Implementation of Trauma-Informed Care in Violence against Women (VAW) Services:
A Literature Review Investigating the Benefits and Barriers

Prepared for the Service System Excellence Committee
VAW Forum for the Central West Region

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November, 2012

Introduction

The purpose of this paper is to review literature pertinent to the implementation of trauma-informed care. The prevalence of trauma-informed systems of care in human services, the rationale behind its implementation, as well as the potential benefits and barriers to its implementation in VAW services are explored.

Indicators of the Prevalence of Trauma-Informed Services Implementation

Elliot, Bjelajac, Fallot, Markoff, and Reed (2005) contend that although some might say that trauma-informed services simply represent high-quality, empowering practices that are not specific to the treatment of trauma, these practices are essential for trauma survivors (hereafter referred to as survivors), who may not be able to participate in or benefit from services without them. As the majority of clients who access human service systems are likely survivors (see Elliot et al., p. 462, for examples of sources supporting this claim), the implementation of trauma-informed services is seen by many as paramount.

As awareness of the prevalence and impacts of trauma increases, a rising number of states in the U.S. have taken significant steps toward integrating knowledge about trauma into existing services. In 2001, about 12 states formed an informal network (State Public Systems Coalition on Trauma [SPSCOT]) to share ideas and support the development of trauma-informed systems of care. State mental health policymakers including commissioners and senior staff, trauma experts, advocates, and mental health consumers with histories of sexual and physical abuse trauma (Consumer/Survivor/Recovering persons [CSRs]) compiled a list of criteria for

building trauma-informed mental health service systems, and a report entitled *Trauma Services Implementation Toolkit for State Mental Health Agencies* was prepared, listing trauma-related activities, initiatives, and resources created by 15 state public services systems. By 2004, the number of states participating in this network had increased to 31, accompanied by an increase in trauma-informed strategies and programs (Jennings, 2007, p.13).[1]

In 2005, the National Center for Trauma-Informed Care (NCTIC) was created to offer technical assistance to stimulate and support interest in and implementation of trauma-informed care in publicly funded systems and programs. The NCTIC is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), and is rooted in the long-term commitment of SAMHSA to improve public behavioural health service system responses to consumers and survivors. Of particular note in the evolution of the NCTIC is the 1998 launch of the Women, Co-Occurring Disorders, and Violence Study (WCDVS), a five year, multi-site project which explored the interrelation between violence, trauma, and co-occurring mental health and substance use disorders among women. The WCDVS sparked the development of guiding principles for positive change, including the principle that providers should be mindful of the ways in which their own practices and policies might put women in danger, physically and emotionally, or bring about re-traumatization (SAMHSA, n.d.). The study found that integrated, trauma-informed models of substance use and mental health treatment for women were more effective than treatment that was not trauma-informed and did not cost more (Veysey & Clark, 2004, as cited in Poole, 2012, p. 1).

Although not nearly as well-developed as in the U.S., some examples of Canadian initiatives which support the implementation of trauma-informed services include: the

[1] See Jennings (2008) for the most recent update of this report.

Coalescing on Women and Substance Use: Linking Research, Practice and Policy project (2003-2008)[2] sponsored by the British Columbia Centre of Excellence for Women's Health (BCCEWH); the Klinic Community Health Centre's (located in Winnipeg, Manitoba) manual on implementing trauma-informed practices, entitled *The Trauma-Informed Toolkit* (2008); the Centre for Addiction and Mental Health's (CAMH, located in Toronto, Ontario), recent publication, *Becoming Trauma Informed* (Poole & Greaves, 2012);[3] Homewood Hospital's (located in Guelph, Ontario) implementation of a program for traumatic stress recovery which merged the concepts of the trauma-informed Sanctuary model with that of the therapeutic community (Wright et al., 2003, as cited in Jennings, 2007, p. 33); the *Trauma Talks* conference[4] which was hosted by Women's College Hospital in Toronto, Ontario on June 3, 2012, in which presenters spoke to what it means to be trauma-informed, why it is important, and how to build trauma-informed care in a multi-disciplinary environment; and the Canadian Mental Health Association's professional training on trauma-informed helping skills for front-line workers (CMHA Ontario, n.d.).

One indicator of the increasing importance that is being placed on the implementation of trauma-informed practices in VAW services specifically is the establishment of the National Center on Domestic Violence, Trauma & Mental Health[5] in the U.S. in 2005. This organization's mission is to develop and promote accessible, culturally relevant, survivor-defined, socially just, and trauma-informed responses to domestic violence and other lifetime

[2] See http://www.coalescing-vc.org
[3] See http://www.bccewh.bc.ca/news-events/documents/BookFlyerBecomingTraumaInformed.pdf for book flyer.
[4] See http://www.traumatalks.ca/
[5] See www.nationalcenterdvtraumamh.org

trauma. Also, a number of domestic violence shelters are members of the Sanctuary[6] network, and thus are Certified Sanctuary Organizations. Additionally, two grey literature publications were found that are specific to the implementation of trauma-informed care in VAW settings: *Trauma-Informed Care: Best Practices and Protocols for Ohio's Domestic Violence Programs* (Ferencik & Ramirez-Hammond, 2011); and *A Practical Guide for Creating Trauma-Informed Disability, Domestic Violence and Sexual Assault Organizations* (Wisconsin's Violence Against Women with Disabilities and Deaf Women Project [WVAWDDWP], 2011). Two journal articles were also found which describe the implementation of trauma-informed care in VAW settings (Madsen, Blitz, McCorkle, & Panzer, 2003; Unknown, 2010). These sources will be discussed in further detail in subsequent sections of this paper. Finally, it is also important to note that the WCDVS included some sites which were defined as VAW settings (e.g. Elliot et al., 2005; Gatz, Russell, Grady, Kram-Fernandez, Clark, & Marshall, 2005; Moses, Reed, Mazelis, & D'Ambrosio, 2003), although as the study was not focused on VAW settings specifically, these sources will be discussed in lesser detail.

What are the Negative Impacts of Trauma?

A traumatic experience is an event that continues to exert negative effects on thinking, feeling, and behaviour long after the event has passed (Haskell, 2001, p. 4). Traumatic experiences can interfere with a survivor's sense of safety, self, and self-efficacy, as well as their ability to regulate emotions and navigate relationships. Trauma can also affect survivors' memory and attention (Ferencik & Ramirez-Hammond; WVAWDDWP, 2011), and has been

[6] See http://www.sanctuaryweb.com/shelters.php. A more thorough description of Sanctuary occurs later in this paper.

associated with a number of physical health conditions (Moses et al., 2003; Jennings, 2007; WVAWDDWP; Larson et al., 2005). Survivors commonly feel terror, shame, helplessness and powerlessness (Poole, 2012, p. 1; Herman, 1997, as cited in Ferencik & Ramirez-Hammond, 2011, p. 3). They often live lives of great pain and confusion, and may not initially recognize trauma as the source of many of their struggles (Moses et al., 2003).

Although 'single blow' traumatic experiences that occur later in life such as accidents, natural disasters, sudden unexpected losses, and other life events that are out of one's control can be devastating (Poole, 2012), the effects of trauma are especially acute when violence is repeated, begins in childhood, and/or is perpetrated by someone the person should be able to trust (Moses et al., 2003).

The terms 'violence,' 'trauma,' 'abuse' and 'post-traumatic stress disorder' (PTSD) are often used interchangeably. Trauma expert Stephanie Covington suggests that one way to clarify these terms is to think of trauma as a response to violence or some other overwhelmingly negative experience. As such, trauma is both an event and a response to an event (2003, as cited in Poole, 2012, p. 1).

Trauma responses are normal responses to abnormal situations (Ferencik & Ramirez-Hammond, 2011, p. 4). They can be viewed as strategies which are often important and self-protective mechanisms in coping with trauma-exposure (Herman, 1997, as cited in Ferencik & Ramirez, p. 3). Many behaviours and responses that may seem ineffective and unhealthy in the present represent adaptive responses to past traumatic experiences (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009, p. 17). For example, coping strategies developed to endure abuse such as denial of the abuse, minimizing its importance and consequences, and/or believing that the

abuse was reasonable, may help the survivor to endure the abuse while it is occurring (and are often encouraged by those perpetrating the abuse), but can eventually limit quality of life and be perceived as pathological conditions (Carmen & Reiker, 1989, as cited in Moses et al., 2003, p. 4).

In the clinical literature (built upon the work of Judith Herman, 1992, as cited in Poole, 2012, p. 1), trauma responses are generally categorized in three 'clusters': (1) reliving the event through recurring nightmares, flashbacks or other intrusive images that 'pop' into one's head at any time; (2) avoiding reminders of the event, including places, people, thoughts or other activities associated with trauma (survivors become emotionally numb, withdraw from friends and family and lose interest in everyday activities); and (3) hyper-arousal or vigilance, which refers to being on guard at all times, and can include irritability or sudden anger, difficulty sleeping, lack of concentration, and being overly alert or easily startled (Haskell, 2001, p. 7).

The mental health diagnoses of borderline personality disorder, schizophrenia, depression and other affective disorders, anxiety disorder, eating disorder, psychosis, dissociative disorder, addiction, somatoform, and sexual impairment have all been related to survivors' past trauma experiences (Jennings, 2007, p. 10; Moses et al, 2003, p. 3). In spite of the prevalence of trauma and its severe impacts on mental health, a primary or secondary trauma-based diagnosis of PTSD is seldom given (Jennings, 2007, p. 10). Many survivors develop extreme coping strategies to manage the impacts of traumatic stress, including suicidality, substance use, self-harming behaviours such as cutting and burning, hallucinations, emotional numbing and dissociation, hyper-vigilance, somatization, aggression and rage, re-enacting abusive relationships, and serious health risk behaviours (Jennings, p. 11).

Fallot & Harris (2004) assert that for many survivors, trauma is central in the development of substance use and mental health issues. Zweig, Schlichter, and Burt (2002, p. 163) cite numerous studies that have linked violent victimization, substance use, and mental health concerns in client populations. There is evidence that substance use and/or mental health concerns can also create vulnerability to violence, and that having these conditions may intensify the effects of abuse; thus, the association among the three issues of violence, mental health concerns, and substance use is dynamic, cumulative, and complex[7] (Gatz et al., 2005).

Trauma responses create obstacles to services, treatment, and recovery for survivors (Saakvitne, Gamble, Pearlman, & Lev, 2000, as cited in Elliot et al., 2005, p. 463). Survivors are often reluctant to engage in, or quickly drop out of, many human services. For example, the trauma responses of vigilance and suspicion may make it more difficult for survivors to feel the safety and trust necessary to benefit from helping relationships (Fallot & Harris, 2006). Unaddressed trauma history can result in a survivor resorting to drug use to manage her anxiety and flashbacks. If this is understood only as a relapse and/or a lack of commitment to sobriety, neither staff nor the survivor will make the connections necessary to assist her to substitute other means of coping, or reducing the trauma response of substance use (Kalinowski & Penney, 1998, as cited in Moses et al., 2003, p. 6; Jennings, 1997, as cited in Moses et al., p. 6). Additionally, the lack of coordination between mental health, substance abuse, and trauma or violence services does not allow for multiple problems to be addressed simultaneously. Trauma survivors often cycle in and out of public mental health and substance abuse systems for years, using a tremendous number of services without experiencing any improvement. Thus, human service

[7] See BCSTH (2011a; 2011b) for further discussion regarding the relationships among violence, substance use, and mental health, as well as promising practices to address service barriers related to these issues which are *not* trauma-informed.

systems erode trust, empowerment, and a sense of safety, and survivors begin to disengage and may refuse assistance (Moses et al.; Harris & Fallot, 2001, as cited in Elliot et al., p. 463).

What are Trauma-Informed Services?

In their seminal manual on the design and implementation of trauma-informed service systems, Harris and Fallot (2001, as cited in Poole, 2012, p. 2) state that trauma-informed services take into account an understanding of trauma in all aspects of service delivery and place priority on survivors' safety, choice and control. They are based on the recognition that many behaviours and responses expressed by survivors are directly related to traumatic experiences (The Center for Mental Health Services, as cited in Ferencik & Ramirez-Hammond, 2011, p. 5).

Building on the work of Harris and Fallot (2001), Elliot et al. (2005)[8] describe 10 principles of trauma-informed service organizations which were developed through consensus decision-making by a workgroup composed of members representing a variety of stakeholders (including direct service staff and CSR women) during the WCDVS. They are as follows: (1) Trauma-informed services recognize the impact of violence and victimization on development and coping strategies; (2) Trauma-informed services identify recovery from trauma as a primary goal; (3) Trauma-informed services employ an empowerment model; (4) Trauma-informed services strive to maximize a woman's choices and control over her recovery; (5) Trauma-informed services are based in a relational context (interpersonal trauma needs to be healed in a context in which interpersonal relationships are opposite of traumatizing); (6) Trauma-informed services create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance; (7) Trauma-informed services emphasize women's strengths, highlighting

[8] Also see Markoff, Fallot, Reed, Elliott, & Bjelaljac (2005).

adaptations over symptoms and resilience over pathology; (8) The goal of trauma-informed services is to minimize the possibilities of re-traumatization; (9) Trauma-informed services strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background; and (10) Trauma-informed agencies solicit consumer input and involve consumers in designing and evaluating services. Additionally, mental health, substance use, and trauma services require integration in order that all services available to women are trauma-informed (Moses et al., 2003).

It is important to clarify the distinction between trauma-informed and trauma-specific services. Trauma-informed services are not specifically designed to treat symptoms or syndromes related to trauma, but they are informed about, and sensitive to, trauma-related issues present in survivors. A trauma-informed system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of survivors seeking services. Trauma-specific services are designed to treat the actual sequelae of trauma. Examples of trauma-specific services include grounding techniques which help trauma survivors manage dissociative symptoms, desensitization therapies which help to make painful images more tolerable and behavioural therapies which teach skills for the modulation of powerful emotions (Harris & Fallot 2001, as cited in Jennings, 2007, p. 21).

Implementation of Trauma-Informed Care in VAW Services

Poole (2012) emphasizes that trauma is pervasive. This is especially so for women and children. It is estimated that in Canada, 1 in 3 women have experienced violence at some point

in their adult lives and that 1 in 10 women are presently experiencing violence (Statistics Canada, 1993, as cited in BCSTH, 2011a, p. 4). Moses et al. (2003, p. 3) cite numerous sources in stating that 20 to 30 percent of women report sexual and/or physical victimization during their lifetime; that 10 to 12 percent of women have been sexually abused during childhood and 13 to 17 percent have been physically abused; and that 20 to 27 percent of women experienced sexual molestation during childhood, with 70 to 90 percent of those reporting the perpetrator as someone they knew. Women who were abused as children are also at increased risk for violence in adulthood, as 70 to 80 percent of women who experience domestic violence have also survived physical and/or sexual abuse during childhood.

Domestic violence is by nature chronic. It is an ongoing traumatic experience for all members of the family. While the physical violence may be episodic and/or infrequent, other forms of abuse are ongoing and complicate the survivor's experience of trauma. Most survivors will be interacting with their perpetrator, who is a loved one, on a regular basis (Ferencik & Ramirez-Hammond, 2011).

As the effects of trauma are especially acute when violence is repeated, begins in childhood, and/or is perpetrated by someone the person should be able to trust (Moses et al., 2003), based on the above statistics as well as the nature of domestic violence, it is clear that survivors of domestic violence are definitely susceptible to the negative impacts of trauma. In a 2010 survey of Ohio's domestic violence programs, over 90 percent of respondents said that most of all adults and children who experience domestic violence have a traumatic experience that impacts their thoughts, feelings, or behaviours. However, only 14 percent of respondents stated that they felt that all staff and volunteers in their organizations had a working understanding of trauma responses and regularly incorporate that knowledge into service

provision (Ferencik & Ramirez-Hammond, 2011). Interestingly, when domestic violence, sexual assault, and disability organizations were asked who they find the most challenging to service, the issues they identified (e.g. people who do not want to be helped or who do not follow the rules) can be very easily reframed as traumatic impacts (WVAWDDWP, 2011). Thus, there is support for the contention that professionals working in VAW services need to develop a basic understanding of how traumatic experiences impact survivors.

Ferencik and Ramirez-Hammond's *Trauma-Informed Care: Best Practices and Protocols for Ohio's Domestic Violence Programs* (2011) applies the principles of trauma-informed care to VAW services in a practical manner, and is intended for direct service domestic violence advocates. They emphasize that services should foster survivor safety, choice, and control, and that the meaning of violence should be explored in a respectful way within the context of the survivor's family and culture. They note the importance of implementing practices to reduce secondary traumatic stress, vicarious trauma, and burnout, as these can affect the quality of life of advocates and can result in a loss of sensitivity toward survivors. Guidelines for taking crisis calls, performing intakes, facilitating support groups, performing exit interviews, physical and emotional safety planning, and providing parenting support in a trauma-informed manner are provided.

Based on Ochberg (1991, as cited in Ferencik & Ramirez-Hammond, 2011, p. 45), it is suggested that support efforts should be framed using four categories: (1) education about the impacts of trauma; (2) focus on holistic health (3); enhancing social support and integration; and (4) when necessary, providing referrals to a clinician who understands both the impact of trauma and the dynamics of domestic violence. Examples of advocate interventions tailored to specific trauma responses are provided; it is noted that when trauma responses are reframed in order that

the survivor can understand them as attempts to cope with intolerable circumstances, this understanding takes power away from perpetrators and an individual's abusive experiences. The potential for intrusive VAW practices (e.g. not permitting children to check on their mother when they feel anxious during intake procedures) to reproduce past abuses and intimidation experienced in the abusive relationship (e.g. the violation and re-imposition of hierarchical boundaries at the whim of the perpetrator) is acknowledged. The authors highlight the importance of embracing the practice of non-violence in words, tone, gesture, and actions in order to provide a sense of safety, respect, and trust, as well as the need for flexible yet consistent programming.

A Practical Guide for Creating Trauma-Informed Disability, Domestic Violence and Sexual Assault Organizations (WVAWDDWP, 2011) functions somewhat like a workbook. Knowledge about the impact of trauma is seen as essential, and the reader is guided through a series of questions in which they are asked to apply information about the impact of trauma to case vignettes as well as the policies and procedures of the organization at which they currently work, volunteer, or receive services. The reader is prompted to imagine what it might be like for a survivor to access services and guided through exercises geared toward the identification of opportunities for trauma-informed organizational change. Safety is considered as it relates to autonomy, hospitality, and accessibility, and explored in terms of how these principles might manifest in every day support situations. Additionally, the violence and abuses of power experienced by individuals with disabilities due to the experiences they have had which put them at more risk to be exploited (e.g. the culture of institutionalization) are recognized. A list of practices that survivors have experienced as misuses of power and control are given, the pivotal

role of supervision in trauma-informed organizational change is highlighted, and a number of universal safeguards meant to prevent re-traumatizing survivors are suggested.

Unknown (2010) discusses the use of Motivational Interviewing (MI), an evidence-based, client-centered, and guiding communication style, within trauma-informed work with survivors of interpersonal violence (IPV). The purpose of MI is to create a nonjudgmental, supportive environment for survivors as they move through various stages of behaviour change, and to guide them in exploring and ultimately strengthening their motivation for health-promoting growth. Both trauma-informed practice and MI focus on strengths and self-efficacy, while emphasizing collaboration, empowerment, respect for choice, and an understanding of the survivor's perspective. A case vignette is provided in order to exemplify what this approach might look like in IPV work. The authors recommend that further research is needed to establish the efficacy of the framework for this population.

Madsen, Blitz, McCorkle, & Panzer (2003) explore the process of implementing the trauma-informed Sanctuary model in a domestic violence shelter as a way to address trauma and its impact on clients and staff. This model is based on theories of trauma and attachment, rests on a basic commitment to safety and nonviolence, and consists of two key components: the creation of a therapeutic milieu designed to help people develop healthy attachments, and psycho-education geared toward emotional, social, cognitive, and behavioural recovery from trauma. It also emphasizes a flattened hierarchy, inclusion of multiple perspectives, and group consensus on norms, values, and expectations. Implementation occurred gradually over a three year period. Anecdotally, the authors claim that implementation resulted in an evolution in shelter function from safe dwelling to a living-learning environment, and the creation of a

therapeutic milieu which helps staff to work collaboratively with increased effectiveness and respect for all members.

Challenges in Implementing Trauma-Informed Services

Although it is clear that there is much support for the implementation of trauma-informed services, it cannot be denied that significant barriers to implementation exist, as well as disagreement regarding the appropriateness of trauma-informed models to VAW services.

The WCDVS sites faced numerous challenges and barriers related to implementation. For example, many aspects of the interrelationship between mental health and substance use services had to be ironed out, including the timing and course of treatment, treatment strategies, and staffing (Moses et al., 2003). Similar to the experience of the WCDVS, research suggests that collaboration between VAW, mental health, and substance use services remains a desirable but elusive goal because providers have difficulty finding common ground with respect to philosophies and priorities. For instance, VAW services tend to emphasize immediate safety, whereas mental health and substance use services emphasize the long-term consequences of violence and related issues (Herz, Stroshine, & Houser, 2005). Although domestic violence advocates acknowledge that experiencing abuse at the hands of an intimate partner can be traumatic, it can also be difficult to view domestic violence through the lens of trauma during daily advocacy activities concerned with physical safety and crisis intervention (Ferencik & Ramirez-Hammond, 2011).

The ability of VAW services to provide assistance to those with mental health or substance use issues is also problematic. Stigma and misperceptions about women with varying levels of mental health and substance use may lead women to be turned away from services.

One study found that the second most common reason women were turned away from transition housing programs across Canada was because of mental health concerns (Personal communication with representative of DAWN Canada, as cited in BCSTH, 2011a, p. 12). A survey of British Columbia VAW service providers revealed that while women with mental health or substance use issues frequently requested services, they were often only granted access if specific conditions were met, including that they were sober, capable of independent living and/or not a threat to other service consumers (Morrow, 2002, as cited in BCSTH, p. 12). Additionally, many VAW advocates may feel ill-equipped to provide services to women who have mental health or substance use concerns. One Ontario study reported that 33 percent of VAW advocates reported fair or poor competence levels in dealing with both substance use and mental health issues (Purdon, 2008, as cited in BCSTH, p. 12).

One of the fundamental principles of the violence against women's movement is the belief that women are not in abusive relationships because of mental health issues (Ferencik & Ramirez-Hammond, 2011). Many VAW services have traditionally seen mental health and substance use as outside of their mandate. Although domestic violence advocates see the connections between women's experiences of violence, mental health, and substance use, they may be unsure of how to safely accommodate women with these intersecting concerns (BCSTH, 2011a). While some women do need additional services to address mental health issues, the potential consequences of being labeled with a mental health diagnosis can have enormous implications in many areas of the survivor's life, particularly around issues of parenting and child custody (Ferencik & Ramierz-Hammond). In one study among women with co-occurring experiences of violence, mental health concerns and substance use, almost three quarters

reported that they had lost custody of their children within the past six months (Becker, Noether, Larson, Gatz, Brown, Heckman, & Giard, 2005, as cited in BCSTH, 2011a, p. 15).

Herz, Stronshine & Houser (2005) suggest that more research should be conducted to qualify and quantify the successes of trauma-informed integrated program models and to examine the risks related to possible unintended harmful consequences. For instance, might comprehensive service provision produce legal ramifications for survivors? Are women at higher risk of losing custody or visitation with their children if they are known to have a mental health diagnosis or undergone treatment for substance use? Have attorneys for interpersonal violence perpetrators or sex offenders been successful in using such information against victims in civil or criminal courts? Might the documentation of such issues cause problems with victim credibility in criminal court proceedings against an assailant? Answers to these questions will provide insights into whether such legal privacy protections have impeded collaborative efforts, or if efforts at collaboration and information sharing between agencies have left survivors feeling out of control of their personal information, and therefore re-traumatized. Most importantly, future efforts to build collaborative services can directly address these issues and explore the possibility of protective measures.

Interestingly, many VAW advocates and feminists argue that trauma-informed services do not go far enough to integrate a gender-based analysis. Given the high percentage of women who experience violence, many VAW advocates and researchers prefer a 'violence-informed'[9] rather than trauma-informed approach to supporting women. These advocates and researchers feel that the trauma-informed framework is too general and does not focus enough on the various forms of violence and oppression women are subjected to at the hands of men (BCSTH, 2011a).

[9] See BCSTH (2011b) for an example of what a 'violence-informed' framework might look like.

Tension between domestic violence and other types of trauma might also present a barrier to trauma-informed services implementation. In the WCDVS, because welfare reform only addressed issues of domestic violence, failing to consider childhood and community violence as real issues for women, the domestic violence site experienced difficulty in negotiating bureaucratic definitions while still meeting the service needs of women (Moses et al., 2003).

Training differences among service providers also hampers cross-discipline agreement (Herz, Stroshine, & Houser, 2005). Blanch (2003, as cited in Herz, Stroshine, & Houser, p. 138) advises that formal, ongoing efforts should be made to collaborate with institutions of higher learning to revise curricula, include CSRs as trainers, and incorporate trauma and violence as a core part of the training of all future human services workers. However, the field as been resistant to requiring formal education for these positions because doing so could effectively limit the number of CSRs who can work in these roles (Herz, Stroshine, & Houser).

All sites in the WCDVS initially encountered resistance, hesitation, and concern from direct service staff. Many feared that the initiation of trauma services would create needs that could not be met. Some saw trauma-specific and trauma-informed services as highly specialized, and did not feel equipped or qualified to provide them. Others were concerned that assessing for trauma histories and providing trauma-specific groups would decrease women's safety by encouraging them to discuss traumatic events in detail, possibly triggering unmanageable symptoms. Many believed that issues such as mental health, substance use, and trauma should be addressed sequentially rather than in a simultaneous, integrated fashion. Many also felt themselves to be extremely overworked, and the creation of new services was seen as yet another thing they had to do. Some felt uncomfortable working in the area of trauma due to

personal, unresolved trauma issues. Additionally, there were few resources to cover staff time needed for preparation in order to run trauma groups effectively (Moses et al., 2003).

Many administrators in the WCDVS were also resistant to the implementation of trauma-informed services, as they felt it would be too much for their organizations to manage due to a pre-existing focus on crisis management. They also did not believe that services and systems could be altered without substantial funding and without hindering agency reimbursement and cash flow (Moses et al, 2003). Because the way services are funded, licensed, and regulated impacts the ability of service organizations to provide integrated, trauma-informed care, changes are likely to be needed on a service system policy level as well (Markoff et al, 2005).

Drawing on trauma theory as well as the organizational development literature, Bloom[10] (2010) suggests organizational stress as a barrier to change. Bloom contends that as result of widespread exposure to acute and chronic stressors, there are organizational processes that parallel the destructive processes that influence the lives of survivors. Just as the lives of people exposed to repetitive and chronic traumatic experiences become organized around those experiences, so too can entire systems become organized around the recurrent and severe stresses that accompany delivery of services to survivors. Destructive organizational processes interfere significantly with the ability of services to address survivors' needs. Individual staff members, many of whom may have a past history of exposure to traumatic experiences, do not feel particularly safe with their clients, with management, or even with each other. Exposure to repetitive, systemic violence and chronic stress creates an atmosphere of constant crisis which severely constrains the ability of staff to be involved in decision-making processes, engage in complex problem-solving, or even talk to each other. Efforts to create change often appear to confound the very process, escalating staff demoralization. Staff members doubt that they will

[10] Bloom is one of the creators of the Sanctuary model.

feel safe in responding to the past traumatic experiences of clients and empowering them to make decisions for themselves.

Change is difficult. Markoff et al. (2005) suggest that it is not necessary or even advisable to develop and establish trauma-informed policies and procedures all at once. Rather, development should be a long-term process that involves continuous input from CSRs and staff members with a variety of roles. Cross-disciplinary teams can be created in order to assess the need and willingness to develop trauma-informed mental health, substance use, and VAW services (Herz, Stronshine, & Houser, 2005). Discussions of trauma-informed program modifications are an opportunity to involve all key groups in the review and planning process; the more inclusive and fully representative these discussions are, the more effective and substantial the resulting changes (Fallot & Harris, 2006; Fallot & Harris, 2009).

Change must be carefully managed, paying attention to clinical and political realities. Sites in the WCDVS found that a shared vision and common language among services were important first steps to successful implementation of trauma-informed care. Eventually, training and other educational strategies worked well to address the concerns of both direct service staff and administrators, although it should be noted that staff turnover necessitated a constant need to educate and train new people, which required extra time and financial resources. On-going, active supervision and on-site technical assistance and support by individuals who were knowledgeable and experienced in trauma issues, as well as involving CSR women as trainers and advocates was also found to be effective (Moses et al., 2003). In addition to knowledge about violence and trauma, staff required substantial and repeated cross-training about substance use, mental health issues, and trauma, and how they interact through the phases of the recovery

process. It is also important that personal staff reactions to trauma be addressed (Markoff et al., 2005).

Overview of Trauma-Informed and Trauma-Specific Models of Potential Benefit to VAW Services

Jenning's (2007) comprehensive technical report describes a mass of trauma-informed and trauma-specific models and notes research which has been completed to date. Examples of models which could potentially be applied in VAW services include:

1) *Developing Trauma-Informed Organizations: A Tool Kit*, which was developed by members of the Massachusetts State Leadership Council of the WCDVS Women Embracing Life and Living (WELL) Project of the Institute for Health and Recovery. The toolkit is geared toward directors of organizations and policymakers, and is designed to help organizations develop plans to improve the quality of care offered to women with co-occurring substance use and mental health issues and histories of experiencing violence. It has been used as the basis for planning changes within substance abuse treatment provider agencies, mental health provider agencies, domestic violence agencies, and correctional programs. No research had been completed on this model as of 2007 (as cited in Jennings, 2007, p. 24).
2) The Sanctuary model (as cited in Jennings, 2007, p. 30), which is a trauma-informed, evidence-supported template for system change based on the active creation and maintenance of a nonviolent, democratic, productive community in which staff are empowered as key decision-makers to influence their lives and the welfare of their constituents.

3) In 2005, the Sanctuary Leadership Development Institute was created. This is an intensive three-year program aimed at trauma-informed organizational change. After an application process that includes full leadership participation and a thorough on-site evaluation, organizations develop a core team that represents participation from every level of the organization. The responsibility of the core team is to actively represent and communicate with their constituency and to become trainers for the entire organization. After the core team has participated in an initial training institute, three years of on-going consultation and technical assistance is provided remotely and on-site by the Sanctuary Leadership Development Institute Faculty. Participation in the Sanctuary Leadership Development Institute qualifies an organization to join the Sanctuary Network and participate in an ongoing certification program. As noted previously, several VAW agencies are current members (e.g. Madsen et al., 2003).
4) The *Trauma Safety Drop-in Group: A Clinical Model of Group Treatment for Survivors of Trauma* (as cited in Jennings, 2007, p. 70), designed by Pat Gilchrist of Ulster County Mental Health and Peri Rainbow of Women's Studies at New Paltz State University of New York, provides trauma survivors with basic safety skills. This is a low-intensity group model that requires no commitment from participants. The group is open to all survivors regardless of diagnosis, level of functioning, and place in the healing process. Goals of the group include increasing the survivor's ability to function and feel safe in a more intensive level of group treatment, to learn about the healing process and the after-effects of trauma, and to assess readiness for further treatment. The drop-in nature of the group is an essential and unique feature. The group is structured so that survivors can

join at any point and complete the cycle at their own pace. No research had been conducted on this model as of 2007.

5) *The Trauma-Informed Organizational Self-Assessment* (as cited in Jennings, 2007, p. 83), was developed by the National Center on Family Homelessness (NCFH). It provides specific ways to understand how to be trauma-informed and contains items that describe specific practices necessary for creating a trauma-informed shelter system. It can be used by staff and administrators in residential programs serving homeless families, including emergency shelters, domestic violence shelter, and transitional and supportive housing programs. This tool has been modified using a number of evaluation procedures in order to increase its rigour.

Summary

Due to increasing awareness of the prevalence of trauma, as well as acknowledgement of the fact that services as usual might be experienced by survivors as physically and/or emotionally dangerous, disempowering, and re-traumatizing, trauma-informed services have become increasingly touted as an effective framework from which to address the impacts of trauma in mental health, substance use, and VAW services. This said, significant barriers to implementation exist, as well as disagreement from some as to the suitability of a trauma-informed practice framework to VAW services. Regardless of which system and program changes are being considered in order to improve services for survivors, it is important to recognize that change takes time, and optimally should be a long-term process which includes continuous input from all stakeholders.

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