another designated time, to focus specifically on completing the *Self-Assessment*.
- People are less likely to invest in a process if they feel that their feedback will not ultimately be used. Explaining the ways that the program will take all information given by staff into consideration when developing goals is a way to empower all individuals in the program to feel that they are contributing to the change process.
- Staff members in different roles often have different perspectives on the program and what needs to change. Becoming trauma-informed involves reconciling these perspectives and including staff at all levels in regular discussions about how to be more trauma-informed.

Step 7:

All staff members complete the *Self-Assessment* within the designated timeframe (this will vary by program and will be based on discussions between program leaders and staff). There should be a designated box or location where staff can return the *Self-Assessment*.

Tips and Strategies:

- It is helpful for program leaders to be available to offer additional help and support throughout the assessment process. There may be confusion about specific items in the *Self-Assessment*, and asking clarifying questions increases the likelihood of accurate answers.
- It is important to remind people that they are not assessing their behaviors alone, but rather the daily practices of the organization as a whole.
- It can be difficult for staff members to talk about a program's weaknesses without feeling defensive. It is helpful to present this process as an opportunity for change and growth rather than a judgment on the program.

COMPILING THE RESULTS OF THE SELF-ASSESSMENT

Step 8:

The following is a suggestion for how to gather responses and examine results: Using an Excel spread sheet, enter each staff member's response to each item in the *Self-Assessment*.

Example:

I. Staff Development	Staff Member 1	Staff Member 2	Staff Member 3
A. Training & Education			
Staff receive training on the following topics:			
1. What traumatic stress is	Strongly Agree	Agree	Do Not Know
2. How traumatic stress affects body and brain	Agree	Disagree	Agree
3. Military Sexual Trauma	Strongly Disagree	Strongly Agree	Agree

Using the information entered above, count the total number of Strongly Disagree, Disagree, Agree, Strongly Agree, Do Not Know and Not Applicable responses for each item. Enter these totals on a blank *Self-Assessment* that can be copied and distributed to all staff.

Example:

I. Staff Development					
A. Training & Education	Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know
Staff receive training on the following topics:					
1. What traumatic stress is			1	1	1
2. How traumatic stress affects body and brain		1	2		
3. Military Sexual Trauma	1		1	1	

UNDERSTANDING THE RESULTS

Step 9:

Agency leaders bring staff together to begin conversations about the results of this organizational assessment process. These conversations may begin in staff meetings or in smaller group meetings, based on what is realistic and feasible for the program. Community-based organizations may decide to form a smaller multi-disciplinary group that examines results and reports back to the larger staff with ideas for possible program changes.

To identify areas for change, the organization leaders and other champions of becoming trauma-informed should look at the following:

- Specific practices in the *Self-Assessment* that most staff "*Do Not Agree*" are being done in the program (responses were "*Disagree*" or "*Strongly Disagree*")
- Specific areas that many people responded "*Do Not Know*," which may mean that these things are not being done or that there is a lack of staff understanding about what is being done in the program
- Items that had a **range of responses**, with some staff strongly agreeing that this practice is done, and others strongly disagreeing. These are helpful to clarify

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

The staff in the veteran department at Interfaith Community Services in Oceanside, CA, completed the *Self-Assessment.* Assessments were returned to the designated point person, a mental health therapist in the program. Staff responses were tallied, and the results were examined. The program therapist looked for areas where there were a high number of "disagree" and "strongly disagree" responses, indicating that most people felt these practices were not being done, highlighting the areas for improvement. The Associate Director of Veterans Services also reviewed the results. Interfaith pulled together a "trauma-informed committee" consisting of five staff members in various roles, who met to decide on specific goals and next steps for the program.

Reviewing results can take a considerable amount of time and focus. It may be helpful to examine the results one domain at a time. For example, start with the "Supporting Staff Development" domain and clarify practices that are and are not being done before moving on to the second domain, "Creating a Safe and Supportive Environment."

DEVELOPING A STRATEGIC PLAN

Step 10:

A strategic plan for the program includes the following: 1) identified and agreed upon goals; 2) specific steps to reach each goal; 3) resources needed to achieve each goal; 4) a realistic timeframe for achievement of each goal; and 5) the names of people responsible for monitoring progress. When identifying areas of change, the program may choose to focus on one domain at a time or identify specific short-term and long-term goals within several of the domains. Each goal includes the necessary action steps, resources, timeframe for achievement, and persons responsible for monitoring progress towards the goal.

The sample described on page 44 can be used for all goal-setting that a community-based organization does based on the results of the assessment process.

Tips and Strategies:

- It is very important that the goals identified are realistic in the current organization. If an organization has a great goal but no time or resources to achieve that goal, it could impact the entire change process. If people begin to feel hopeless that change cannot be made, it may impact their drive to make smaller, more manageable changes. With the creation of each goal, all staff should have a sense that it can be achieved, whether in the short term or in the long term.
- Change is most effective when identified goals reflect the needs of service providers in varying roles, at all levels of the organization.

  Example: Community-based organization "A" has just completed the *Self-Assessment*. Direct care staff members are feeling burned out and unsupported by the larger organization. They would like to focus their program goals in the area of "Supporting Staff Development." Administrative staff members have other priorities and while they believe that staff support is important, they would like to focus their efforts in the area of "Adapting Policies." In order to reconcile conflicting agendas, organization "A" will need additional discussions to identify goals that will meet everyone's needs. Ideally this type of democratic change process encourages the "flattening" of these hierarchies among staff, and models the need for all to have a voice in how the program is run.
- Becoming trauma-informed is as much about changing a program's culture as it is about changing program practices. Changing the culture of an organization can be much more difficult, as attitudes and values are often subtle, ingrained, and hard to identify and shift. As an organization begins to incorporate new practices, it is helpful to have continued discussions about the ways that these practices are attempts to shift tone, culture, and atmosphere in the program.

SAMPLE STRATEGIC PLAN

The director of Social Services at St. Vincent De Paul Village in San Diego and her veteran team completed the *Self-Assessment* and examined the results, with a particular focus on *Self-Assessment* practices that were not being incorporated into the program. The director identified four possible areas of focus and e-mailed them to the group with a request that each person choose his or her top 1-2 priority areas. Goals were developed based on group consensus. The following plan was developed by St. Vincent De Paul Village and represents one goal for that organization:

Staff Development Goal #1: "Staff is trained and knowledgeable about military and Veteran issues, with an emphasis on women Veterans."

Action Steps:

1. In consultation with the U.S. Department of Veterans Affairs (VA) Liaison and partner agency Veterans Village of San Diego, develop training curriculum that includes information on the following topics:

All Veterans

- The different branches of the military
- Overview of the military "culture" and how it differs from civilian life
- The experiences of veterans serving in a combat zone and during an active campaign
- Types of discharges from the military
- Types of benefits available and eligibility criteria for Veterans, including women Veterans (e.g., VA medical and disability services, U.S. Department of Housing and Urban Development's Veterans Affairs Supportive Housing Program (HUD-VASH), Supplemental Security Income, housing options)
- How to read and understand military forms (e.g., DD214)
- Basics on how to access VA services

Women-Specific Issues

- The experiences of women serving in the military
- The experiences of women upon discharge from the military
- How VA services differ for women veterans
- The specific service needs of women veterans (e.g., types of services needed, how they are delivered, who provides the services)
- The resources available to women veterans (e.g., VA, community-based, Web-based)
- The barriers/challenges to accessing services for women veterans (e.g., availability, location, experiences with the VA)

2. Determine if curriculum exists or needs to be developed
3. Ask for help in developing curriculum, reviewing curriculum, and identifying trainers
4. Write draft curriculum and distribute to VA Liaison, Veterans Village, and internal stakeholders for review
5. Schedule and host training sessions for members of the Veteran Team
6. Schedule, advertise, and host training sessions that are open to any Village staff members who are interested in the topic or who are recommended by their supervisor

Resources:

- Line staff time for curriculum development, review of curriculum, and attending training
- Supervisor/Manager time for curriculum development and facilitating training

Timeframe: 3 months

Persons responsible for monitoring progress on action steps:

- Program Project Coordinator
- Veteran Team Leader
- Social Services Program Manager

IMPLEMENTING TRAUMA-INFORMED CHANGES

Step 11:

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

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

Tips and Strategies:

- Staff at all levels of an organization should have a voice in the trauma workgroup. If all staff roles within a program are not represented in the workgroup, it leads to a sense that some positions are less valued than others.
- Ongoing feedback from consumers provides organizations with essential information about whether daily programming and services actually seem different.

Step 12:

Becoming trauma-informed is a process that involves ongoing growth and development. There is no specific end-date at which point agencies are "trauma-informed" and therefore "finished" with the process. The *Self-Assessment* is one tool that programs can use to become more trauma-informed. As programs begin to incorporate practices from the *Self-Assessment*, the hope is that they will also begin to generate additional ideas for creating trauma-informed programming that go beyond what is outlined in the *Self-Assessment*.

Step 13:

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

II. What Does Becoming Trauma-Informed Look Like?

Becoming trauma-informed is a process that involves striving towards a new way of understanding people and providing services and supports. This process involves a gradual integration of trauma concepts and trauma-sensitive responses into daily practice. What it looks like to become "trauma-informed" can vary from program to program. The community-based organizations participating in the Women veterans Who Are Homeless Demonstration Project have identified practical and attitudinal shifts as a result of receiving trauma training, completing the *Self-Assessment*, and developing strategic plans related to providing trauma-informed care and serving female veterans. Providers point out that understanding trauma "provides a context to staff regarding why we do/don't do certain things." Organizations participating in piloting the *Self-Assessment* found that it has allowed their staff to "step back," and approach their work differently. They have become "more aware of possible traumas in the program." They explain that with a better understanding of trauma, they have been able to be "more collaborative," less punitive with consumers, and more "solutions-based" in their approach. Education on the prevalence of trauma in the lives of female veterans has resulted in programs asking about women's experiences before, during, and after military service. Program leaders express their hope of being able to take an awareness of trauma-informed care and "translate [this awareness] into daily practice for all clients, including veterans, while also hoping to better serve female veterans specifically."

The following is a sampling of site-specific goals identified by pilot project participants:

- Develop training curriculum that includes information on all veterans and women-specific issues to ensure that all staff is knowledgeable about military-related issues and culture
- Incorporate a commitment to providing trauma-informed care to homeless female veterans as part of the broader organizational strategic plan
- Assign female case managers to female veterans whenever possible
- Enhance organizational awareness of trauma and its impact by having staff attend twice-yearly trainings on related topics
- Enhance cultural competence across the organization and within the veteran program
- Enhance staff knowledge of available resources for female veterans experiencing homelessness
- Incorporate trauma-specific assessment tools for use with female veterans (e.g., a PTSD scale)

III. Sustaining Trauma-Informed Change

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

- Ongoing review: Review of short-term and long-term goals related to becoming trauma-informed. Programs can do a yearly reassessment of their program, using the *Self-Assessment* to identify changes. Other assessment tools include staff and consumer surveys, focus groups, and individual interviews. Have these strategies built into your long-term plan.
- Ongoing training: Include trauma and military cultural competence training as part of the new hire process and refresher trainings on trauma and trauma-related topics for all staff.
- Making connections: Find ways to connect with experts in a variety of areas including: trauma, mental health, substance abuse, and military-related experience. This includes building and maintaining relationships with the VA and Vet Centers. These consultants/agencies can provide ongoing support and consultation. Networking with other programs that are integrating trauma-informed organizational models and finding ways to share information and experiences are critical.
- Bringing trauma-informed concepts to the broader system: Program staff can bring their understanding of trauma, trauma-informed care, and the needs of homeless female veterans to the broader service system. This means educating providers and service systems working with female veterans on the importance and impact of trauma and trauma-sensitive responses.

IV. Conclusion

Female service members play a significant and ever-growing role in military defense. The numbers of female veterans are growing, and it is the responsibility of our society to meet the needs of these women as they return home. Female veterans often face immense challenges as they reintegrate into civilian life. For female veterans, experiences of trauma, including chronic exposure to trauma, occur at higher rates than they do for male veterans or female civilian counterparts. For some, the combination of traumatic stress and economic hardship leads to residential instability and homelessness. Once homeless, female veterans find that services designed to meet their needs are minimal, and acknowledgment of and respect for their service and status as veterans is often lacking. The National Center created *Trauma-Informed Care for Women Veterans Experiencing Homelessness* to provide organizations with knowledge and guidelines for how to best engage with and meet the needs of this population. Understanding how experiences of trauma impact homeless female veterans and tailoring practices to provide trauma-informed care allows providers serving female veterans to respond in ways that best cultivate recovery and success. The ultimate goal is to create a network of community-based service organizations equal to the task of serving those women who have so proudly and courageously served our country.

ORGANIZATIONAL SELF-ASSESSMENT FOR PROVIDERS SERVING FEMALE VETERANS

INSTRUCTIONS FOR COMPLETING THE *SELF-ASSESSMENT*

The central component of *Trauma-Informed Care for Women Veterans Experiencing Homelessness* is the *Organizational Self-Assessment for Providers Serving Female Veterans* (the *Self-Assessment*). The *Self-Assessment* is a tool that community-based organizations can use to evaluate current practices and adapt their programming to respond to the needs of female veterans experiencing homelessness. The *Self-Assessment* should be completed by all staff in an organization working with homeless female veterans. This group may include direct care staff (full-time, part-time, and relief), supervisors, case managers, clinicians, administrators (e.g., program managers, directors, executive directors, etc.), and support staff (e.g., office support, maintenance, kitchen staff, etc.).

The Self-Assessment is organized into six main "domains" or areas of programming:

1) Supporting Staff Development

2) Creating a Safe and Supportive Environment

3) Assessing and Planning Services

4) Involving Consumers

5) Adapting Policies

6) Working with Children

"When you think veterans—you don't think of women."

—Female Veteran

Within each domain is a list of trauma-informed practices. For each item, please consider the extent to which you agree that your program incorporates this practice using the following scale:

- Strongly Disagree (This rarely or never happens)
- Disagree (This usually does not happen)
- Agree (This happens some of the time)
- Strongly Agree (This happens most of the time)
- Do Not Know (I don't know if this happens in the program)
- Not Applicable to My Program (This practice is not applicable to what we do in our program)

For example: "*The program incorporates military-related decorations and materials that include female veterans.*" Staff respond, "*Strongly Disagree, Disagree, Agree, Strongly Agree, Do Not Know, or Not Applicable to My Program.*"

When responding to *Self-Assessment* items, please answer based on your experience in the organization over the past six months. The *Self-Assessment* can be completed in one sitting or in sections and takes approximately 30-40 minutes to complete all at once.

Community-based organizations serve female veterans as well as others who are homeless. Many items in the *Self-Assessment* refer specifically to female veterans and represent trauma-informed practices for this unique population. Some items use the term "consumer." These items represent trauma-informed practices that are applicable to all consumers served by the agency. The term "staff" refers to paid and voluntary individuals providing services, which include but are not limited to: those working directly with consumers and children, administrators, policymakers, groundskeepers, maintenance, transportation specialists, and community service providers.

I. SUPPORTING STAFF DEVELOPMENT

A. Training and Education

Staff serving female veterans at all levels of the organization receive training and education (e.g., face-to-face trainings, on-line courses, special presentations) on the following topics:

I. Supporting Staff Development **A. Training and Education** Trauma and Mental Health	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
1. Traumatic stress and its impact on the brain and body						
2. Intimate partner violence and its impact						
3. Military sexual trauma and its impact						
4. Combat-related trauma and its impact						
5. Complex trauma and its impact						
6. Post-traumatic stress disorder (PTSD)						
7. Traumatic brain injury (TBI)						
8. How trauma affects development						
9. How trauma affects attachment to caregivers and others						
10. The relationship between childhood trauma and adult challenges and/or re-victimization (e.g., intimate partner violence, sexual assault, homelessness)						

I. Supporting Staff Development **A. Training and Education** Trauma and Mental Health (continued)	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
11. Cultural differences in how people understand and respond to trauma						
12. How working with trauma survivors impacts staff (e.g., compassion fatigue/vicarious trauma)						
13. Common mental health disorders among people who are homeless, including female veterans (causes, symptoms, treatments)						
14. Substance abuse disorders (causes, symptoms, treatments)						
15. Suicide (risk factors, red flags, crisis intervention)						

I. Supporting Staff Development **A. Training and Education** Military Knowledge	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
16. The different branches of the military						
17. Military-specific language/terminology, acronyms, rules/regulations						
18. How to read and understand military forms (e.g., DD214)						
19. The unique experiences of female service members						
20. Types of discharges from the military						
21. The experiences of female veterans upon discharge from the military						
22. Types of benefits for female veterans (e.g., VA, SSI, housing options)						
23. Eligibility criteria for various benefits						
24. The U.S. Department of Labor's assistance programs for veterans (e.g., Homeless Female Veterans, a new Homeless Veterans' Reintegration Program or Homeless Veterans with Families Program; Veterans Workforce Investment Program; Incarcerated Veterans' Transition Program)						
25. The specific service needs and preferences of female veterans (e.g., types of services, methods of delivery, who provides the services)						
26. The resources available to female veterans (e.g., VA, community-based, Web-based)						
27. The barriers/challenges to accessing services for female veterans (e.g., availability, location, experiences with the VA)						
28. The process for attaining benefits and services through the local VA						

I. Supporting Staff Development **A. Training and Education** Skills and Strategies	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
29. Motivational interviewing techniques						
30. De-escalation strategies (e.g., ways to help people calm down before reaching the point of crisis)						
31. Steps for helping female veterans identify triggers (e.g., reminders of dangerous or frightening things that have happened in the past)						
32. Developing safety and crisis prevention plans						
33. Establishing and maintaining healthy professional boundaries						
34. Case management strategies for helping female veterans make and maintain community-based provider connections (e.g., VA, housing, employment, education)						
35. Providing culturally competent services to female veterans from a variety of backgrounds and experiences						

B. Staff Supervision, Support and Self-Care

I. Supporting Staff Development **B. Staff Supervision, Support, and Self-Care**	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
36. Staff members have regular team meetings.						
37. Topics related to the needs and experiences of female veterans are addressed in team meetings.						
38. Topics related to self-care are addressed in team meetings (e.g., vicarious trauma, burnout, stress-reducing strategies).						
39. Staff members have a regularly scheduled time for individual supervision.						
40. Supervisors are trained in understanding trauma and trauma-informed care.						
41. Supervisors are knowledgeable about the VA and veteran-specific needs.						
42. Part of supervision time is used to help staff members understand their own stress reactions and how these impact their work.						
43. The organization has a process for helping staff members debrief after a crisis.						
44. The organization has a formal system for reviewing staff performance.						
45. The organization provides opportunities for ongoing staff evaluation of the program.						
46. The organization provides opportunities for staff input into agency practices.						

I. Supporting Staff Development **B. Staff Supervision, Support, and Self-Care**	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
47. Outside consultants or staff members with expertise related to female veterans provide ongoing education and consultation.						
48. Outside consultants or staff members with expertise in trauma and trauma-informed care provide ongoing education and consultation.						
49. Outside agencies with expertise in cultural competence (including military knowledge/ competence) provide ongoing training and consultation.						

II. CREATING A SAFE AND SUPPORTIVE ENVIRONMENT

A. Establishing a Safe Physical Environment

II. Creating a Safe and Supportive Environment **A. Establishing a Safe Physical Environment**	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
1. The organizational facility has a security system.						
2. Agency staff monitors who is coming in and out of the program.						
3. The environment outside the organizational facility is well lit.						
4. The common areas are well lit.						
5. Bathrooms are well lit.						
6. Bathroom doors can be locked.						
7. The organization has a space that is only for women.						
8. The organization incorporates military-related decorations and materials that include and are relatable to female veterans.						
9. When applicable, there are private, locked spaces for belongings.						
10. The organization provides consumers with opportunities to make suggestions about ways to improve/change the physical space.						

B. Establishing a Supportive Environment

II. Creating a Safe and Supportive Environment **B. Establishing a Supportive Environment** Information Sharing	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
11. The organization regularly reviews rules, rights, and grievance procedures with consumers.						
12. Consumers are informed about how the program responds to personal crises.						
13. When applicable, expectations about room/apartment checks are clearly written and verbalized to consumers.						
14. When applicable, the organization obtains permission from consumers prior to giving a tour of its space (e.g., client notified of date, time, and who will see her space).						
15. Consumer rights are posted in places that are visible.						
16. Material is posted about traumatic stress (e.g., what it is, how it impacts people, and available trauma-specific resources).						
17. Material is posted about what it means to be a "Veteran."						
18. Material is available about military sexual trauma (e.g., what it is, how it impacts people, and available resources).						
19. Material is posted about available benefits for female veterans.						
20. Material is posted about local VA resources for female veterans.						
21. Material is posted about community and Web-based resources for female veterans.						

II. Creating a Safe and Supportive Environment **B. Establishing a Supportive Environment** Cultural Competence	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
22. Organizational information (e.g., policies, procedures, services, requirements) is available in different languages.						
23. Consumers are allowed to speak their native language within the organization.						
24. When applicable, consumers are allowed to prepare or have ethnic-specific foods.						
25. The organization provides ongoing opportunities for consumers to share their culture with each other (e.g., potlucks, culture nights, incorporating different types of art and music, etc.).						
26. Staff shows respect for personal religious or spiritual practices.						
27. The organization demonstrates an understanding of the military culture (e.g., familiar with [and can refer to] acronyms, branches, forms, how the military system works, experiences of service members).						

II. Creating a Safe and Supportive Environment **B. Establishing a Supportive Environment** Privacy and Confidentiality	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
28. The organization informs consumers about the extent and limits of privacy and confidentiality (e.g., the kinds of records that are kept, where they are kept, who has access to this information, when the program is obligated to report information to child welfare or police).						
29. Staff does not talk in common spaces about consumers.						
30. Staff does not talk outside of the program about consumers.						
31. Staff does not discuss the personal issues of one consumer with another consumer.						
32. Consumers who have violated rules are approached in private.						
33. There are private spaces for staff and consumers to discuss personal issues.						

II. Creating a Safe and Supportive Environment **B. Establishing a Supportive Environment** Safety and Crisis Prevention Planning	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
For the following items, the term "safety plan" is defined as a plan for what a consumer and staff members will do if the consumer feels threatened by another person outside of the agency.						
34. Consumers work with staff to create written, individualized safety plans.						
35. Written safety plans are incorporated into consumers' individual goals and plans.						
For the following items, the term "crisis-prevention plan" is defined as an individualized plan to help each consumer manage stress and feel supported.						
36. Every consumer in the organization has a written crisis-prevention plan.						

Written crisis prevention plans include the following:

37. A list of triggers (e.g., situations that are stressful or overwhelming and remind the person of past traumatic experiences).						
38. A list of ways that the person shows that she is stressed or overwhelmed (e.g., types of behaviors, ways of responding, etc.).						
39. Specific strategies and responses that are helpful when the person is feeling upset or overwhelmed.						
40. Specific strategies and responses that are not helpful when the person is feeling upset or overwhelmed.						
41. A list of people with whom the person feels safe and can go to for support.						

II. Creating a Safe and Supportive Environment **B. Establishing a Supportive Environment** Open and Respectful Communication	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
42. Staff uses descriptive language, rather than characterizing terms, to describe consumers (e.g., describing a person as "having a hard time getting her needs met" rather than "attention-seeking").						
43. The organization uses "people-first" language rather than labels (e.g., "people who are experiencing homelessness" rather than "homeless people").						
44. Staff members use motivational interviewing techniques with consumers (e.g., open-ended questions, affirmations, and reflective listening).						
45. Staff acknowledges female veterans' military service and strengths, skills, and past successes related to this service.						

II. Creating a Safe and Supportive Environment **B. Establishing a Supportive Environment** Consistency and Predictability	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
46. When applicable, the organization regularly schedules community meetings for consumers.						
47. The organization provides advance notice of changes in the daily or weekly schedule.						
48. The organization has structures in place to support staff consistency with consumers across roles and shifts (e.g., trainings, staff meetings, shift change meetings, and peer supervision).						
49. The organization is flexible with rules, if needed, based on individual circumstances.						

III. ASSESSING AND PLANNING SERVICES

A. Conducting Intake Assessments

III. Assessing and Planning Services **A. Conducting Intake Assessments** The intake assessment for female veterans includes questions about:	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
1. Personal strengths						
2. Cultural background						
3. Cultural strengths (e.g., world view, role of spirituality, cultural connections)						
4. Social supports in the family and the community						
5. Current level of danger from other people (e.g., restraining orders, history of intimate partner violence, threats from others)						
6. Suicidal thoughts and behaviors						
7. Military service (branch, rank, job in the military)						
8. Experiences in the military						
9. History of trauma (e.g., physical, emotional or sexual abuse; neglect; loss; interpersonal violence; community violence; past homelessness; combat; military sexual trauma)						
10. History of mental health issues						
11. History of substance use/abuse						
12. Previous head injury						
13. Quality of relationship with child or children (e.g., caregiver/child attachment)						
14. Housing history						
15. Employment and job training history						
16. Perceived barriers to housing and employment						

III. Assessing and Planning Services **A. Conducting Intake Assessments** **(continued)** The intake assessment for female veterans includes questions about:	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
17. VA services that they have received/are receiving and their experiences with them						
18. How best to receive information and communicate with providers (e.g., cell phone, text messaging, Web-based, in-person)						
Intake assessment tools for female veterans include:						
19. A screening for post-traumatic stress disorder						
20. A screening for traumatic brain injury						

III. Assessing and Planning Services **A. Conducting Intake Assessments** Intake Assessment Process	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
21. There are private, confidential spaces available to conduct intake assessments.						
22. Staff informs consumers about why questions are being asked.						
23. Throughout the assessment process, staff checks in with consumers about how they are doing (e.g., asking if they would like a break, water, etc.).						
24. The organization provides an adult translator for the assessment process if needed.						
25. Consumers are given the option of writing down responses to assessment questions, when preferred.						

III. Assessing and Planning Services **A. Conducting Intake Assessments** Intake Assessment Follow-up	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
26. Based on the intake assessment, staff determines female veterans' eligibility for VA and non-VA benefits and services.						
27. Based on the intake assessment, consumers are referred for specific services, as necessary.						
28. Releases and consent forms are updated whenever it is necessary to speak with a new provider.						
29. The assessment is updated on an ongoing basis.						

B. Developing Goals and Plans

III. Assessing and Planning Services **B. Developing Goals and Plans**	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
30. Staff partners with consumers in setting goals.						
31. Consumer goals are reviewed and updated regularly.						
32. Staff offers consumers step-by-step support as they begin to access outside services.						

C. Offering Services and Supports to Female Veterans

III. Assessing and Planning Services **C. Offering Services and Supports to Female Veterans** Emotional Supports	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
33. The organization has connections with mental health agencies with expertise in trauma (e.g., interpersonal violence, military sexual trauma, childhood abuse, combat-related trauma).						
34. The organization has connections with mental health agencies with expertise in working with female veterans.						
35. The organization has connections with agencies that provide substance abuse treatment.						
36. The organization has connections with agencies that provide services specifically for veteran youth/ young adults.						
37. The organization has connections with agencies that can address the needs of the gay, lesbian, bi-sexual, transgendered veteran community.						
38. The organization provides or refers female veterans to gender-specific therapy groups.						
39. The organization provides or refers female veterans to support groups with other female veterans.						
40. The organization supports a variety of peer-to-peer activities among female veterans within the agency.						
41. The organization provides opportunities for former homeless female veterans to mentor female veterans who are currently homeless and receiving services.						
42. The organization provides opportunities for female veterans to express themselves in creative and nonverbal ways (e.g., art, theater, dance, movement, music).						

III. Assessing and Planning Services **C. Offering Services and Supports to Female Veterans** Instrumental Supports	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
43. The organization has connections with agencies that provide a variety of services including housing, legal and educational advocacy, job training and placement programs, and health services.						
44. The organization has connections with the U.S. Department of Labor's Veteran employment and training service providers.						
45. The organization offers child care support/ alternatives for female veterans while they participate in services.						
46. The organization offers transportation options (e.g., bus passes, stipends) for female veterans.						
47. The organization considers child care and transportation issues when referring female veterans for additional services.						
48. The organization has connections with area hospitals/clinics/organizations that can provide gender-specific health care (female physicians, mammograms, etc.).						

III. Assessing and Planning Services **C. Offering Services and Supports to Female Veterans** Staffing and Hours	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
49. Female veterans have access to female case managers.						
50. Female veterans have access to female case managers who are veterans.						
51. The organization has clinicians with expertise in trauma and trauma-related interventions available (on staff or available for regular consultation).						
52. The organization has female clinicians who are veterans on staff or available for consultation.						
53. The organization has flexible hours for female veterans who work day and evening shifts.						

Community Outreach						
54. The organization has a relationship with its state VA women veterans coordinator.						
55. The organization has regular contact with the closest VA and Vet Center.						
56. The organization is aware of, and advertises, local stand-downs.						
57. The organization maintains communication and connections with a variety of agencies that provide services to female veterans.						
58. The organization educates community providers (mental health, homelessness, law enforcement, employers, schools, etc.) about the needs of female veterans.						
59. The organization provides community-based outreach regarding available resources and support for female veterans (street outreach, shelters and housing programs, colleges/universities, law enforcement agencies, employment and housing agencies, etc.).						

IV. INVOLVING CONSUMERS

A. Involving Current and Former Consumers

IV. Involving Consumers **A. Involving Current and Former Consumers** Current Consumers	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
1. The organization provides consumers with opportunities to express their needs and concerns.						
2. The organization provides opportunities for consumers to lead activities.						
3. Current consumers are involved in the development of agency activities and services.						
4. Current consumers are given opportunities to evaluate the organization and offer their suggestions for improvement in anonymous and/or confidential ways (e.g., suggestion boxes, regular satisfaction surveys).						
Former Consumers						
5. Formerly homeless consumers are involved in program development.						
6. Formerly homeless consumers are involved in providing services.						
7. Female veterans who have experienced homelessness are invited to share their thoughts, ideas, and experiences with the organization.						

V. ADAPTING POLICIES

A. Creating Written Policies

V. Adapting Policies **A. Creating Written Policies**	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
1. The organization has a written statement that includes a commitment to understanding trauma and engaging in trauma-sensitive practices.						
2. The organization has a written statement that includes a commitment to understanding the needs of female veterans and tailoring services to meet those needs.						
3. The organization has a written commitment to demonstrating respect for cultural differences and practices.						
4. The organization has a written commitment to hire staff who have experienced homelessness.						
5. The organization has a written commitment to hire female veterans and/or female military-affiliated staff and former homeless female veterans.						
6. The organization has a written policy to address potential threats to consumers from persons outside of the agency.						
7. The organization has a written policy outlining program responses to consumer crises (e.g., self-harm, suicidal thinking, aggression towards others).						
8. The organization has written policies outlining professional conduct for staff (e.g., boundaries, responses to consumers, etc.).						

B. Reviewing Policies

V. Adapting Policies **B. Reviewing Policies**	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
9. The organization reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors.						
10. The organization reviews its policies on a regular basis to identify whether they are sensitive to the specific needs of female veterans.						
11. The organization involves staff in its review of policies.						
12. The organization involves consumers in its review of policies.						

VI. WORKING WITH CHILDREN

VI. Working with Children The following are trauma-informed practices for working with children:	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
1. The organization incorporates child-friendly decorations and materials.						
2. The organization provides a space for children to play.						
The intake assessment includes questions about:						
3. Children's trauma exposure (e.g., neglect, abuse, exposure to violence).						
4. Children's achievement of developmental tasks.						
5. Children's history of mental health issues.						
6. Children's history of physical health issues.						
7. Children's prior experiences of homelessness.						
8. Children's experiences during and after the deployment of their parents.						
9. Based on the intake assessment, children are referred for further assessment and services as needed.						
10. Staff works with consumers to identify a plan to address their children's needs.						
11. Every child in the program has a written crisis-prevention plan.						

VI. Working with Children **(continued)**	Strongly Disagree (This rarely or never happens)	Disagree (This usually does not happen)	Agree (This happens some of the time)	Strongly Agree (This happens most of the time)	Do Not Know	Not Applicable to My Program
12. The program has connections with mental health agencies that have expertise in working with children who have experienced trauma.						
13. The program has access to early childhood education programming.						
14. The program has access to services that are designed for military families and children of veterans.						

RESOURCE LISTS

Selected Resources On Female Veterans, Homelessness, and Trauma

Below you will find additional resources that include those designed to address the needs of women veterans, particularly new programs to help women veterans who are homeless.

All private sector publications and websites listed are for information purposes only. The inclusion of such references should not be construed as an official endorsement by the Department of Labor or the Women's Bureau of the identified entities, their products, or their services.

FEMALE VETERANS

Printed Material and Video

Foster, L., & Vince, S. (2009). *California's women Veterans: The challenges and needs of those who serve.* California Research Bureau, California State Library. Available at www.library.ca.gov/crb/09/09-009.pdf

In Their Boots. Video documentary series. Available at www.intheirboots.com/itb

Lohaus, D. (Director). (2006). *When I Came Home* [Lohaus Films LLC]. Available at www.whenicamehome.com

McLagan, M. (Director) & Sommers, D. (Director). (2008). *Lioness* [Room 11 Productions]. Available at www.lionessthefilm.com

Mulhall, E. (2009). *Women warriors: Supporting she 'who has borne the battle.'* (Issue Report). Available at www.media.iava.org/IAVA_WomensReport_2009.pdf

U.S. Department of Veterans Affairs Center for Women Veterans (September, 2010). *Women Veterans – A proud tradition of service.* Advisory Committee on Women Veterans Report. Available at www.va.gov/WOMENVET/docs/ACWV_Report_2010.pdf

Websites

Grace After Fire. www.graceafterfire.org

Service Women's Action Network (SWAN). www.servicewomen.org

Swords to Plowshares (Swords). www.swords-to-plowshares.org

U.S. Department of Veterans Affairs, Center for Women Veterans. www.va.gov/womenvet

U.S. Department of Veterans Affairs, Homeless Veterans. www.va.gov/Homeless

U.S. Department of Veterans Affairs, National Center for PTSD. www.ptsd.va.gov

U.S. Department of Veterans Affairs, Women Veterans Health. www.va.gov/womenvet

GENERAL TRAUMA INFORMATION

Printed Material

American Psychological Association (2007, February). *The psychological needs of U.S. military members and their families: A preliminary report.* Presidential Task Force on Military Deployment Services for Youth, Families and Service Members. Available at www.apa.org/about/governance/council/policy/military-deployment-services.pdf

Bassuk, E.L., Dawson, R., Perloff, J., & Weinreb, L. (2001). Post-traumatic stress disorder in extremely poor women: Implications for health care clinicians. *Journal of the American Medical Women's Association,* 56, 79-85.

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

Van der Kolk, B.A., McFarlane, A.C., & Weisaeth, L. (Eds.). (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society.* New York, NY: Guilford Press, 214-241.

Websites

The Adverse Childhood Experiences (ACE) Study. www.acestudy.org

Community Connections. www.communityconnectionsdc.org

National Center for Post Traumatic Stress Disorder (PTSD). www.ptsd.va.gov

National Child Traumatic Stress Network. www.nctsnet.org

Traumatic Brain Injury Model Systems National Data and Statistical Center (TBINDSC). www.tbindsc.org

HOMELESSNESS AND TRAUMA

Printed Material

Bassuk, E.L., & Friedman, S.M. (2005). *Facts on trauma and homeless children.* The National Child Traumatic Stress Network, Homelessness and Extreme Poverty Working Group. Available at www.nctsnet.org

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

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

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Nyamathi, A., Wenzel, S., Lesser J., Flaskerud, J., & Leake, B. (2001). Comparison of psychosocial and behavioral profiles of victimized and non-victimized homeless women and their intimate partners. *Research in Nursing and Health, 24*(4), 324-335.

The National Center on Family Homelessness. (1999). Homeless children: America's new outcasts. Newton, MA. Available at www.familyhomelessness.org

Vostanis, P., Tischler, V., Cumella, S., & Bellerby, T. (2001). Mental health problems and social supports among homeless mothers and children victims of domestic and community violence. *International Journal of Social Psychiatry, 47*(4), 30-40.

Wenzel, S., Leake, B., & Gelberg, L. (2001). Risk factors for major violence among homeless women. *Journal of Interpersonal Violence, 16*(8), 739-752.

Zlotnick, C., Tam, T., & Bradley, K. (2006). Impact of adulthood trauma on homeless mothers. *Community Mental Health Journal, 43*(1), 13-32.

Websites

Department of Housing and Urban Development and the Department of Veteran's Affairs HUD-VASH Program provides housing vouchers for eligible homeless Veterans and families. More information available at www.hud.gov/offices/pih/programs/hcv/vash/#1

National Coalition for Homeless Veterans. www.nchv.org

SAMHSA's Resources for Returning Veterans and Their Families. www.samhsa.gov/vets

The Homelessness Resource Center. www.homeless.samhsa.gov

The National Center on Family Homelessness. www.familyhomelessness.org

U.S. Department of Veterans Affairs Homeless Veterans Page. www.va.gov/homeless

CULTURAL COMPETENCE

Printed Material

Bronheim, Suzanne. (2006). *Cultural competence: It all starts at the front desk.* National Center on Cultural Competence. Georgetown Center for Child and Human Development. Washington, DC.

Center for Deployment Psychology, Course 101: Military Culture and Terminology available at www.deploymentpsych.org/training/training-catalog/military-culture-and-terminology

Department of Veteran Affairs, National Center for PTSD. *Military culture.* Available at www.ptsd.va.gov/professional/ptsd101/course-modules/military_culture.asp

Essential Learning, *Military cultural competence.* Available at www.essentiallearning.net/student/content/sections/Lectora/MilitaryCultureCompetence/index.html

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The National Child Traumatic Stress Network. (2006). *Trauma among lesbian, gay, bisexual, transgender, and/or questioning youth.* Washington, DC. Available at www.nctsnet.org/nccts/asset.do?id=885

Website

National Child Traumatic Stress Network. www.nctsnet.org

TRAUMA-INFORMED SERVICES

Printed Material

Harris, M. and Fallot, R. (Eds). (2001). *Using trauma theory to design service systems.* San Francisco, CA: Jossey-Bass.

Jahn Moses, D., Huntington, N., & D'Ambrosio, B. (2004). *Developing integrated services for women with co-occurring disorders and trauma histories: Lessons from the SAMHSA women with alcohol, drug abuse and mental health disorders who have histories of violence study.* National Center for Trauma Informed Care. Available at www.mentalhealth.samhsa.gov/cmhs/womenandtrauma

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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

Website

National Center for Trauma-Informed Care. www.mentalhealth.samhsa.gov/nctic

CONSUMER INVOLVEMENT

Printed Material

Prescott, L. (2001). *Consumer/survivor/recovering women: A guide for partnerships in collaboration.* Delmar, NY: Policy Research Associates. Available at www.mentalhealth.samhsa.gov/cmhs/womenandtrauma

Prescott, L. (2001). *Defining the role of consumer-survivors in trauma-informed systems.* In M. Harris & R. Fallot (Eds.). *Using trauma theory to design service systems.* San Francisco, CA: Jossey-Bass.

Websites

National Consumer Advisory Board to the National Health Care for the Homeless Council. www.nhchc.org/advisory.html

National Empowerment Center. www.power2u.org

EMPLOYMENT

Printed Material

Job Accommodation Network. *Employees with mental health impairments.* Available at www.askjan.org/media/Psychiatric.html

U.S. Department of Labor, Bureau of Labor Statistics. *Employment situation of Veterans.* Available at www.bls.gov/spotlight/2010/Veterans/ and www.bls.gov/spotlight/2010/Veterans/ and www.bls.gov/news.release/pdf/vet.pdf

Websites

America's Heroes at Work. www.americasheroesatwork.gov/

Ending Chronic Homelessness through Employment and Housing Grantees. www.csh.org/index.cfm?fuseaction=page.viewPage&pageID=3641&nodeID=81

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SELF-CARE FOR SERVICE PROVIDERS

Printed Material

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Stamm, B.H. (2005). *The ProQOL manual: The professional quality of life scale: Compassion satisfaction, burnout and compassion fatigue/secondary traumatic stress scales.* Washington, DC: Register Report: A Publication of the National Register of Health Service Providers in Psychology.

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Volk, K., Guarino, K., Grandin, M.E., Clervil, R. (2008). *What about you? A workbook for those who work with others.* Newton, MA: National Center on Family Homelessness. Available at www.familyhomelessness.org

Website

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INTERVENTIONS AND TRAINING RESOURCES

Printed Material

Clark, C., & Fearday, F. (Eds.). (2003). *Triad women's project: Group facilitator's manual.* Tampa, FL: Louis de la Parte Florida Mental Health Institute, University of Southern Florida. For more information, contact Dr. Colleen Clark at cclark@fmhi.usf.edu

D'Ambrosio, B. & Jahn Moses, D. (2002). *Nurturing families affected by substance abuse, mental illness, and trauma: A parenting curriculum for women and children.* The Coordinating Center of the SAMHSA Women, Co-Occurring Disorders, and Violence Study. Available at www.mentalhealth.samhsa.gov/cmhs/womenandtrauma

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Greendlinger, R. and Spadoni, P. (2010). *The tool kit for effectively engaging and delivering services to America's Veterans and their families.* Newton, MA: The National Center on Family Homelessness. Available at www.familyhomelessness.org/resources

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Harris, M., & Anglin, J. (1998). *Trauma recovery and empowerment: A clinician's guide for working with women in groups.* New York, NY: Free Press. This and other resources about TREM are available at www.communityconnectionsdc.org/

Kinniburgh, K. and Blaustein, M. (2005). *Attachment, self-regulation, and competency: A comprehensive framework for intervention with complexly traumatized youth.* Brookline, MA: The Trauma Center.

Najavits, L. (2001). *Seeking safety: A treatment manual for PTSD and substance abuse.* New York, NY: Guilford Press.

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SUBSTANCE ABUSE AND TRAUMA

Printed Material

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

Miller, D. & Guidry L. (2001). *Addictions and trauma recovery: Healing the body, mind, and spirit.* New York, NY: NP Psychotherapy Books.

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CHILDREN AND TRAUMA

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Greenwald, R. (2005). Child trauma handbook. New York, NY: Haworth Press.

Sesame Workshop's Talk, Listen, Connect Initiative - Bilingual resources and support to military families with young children facing challenging transitions in their life including coping with deployments, homecomings, injuries, and death. More information available at www.sesameworkshop.org/initiatives/emotion/tlc/fundingpartners

APPENDIX I: ENHANCEMENTS TO VA SERVICES FOR WOMEN VETERANS

Women are one of the fastest growing subgroups of U.S. veterans. The number of women veterans is expected to increase dramatically over the next 10 years, and VA benefits, particularly health care, are in high demand by the women veterans of Operation Enduring Freedom and Operation Iraqi Freedom. The Department of Veterans Affairs is committed to meeting the needs of women veterans and is enhancing services in the following areas:

HEALTH CARE

VA is enhancing health care services for women veterans in its endeavor to be a national leader in the provision of women's health care. Current initiatives include:

- Redesigning primary care for women veterans so that care for acute and chronic illness, gender-specific primary care, preventive services, mental health services, and coordination of specialty care is delivered by one provider at one site
- Integrating mental health into the primary care setting for better continuity of care
- Staffing every VA medical center with a full-time Women Veterans Program Manager to assist women veterans in navigating the health care system
- Creating a mini-residency training program to educate primary care providers on women's health
- Supporting a multi-faceted research program on women's health
- Improving communication and outreach to women veterans through a national health outreach campaign, spearheaded by the Women Veterans Program Managers
- Working to make the language, practices, and culture of the VA more inclusive of women veterans
- Exploring ways to enhance care for women veterans with disabilities through a Prosthetics Women's Workgroup, focusing on technology, research, training, and repair and replacement of prosthetic appliances specific to women

HOMELESSNESS

Women were 7.5% of the 136,334 homeless veterans who were sheltered sometime between October 1, 2008 and September 30, 2009. In 2009, Secretary of Veterans Affairs Eric K. Shinseki pledged to end homelessness among veterans within the next five years. Efforts to meet this goal include:

- In 2010, making available $17 million in grants to community groups in 19 states, the District of Columbia, and Puerto Rico to create 1,155 beds for homeless veterans this year
- Launched a 24/7 **National Call Center for Homeless Veterans** staffed by VA counselors trained to help homeless veterans or veterans at risk for homelessness **1-877-4AID-VET (1-877-424-3838)**
- Operating the Health Care for Homeless Veterans Program to provide outreach, physical, and psychiatric examinations and referrals for more than 40,000 veterans annually at 132 sites
- Providing residential treatment to more than 5,000 homeless veterans each year in VA domiciliaries

- In collaboration with the Department of Housing and Urban Development (HUD), created independent housing opportunities for homeless veterans through its HUD-VASH (VA Supported Housing) Program. Approximately 30,000 Section 8 Housing Choice Vouchers have been made available for homeless veterans, including homeless veterans with families. Veterans who receive vouchers are also provided with case management by VA Staff.

BENEFITS

VA administers a variety of benefits and services that provide financial and other forms of assistance to veterans, their dependents, and survivors. VA is working to streamline paperwork and expedite the process for veterans seeking compensation for disabilities related to their military service. Recent progress includes:

- Shortening application forms for veterans applying for the first time to the VA for disability compensation or pension benefits
- Introducing two new forms for veterans participating in the Department's new, fully developed claim (FDC) program, which is one of the fastest means to a claims decision

VA has also recently added eBenefits.va.gov, an online resource for benefits-related information for veterans.

READJUSTMENT SERVICES

VA Vet Centers provide professional readjustment counseling, military sexual trauma counseling, community education, outreach to special populations, and brokering of services with community agencies to veterans — men and women — who have served in combat zones or who have experienced military sexual trauma or harassment. More than 40% of Vet Center staff are women, allowing centers to offer gender-sensitive transition assistance, including military sexual trauma counseling, to women veterans.

Recent efforts of special interest to women include:

- **Enhanced access to MST counseling** – To increase the program's capacity to provide MST counseling, a qualified MST counselor is planned for every Vet Center. During the interim, Vet Centers currently without a qualified MST counselor will minimally have the capacity to assess and refer MST veterans.
- **Improved access to Family counseling** – Vet Centers recognize that family members are central to the combat veteran's readjustment. To meet the need for qualified family counselors, the VA Readjustment Counseling Service has developed qualifying criteria for family counselors in Vet Centers. The Vet Center program is implementing a plan to place at least one qualified, specialized, family counselor in every Vet Center nationwide.

APPENDIX 2: ADDITIONAL ENHANCEMENTS FOR WOMEN VETERANS THROUGH THE WOMEN VETERANS HEALTH STRATEGIC HEALTH GROUP

The VA began providing medical and psychosocial services for women in 1988, when women represented 4.4 percent of all veterans. Currently, VA projects that women will make up 15% of the veteran population receiving care from VA by 2012. The Women Veterans Health Strategic Health Care Group (WVHSHG) provides programmatic and strategic support to implement positive changes in the provision of care for all women veterans. The VA is actively addressing resource needs so that the proper training, as well as equipment and supplies (including DEXA scans, mammography machines, ultrasound and biopsy equipment) are in place in its facilities. The WVHSHG is coordinating closely with Primary Care Services to redesign the delivery of primary care to women veterans to include gender-specific care at every VA site. Ultimately, comprehensive primary care delivered by a single provider in the same location — including gender-specific care and mental health — will be the predominant model of care throughout the VA health care network in alignment with the principles of Patient-Centered Medical Home.

The WVHSHG partners with VA Employee Education Services to conduct mini-residencies in Women's Health. To date, more than 400 VA providers have been trained. A second round of mini-residencies, covering additional women's health topics will get underway in late 2010, focuses on more advanced women's health topics. Grants released to the field allow for the training of additional providers by facilities. In addition, VA facilities are recruiting new providers interested and proficient in women's health to meet the needs of its growing population of women veterans.

In collaboration with VA experts, WVHSHG is tackling women's reproductive health issues. Reducing the risk of birth defects due to teratogenic medications is a top priority for WVHSHG. Other important efforts include improving follow-up of abnormal mammograms, tracking the timeliness of breast cancer treatment, and developing specific clinical action strategies for women with human papillomavirus.

The WVHSHG is leading development of a Veterans Health Administration-wide communication plan to enhance the language, practice, and culture of the VA to be more inclusive of women veterans. A national Women's Health Communications Workgroup develops and disseminates standardized outreach materials to raise awareness of the women veteran population and their unique needs. Branding Women Veterans Health Care with a powerful identity, including a visual logo and tagline — You Served, You Deserve the Best Care Anywhere — is helping establish a consistent, nationally recognized symbol for high quality services that women veterans should expect at every VA facility.

WVHSHG also works closely with VA analysts and data specialists to ensure that women veteran populations are represented clearly in statistical data, including demographics, epidemiology, health status, and quality of care. Enhanced web capabilities are continually being implemented to improve the transfer of information among field and leadership personnel.

For the first time in 25 years, the VA surveyed women veterans across the country to: (1) identify in a national sample the current status, demographics, health care needs, and VA experiences of women veterans of the U.S. Armed Forces; (2) determine how health care needs and barriers to VA health care use differ among women veterans of different periods of military service; and (3) assess women veterans' health care preferences in order to address VA barriers and health care needs. The interim report, released in summer 2010, informs policy and planning and provides a new baseline for program evaluation with regard to veterans' perceptions of VA health services. The final report will be released in spring 2011.

Contact Us

U.S. Department of Veterans Affairs
Women Veterans Health Strategic Health Care Group (13E)
810 Vermont Avenue, NW
Washington, DC 20420

Women veterans who are interested in receiving care at the VA should contact the nearest VA Medical Center and ask for the Women veterans Program Manager. Women Veterans Program Managers are designated at every VA medical center across the nation to advise and advocate for women veterans.

To find the nearest VA health care facility:

By phone: 877-222-VETS (8387)

www.publichealth.va.gov/womenshealth

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