Good Morning Participants:

On behalf of The **Cape Cod Behavioral Health (CCBH) Steering Committee**, we would like to welcome you to our first Cape Cod and Islands Behavioral Health Summit. Our Committee was formed to address concerns regarding the fragmentation of behavioral health care in our community. As a participant in today's program, you will be able to identify opportunities to effect change and utilize principles of recovery in our local behavioral health care system.

The CCBH Steering Committee provides opportunities for networking and bridges the gaps in our community service system that create barriers to achieving sustained recovery of the people we serve. Our Committee includes behavioral health and medical providers, human service organizations and those with "lived experience" of mental illness and/or substance use disorders on Cape Cod and the Islands.

If you would like to be a part of the CCBH Steering Committee, please join us at our next meeting on Thursday, October 24th at 1:00 pm in the Martins Conference Room at Cape Cod Hospital. We will be reviewing feedback collected from our summit survey and discuss opportunities to improve communication in our community by creating a network of learning and collaboration.

If you would like to attend our next meeting, please RSVP at (508) 862-7811.

We hope you enjoy today's program!

The CCBH Steering Committee would like to thank the following organizations for their sponsorship:

- Cape Cod Five Foundation
- Cape Cod Healthcare
- Duffy Health Center
- Gosnold on Cape Cod
- Hampton Inn & Suites Cape Cod

Summit Schedule - Friday, October 4th

8:00 am to 8:30 am – Registration

8:30 am to 8:45 am – Welcome and Overview of Day

Michael K. Lauf, MBA, President and CEO
Cape Cod Healthcare

Ron Holmes, Executive Director
Cape Cod National Alliance On Mental Illness

8:45 am to 9:30 am – Advancing the Nations Behavioral Health

A. Kathryn Power, M.ED, Regional Administrator
Substance Abuse and Mental Health Services Administration (SAMHSA)

9:30 am to 10:15 am – Mental Health: The Experience of Stigma

Patricia Durgin, OTR/L, Facilitator – Panel Discussion
Human Rights Officer, Cape Cod Hospital

10:15 am to 10:30 am – Break

10:30 am to 12:00 pm – Trauma Informed Care

Katie Volk, M.A., Managing Director of t3
Senior Associate at the Center of Social Innovation

12:00 pm to 1:15 pm – Lunch

1:15 pm to 2:30 pm - Crisis Systems of Care

Kappy Madenwald, LISW-S, Independent Consultant
Madenwald Consulting, LLC

2:30 pm to 2:45 pm – Break

2:45 pm to 3:45 pm – Systems of Care: The Continuum

Jean Calvert, LICSW, Facilitator – Panel Discussion
Director of Mobile Crisis Team Cape Cod and Islands

3:45 pm to 4:00 pm - Closing and Invitation to Join Initiative

Ron Holmes, Executive Director
Cape Cod National Alliance On Mental Illness

Speaker Biographies

A. Kathryn Power, M.Ed. – Keynote Speaker

Regional Administrator of Region One
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Substance Abuse and Mental Health Services Administration (SAMHSA)
U.S. Department of Health and Human Services

Ms. Power represents, at the regional level, the agency's mission of reducing the impact of mental illness and substance abuse on America's communities. She provides authoritative advice and assistance on behavioral health policies and innovations for use in the delivery and financing of prevention, treatment and recovery services. She has received many distinguished service awards for her work in mental health, substance abuse and civic leadership, recognized both nationally and locally for her advocacy on behalf of individuals with behavioral health conditions. She has extensive practical training and teaching experience in leadership, ethics and public service, policy development and program implementation. Ms. Power is a retired Captain in the U.S. Navy Reserve.

Katie Volk, M.A. – Trauma Informed Care

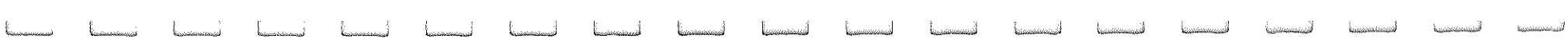
Managing Director of t3 and Senior Associate at the Center of Social Innovation

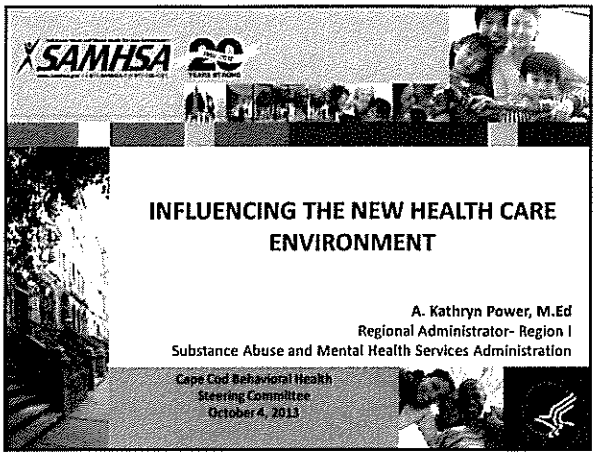
Ms. Volk has directed numerous trainings, technical assistance and curriculum development efforts. She has trained thousands of service providers throughout the country and was a lead author of SAMHSA's Homelessness and Traumatic Stress Training Package. This 90 minute session on traumatic stress and trauma-informed care will include the foundational aspects of the topic. Using examples and activities, we will begin a discussion on incorporation a trauma-informed perspective to our work as individuals, teams and programs.

Kappy Madenwald, LISW-S – Crisis Systems of Care

Independent Consultant, Madenwald Consulting, LLC

Ms. Madenwald is an independent consultant with extensive experience providing consultation to federal, state and local governments, community treatment providers and managed-care entities in building competency-rich and multifaceted behavioral health systems. She offers unique expertise in the evaluation, development, implementation and/or operation of community-based models of crisis intervention that result in creating close-to-home, recovery oriented and less restrictive alternatives to inpatient hospitalization or residential treatment. Ms. Madenwald worked extensively with the Commonwealth of Massachusetts, Office of Behavioral Health and Massachusetts Behavioral Health Partnership (MBHP) in the design and implementation of Mobile Crisis Intervention (MCI) services for youth and their families, as well as training, coaching and technical assistance of the 21 Emergency Service Programs that provide the MCI service.





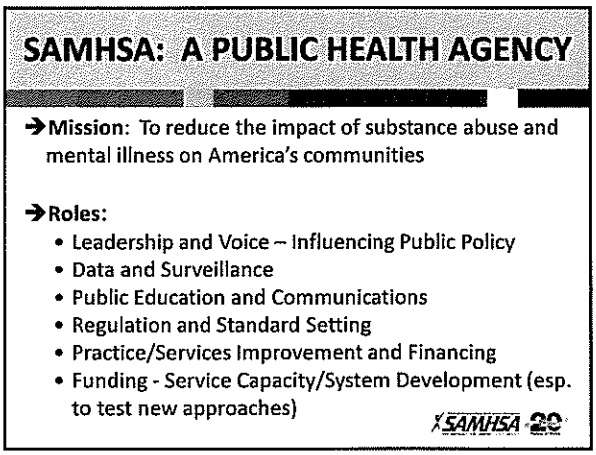
we feel trauma in our bodies

control, connection and meaning

* we can respond rather than react.

SAMHSA → Trauma - informed Care

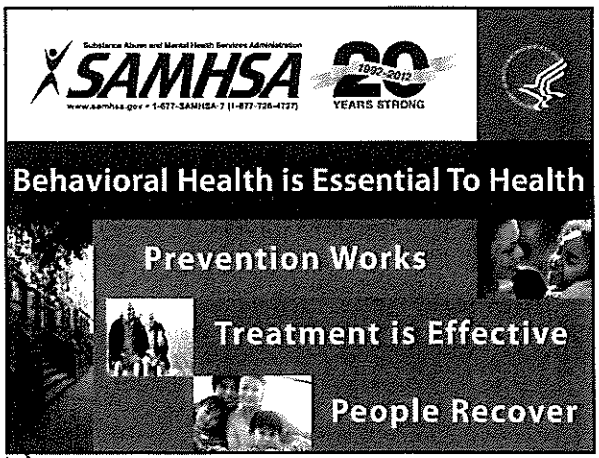
trauma informed organizations programs, and services are based on an understanding of the N



mirror in slide →

We cannot eliminate every trigger.

we can work in a way that is more responsive to trauma dynamics



* Part of trauma is not talking about trauma. We need to ask the questions

Prefrontal Cortex when we are stressed the front of our brain shuts down (executive functioning thinking)

write down things have them (client) say things back to you.

Region I Profile

State	Capital	Population[1]	Pop. Density[2]	Urban	SA Prevalence[3]	SMI Prevalence[3]	Suicide Rate[4]
Connecticut	Hartford	3,574,097	738.1	Yes	10.01	4.39	8.6
Maine	Augusta	1,328,361	43.1	Yes	8.49	4.67	12.8
Massachusetts	Boston	6,547,629	839.4	No	9.88	4.19	7.5
New Hampshire	Concord	1,316,470	147	No	9.81	4.57	13.1
Rhode Island	Providence	1,052,567	1018.1	Yes	10.72	7.2	9.9
Vermont	Montpelier	625,741	67.9	No	9.57	4.69	14.0
United States	*Washington, DC*	*309,349,689*	*87.4*	*N/A*	*9.1*	*4.6*	*11.3*

[1] U.S. Census 2010
[2] U.S. Census 2010
[3] SAMHSA, NSDUH 2008-2009 Table 16 Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year among Persons Aged 18 or Older
[3] SAMHSA, NSDUH 2008-2009 Table 22 Serious Mental Illness in Past Year among Persons Aged 18 or Older, by State
[4] CDC National Vital Statistics System-Mortality (NVSS-M) 2009 per 100,000

SAMHSA 20

TODAY'S DISCUSSION

- CHANGING HEALTH CARE ENVIRONMENT
- BEHAVIORAL HEALTH AS PUBLIC HEALTH
- SAMHSA'S STRATEGIC INITIATIVES

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CHANGING HEALTH CARE ENVIRONMENT

- → ***Prevention/Wellness*** Rather Than Illness
- → ***Behavioral Health is*** Essential to ***Health***
- → ***Quality*** Rather Than Quantity – saving costs through better care rather than less care
- → Inclusive – Everyone's ***Eligible*** for Something
- → ***Public Payers' Roles*** Changing
- → Implications for ***State's Role***

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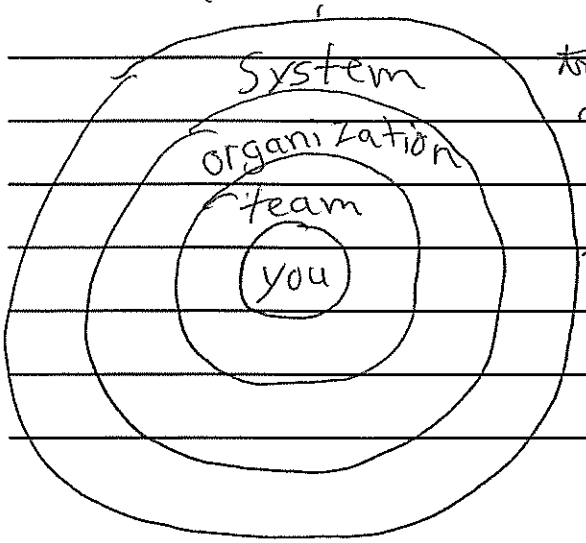
WRAP.com or org

Mental issues instead of mental health

* Be mindful of asking loaded questions
* Promoting safety
* support client control, choice and autonomy!

The environmental piece is important to allow our clients to be comfortable - water, noises, lighting, seating, safe zone pics and more!



transformate at every level

www.nctsn.org
www.think3.com

provider may say client is attention seeking when a client is asking for help!

* Having a wellness toolbox
* Don't interrupt client when he or she is speaking

WHY BEHAVIORAL HEALTH MATTERS TO PUBLIC HEALTH – 1

→BH Affects Most Americans
- Half will meet criteria for MI or substance abuse
- Half know someone in recovery from addiction (23 M +)
- One in four Americans will experience mental illness

→Increases Risks for/Co-Exists with Other Diseases, Yet is Preventable
- HIV/AIDS, STDs, diabetes, cardiovascular disease, obesity, asthma, hypertension
- More adverse childhood experiences (ACEs) = more health/BH conditions in adulthood
- Half of adult mental illness begins before age 14 and three-quarters before age 24

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Peter Lesvin Restoring goodness
Renewal, Recovery and Resiliency
SW are potential resources to businesses

WHY BEHAVIORAL HEALTH MATTERS TO PUBLIC HEALTH - 2

→ High Impact on Health Systems – Practice and Costs
- ~ ¾ of pediatric visits and community hospital stays
- ~ 1/5 of ER visits involve illicit drugs (21 percent) or alcohol (19 percent)
- 2010: Medicare spent 5 x more on beneficiaries age 65+ w/SMI & SUDs than similar beneficiaries w/out these diagnoses
- 2010: Of Medicare beneficiaries w/out SMI, 17 percent were hospitalized; 46 percent of those w/SMI diagnosis; 88 percent of those with SMI/SUDs
- One of 5 top diagnoses in 30-day readmissions
  - 22 percent of Medicare beneficiaries age 65+ w/ SMI compared to 13 percent of those w/out SMI
  - Co-occurring SMI/SUDs – 34 percent rehospitalized w/in 30 days

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What changed that resulted in relief?
What were the thoughts you had?
What were the accompanying emotions & behaviors
What would others have noticed about you at the point of relief?

reaction, acceptance, perception

WHY BEHAVIORAL HEALTH MATTERS TO PUBLIC HEALTH - 3

→High # BH-Related Premature Deaths/Preventable Illnesses
- Persons w/BH conditions die 8+ years younger, mostly from preventable health issues
- Half of all tobacco deaths occur among those w/BH conditions
- More deaths from suicide than HIV/AIDS and traffic accidents combined; plus breast cancer for all BH-related deaths

→Study out of Germany using Composite International Diagnostic Interview and DSM-IV
- Much higher annualized death rates for women: 4.6-fold ↑ for females and 1.9-fold ↑ for males compared to age/gender-specific general pop
- Mean age of death 20 years ↓ for both genders
- Inpatient treatment had no impact on premature mortality

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☆ Remain person centered what's meaningful to the cl.
Crisis is predominately about a loss of control
V Section -12, ER restrictions and more

WHY BEHAVIORAL HEALTH MATTERS TO PUBLIC HEALTH - 4

→ High Impact of Disparities (race, gender, ethnicity, LGBT, poverty) and Social Issues/Costs (homelessness, jails, child welfare)

- Most homeless and jailed individuals have BH needs; relatively few receive treatment; most are in or released to the community
- LGBT population – elevated rates of tobacco use, certain cancers, depression and suicide deaths/attempts
- Majority of foster children have drug-involved parents
- Ethnic minorities more likely to be uninsured, have ↑ rates of certain disorders or incidence (e.g., suicide, drinking)
- Persons with BH needs more likely to be uninsured and to "churn," creating issues within the health delivery system

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tell me about that ... --
tell me why ... ---

PUBLIC PERCEPTION OF VALUE

→ Public Willing to Pay 40 percent LESS . . .

- To avoid mental illnesses (MI) compared to avoiding medical illness, even when MI (including SUDs) are recognized as burdensome*

→ Mental Illnesses Account for 15.4 Percent of Total Burden of Disease**

- Yet MH expenditures in U.S. account for only 6.2 percent of total health expenditures
- SA expenditures account for only about 1 percent

* Source: NCHD 2011
** Source: World Health Organization

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remapping your brain

WHY DOES IT MATTER?

→ Public sees social consequences of behavioral health rather than health consequences

- Homelessness, gangs, jails, tragedies (e.g., mass casualty shootings), disability, lost productivity, high government costs

→ M/SUDs seen as matter of will instead of diseases or conditions to be prevented, treated and recovered from

- Compare diabetes – not just about eating choices

→ Universal Knowledge of First Aid for Health Conditions; Don't Teach or Know Signs, Symptoms, How to Get Help for MH or SA Issues

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establishing trust

Based on strengths identified ↑

The whole person
↳ may not need a med eval because they are mad, they may need to talk about what made them mad

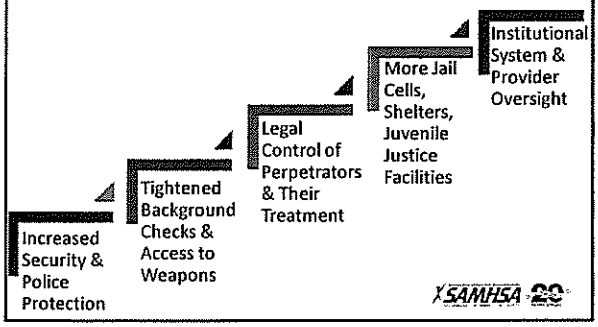
Recovery, resilience and natural supports.

human conditions
fear, sadness loneliness/ isolation, exhaustion grief/loss

reaffirm the need for partnership

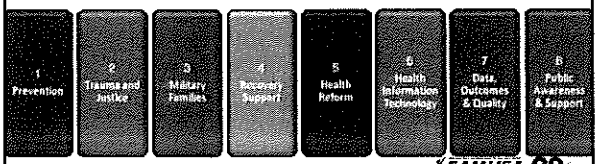
Think longitudinally for the person in crisis

BH AS A SOCIAL PROBLEM LEADS TO INSUFFICIENT RESPONSES



SAMHSA'S STRATEGIC INITIATIVES

AIM: Improving the Nation's Behavioral Health (1-4)
AIM: Transforming Health Care in America (5-6)
AIM: Achieving Excellence in Operations (7-8)



STRATEGIC INITIATIVE: PREVENTION

➔Substance Abuse and Mental Illness; Build Emotional & Behavioral Health

➔***Suicide Prevention***

➔Prevent Underage Drinking

➔***Prescription Drug Abuse/Misuse***

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SUICIDE AND MENTAL ILLNESS: TOUGH REALITIES

50 Percent of Those Who Die By Suicide Had Major Depression – Suicide rate of people with major depression is 8 times that of the general population

90 Percent of Individuals Who Die By Suicide Had a Mental Disorder

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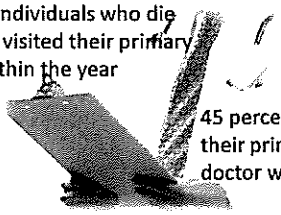
MISSED OPPORTUNITIES = LIVES LOST

77 percent of individuals who die by suicide had visited their primary care doctor within the year



45 percent had visited their primary care doctor within the month

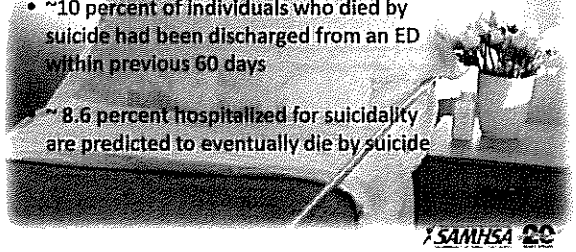
18 percent of elderly patients visited their primary care doctor on same day as their suicide

THE QUESTION OF SUICIDE WAS SELDOM RAISED SAMHSA

MISSED OPPORTUNITIES = LIVES LOST

→ Individuals Discharged from An Inpatient Unit or Emergency Room Continue to Be at Risk for Suicide

- ~10 percent of individuals who died by suicide had been discharged from an ED within previous 60 days
- ~8.6 percent hospitalized for suicidality are predicted to eventually die by suicide



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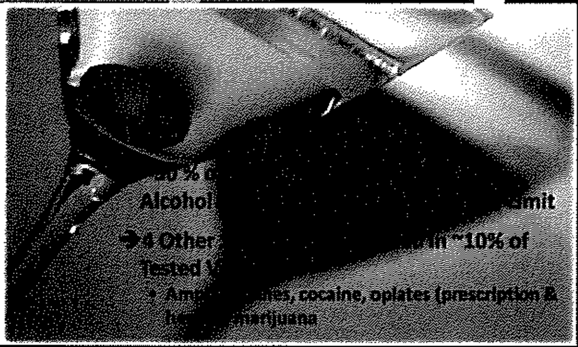
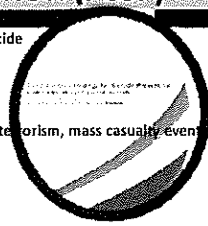
SUICIDE AND SUBSTANCE ABUSE: TOUGH REALITIES



SURGEON GENERAL'S NATIONAL STRATEGY FOR SUICIDE PREVENTION (NSSP)



→ Annually, 11 M+ Americans Seriously Consider Suicide
- 8 M make a plan
- 2.5 M > 14 years attempt

→ America Loses ~100 People/24 Hrs
- 38,000 in 2010 – not to battles of war, acts of terrorism, mass casualty events or natural disasters
- Half w/ firearms; many w/prescription drugs
- America lost more service members to suicide (349) than to combat (229) in 2011

→ NSSP – Public/Private Partnership
- Survivors, practitioners, funders, advocates, standard setters
- Released 9/10/12 – World Suicide Prevention Day
- Data, standards, screening, high impact models, awareness, high need populations, payment policies
- SAMHSA's Garrett Lee Smith Suicide Prevention Grants

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PRESCRIPTION DRUGS

→ Most Prevalent Illicit Drug Problem After Marijuana
- ~*22 M* persons initiated nonmedical pain reliever use since 2002
- ~1 in 22 (*4.6 percent*) reported misuse/abuse of prescription pain relievers (2010 & 2011)
- US represents 4.5 percent of world's population, yet consumes **99 percent** of world's hydrocodone (International Narcotics Control Board)

→ Emergency Room Visits
- Non-medical use of ADHD stimulant medications *nearly tripled* from 5,212 to 15,585 visits; (2005 – 2010)

→ SU Treatment Admissions
- Benzodiazepine and narcotic pain reliever abuse ↑ *569.7 percent* (2000 to 2010)

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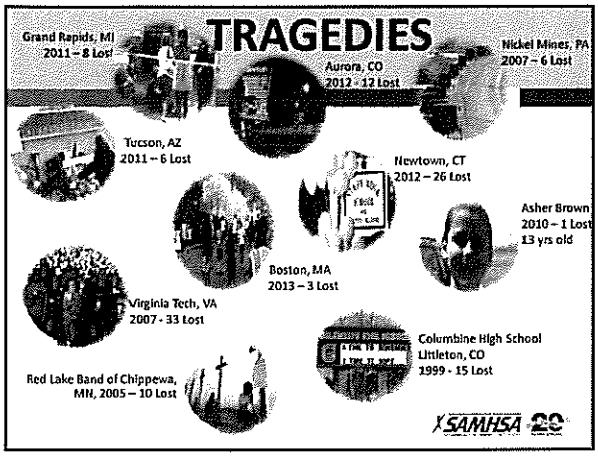

SAMHSA's DISASTER TECHNICAL ASSISTANCE CENTER (DTAC): NATURAL AND HUMAN-CAUSED DISASTERS

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Disaster Training and Technical Assistance

- → Technical Assistance, Training, and Expert Consultation
  - Review state/local all-hazards disaster BH plans
- → Disaster BH Resources
  - >1,800 tip sheets, publications, studies, and articles
- → Information Exchange and Knowledge Brokering
  - Connects those seeking technical assistance w/peers and experts in BH field

www.samhsa.gov/dtac

SAMHSA

ADDITIONAL SAMHSA RESOURCES & WORK

SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)

TREATMENT LOCATOR

24/7 Treatment Referral Line
1-800-662-HELP(4357)

Disaster Distress Helpline
1-800-985-5990
Text TalkWithUs to 66746

- → www.samhsa.gov
- → www.suicidepreventionlifeline.org
- → www.samhsa.gov/treatment
- → www.disasterdistress.gov
- → Research efforts with Assistant Secretary for Preparedness and Response (ASPR) and NIH

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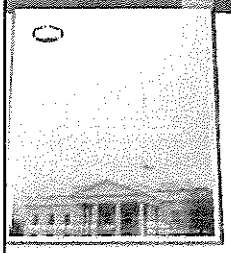
THE PRESIDENT'S PLAN: MENTAL HEALTH AS A PUBLIC HEALTH ISSUE



"We are going to need to work on making access to mental health care as easy as access to a gun."
--President Obama

- → Less than half of people w/BH conditions receive the care they need
- → 23 Executive Actions to Reduce Access to Guns and Increase Mental Health Services
- → FY 2014 Budget Mental Health Proposals -- $235 M
- → National Dialogue on Mental Health – to be launched this Spring

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PRESIDENT'S EXECUTIVE ACTIONS ON GUN VIOLENCE – MAJOR IMPLICATIONS FOR BH

→ Among the 23 Executive Actions

- No. 17: "Release a letter to health care providers clarifying that no federal law prohibits them from reporting threats of violence to law enforcement authorities."
  - -- **January 16: Letter issued by Secretary Sebelius**
- No. 2: "Address unnecessary legal barriers, particularly relating to the Health Insurance Portability and Accountability Act, that may prevent states from making information available to the background check system." – ***Advance Notice of Proposed Rule-Making (ANPRM)***
  - -- ANPRM available for review at: https://federalregister.gov/a/2013-01073
  - -- Comments can be submitted to: http://www.regulations.gov/
  - -- Comments due June 7, 2013

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STRATEGIC INITIATIVE: MILITARY FAMILIES

→ Access to Community-Based BH Care

- ***President's Executive Order – VA pilots; peers; suicide prevention; quality measures; National Research Action Plan (PTSD, TBI, suicide prevention)***
- TRICARE – credentialing and service package for current military personnel
- State policy academies – 30 + states/territories and DC – National Guard, Reservists, families not otherwise covered

→ Military Culture Training

- With HRSA and private partners – National Council/SAAS

→ Promote Emotional Health/Resilience of Veterans, Services Personnel, and Military Families

- Programs & evidence-based practices in HHS programs

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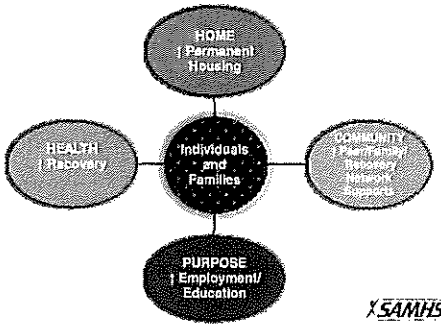
STRATEGIC INITIATIVE: RECOVERY SUPPORT



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STRATEGIC INITIATIVE: HEALTH REFORM

- ***Essential Health Benefits (EHBs) – Parity***
- ***Enrollment and Eligibility – Qualified Health Plans (QHPs)***
- Uniform Block Grant Application – TA to States
- Services, Payment Policies, Quality/Measures
  - Medicaid (health homes, rules/regs, good & modern services, screening, prevention)
  - Medicare (duals, partial hospitalization, same day billing)
- ***Primary/Behavioral Health Care Integration (PBHCI)***
- HIV/AIDS Prevention and Mental Health Treatment

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ESSENTIAL HEALTH BENEFITS (EHB) 10 BENEFIT CATEGORIES

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. ***Mental health and substance use disorder services, including behavioral health treatment***
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

SAMHSA

PARITY/ACA: PROJECTED REACH

	Individuals who will gain MH, SUD, or both benefits under the ACA including federal parity protections	Individuals with existing MH and SUD benefits who will benefit from federal parity protections	Total individuals who will benefit from federal parity protections as a result of the ACA
Individuals currently in individual plans	3.9 million	7.1 million	11 million
Individuals currently in small group plans	1.2 million	23.3 million	24.5 million
Individuals currently uninsured	27 million	n/a	27 million
Total	32.1 million	30.4 million	62.5 million

NOTE: These estimates include individuals and families who are currently enrolled in grandfathered coverage

Source: ASPE Research Brief, February 2013

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IN 2014: MILLIONS MORE AMERICANS WILL HAVE HEALTH COVERAGE OPPORTUNITIES

→ Currently, 37.9 Million Are Uninsured <400% FPL*

- 18.0 M – Medicaid expansion eligible
- 19.9 M – ACA exchange eligible**
- ***11.019 M (29%) – Have BH condition(s)***
- http://www.samhsa.gov/healthreform/enrollment.aspx

Source: 2010 NSDUH
**Eligible for premium tax credits and not eligible for Medicaid

SAMHSA 20

ACA: HHS ENROLLMENT ASSISTANCE ACTIVITIES

→ Consumer Assistance Grants
- Employed directly by Medicaid agency or Exchange entity
- Support state development of appeals assistance services and claims dispute processes

→ Marketplace Assisters
- Employed directly by Medicaid agency or Exchange entity, or funded by grant or contract to fulfill additional non-navigator assistance requirement

→ Navigator Program (2014)
- Include at least one consumer-focused non-profit
- Required for and financed by each Exchange
- At least 13 States engaged in public planning work
  AR, WA, WV, CA, CO, CT, DC, HI, MN, NV, OR, VT

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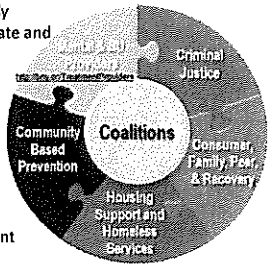
SAMHSA ENROLLMENT STRATEGY

- Collaborate w/national organizations whose members/constituents interact regularly w/individuals who have M/SUDs to create and implement enrollment communication campaigns
- Promote and encourage use of CMS marketing materials
- Provide T/TA in developing enrollment communication campaigns using these materials
- Provide training to design and implement enrollment assistance activities
- Channel feedback and evaluate success



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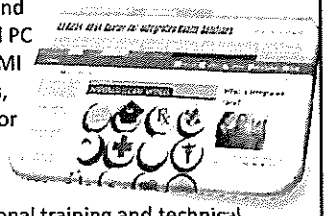
BH AND PRIMARY CARE INTEGRATION: SAMHSA, HRSA, AHRQ, CMS

- Joint or Coordinated Products, TA, Grants
- Models of Integrated Care
  - Primary – SBIRT approach; integrated care approach
  - Specialty – Before, After or AS primary care
- Clinical Practice Issues
  - Capacity
  - Workforce competencies
  - System issues
  - Office flow issues
- Payment – Financing – Cost Issues
- Metrics re Value (Quality and Cost)

SAMHSA 20

SAMHSA/HRSA – CENTER FOR INTEGRATED HEALTH SOLUTIONS (CIHS)

- ***Goal:*** Promote planning and development of integrated PC and BH care for those w/SMI and/or addiction disorders, whether seen in specialty or PC settings (bi-directional)



- ***Purpose:*** Serve as a national training and technical assistance center on bi-directional integration of PC and BH care and related workforce development needs

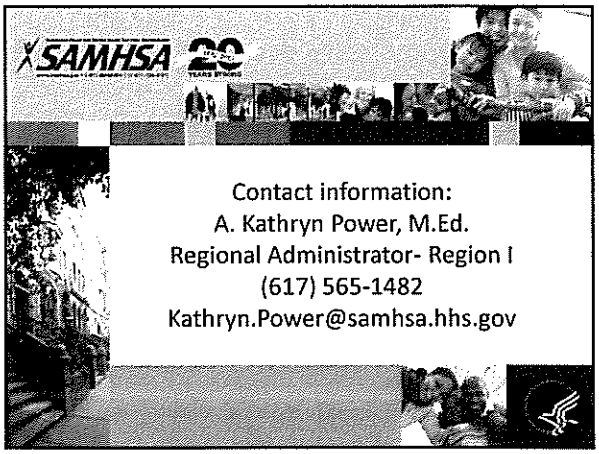
SAMHSA 20

SAMHSA'S VISION

➔A Nation that Acts on the Knowledge that:

- Behavioral health is essential to health
- Prevention works
- Treatment is effective
- People recover

SAMHSA 20



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Principles of Trauma-Informed Care

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

Principles of trauma-informed care include:

1. **Understanding Trauma and Its Impact:** Understanding traumatic stress and how it impacts people and recognizing that many behaviors and responses that may be seem ineffective and unhealthy in the present, represent adaptive responses to past traumatic experiences.

2. **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.

3. **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.

4. **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.

5. **Sharing Power and Governance:** Promoting democracy and equalization of the power differentials across the program; sharing power and decision-making across all levels of an organization, whether related to daily decisions or in the review and creation of policies and procedures.

6. **Integrating Care:** Maintaining a holistic view of consumers and their process of healing and facilitating communication within and among service providers and systems.

7. **Healing Happens in Relationships:** Believing that establishing safe, authentic and positive relationships can be corrective and restorative to survivors of trauma.

8. **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.

Source: Guarino, K., Soares, P., Konnath, K., Clervil, R., and Bassuk, E. (2009). *Trauma-Informed Organizational Toolkit.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation, page 17.

think
teach
transform

Principles of Trauma-Informed Care

In the space provided, explain how your agency integrates each principle into daily practice and offer ideas for how the agency might add to what it currently does in each area.

1. Understanding Trauma and Its Impact:
Understanding traumatic stress and recognizing that many behaviors and responses that seem ineffective and unhealthy in the present represent adaptive responses to past traumatic experiences.

How does your agency integrate this principle into daily practice?

How might your agency more fully integrate practices related to this principle?

2. 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.

How does your agency integrate this principle into daily practice?

How might your agency more fully integrate practices related to this principle?

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3. Ensuring Cultural Competence:
Respecting diversity within the program, providing opportunities for consumers to engage in cultural rituals, and using interventions specific to cultural backgrounds.

How does your agency integrate this principle into daily practice?

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How might your agency more fully integrate practices related to this principle?

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4. Supporting Consumer Control, Choice and Autonomy:
Helping consumers regain a sense of control over their daily lives. Keeping consumers well-informed about all aspects of the system, providing opportunities for consumers to make daily decisions and participate in the creation of personal goals.

How does your agency integrate this principle into daily practice?

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How might your agency more fully integrate practices related to this principle?

5. Sharing Power and Governance:
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.

How does your agency integrate this principle into daily practice?

How might your agency more fully integrate practices related to this principle?

6. Integrating Care:
Maintaining a holistic view of consumers and their process of healing and facilitating communication within and among service providers and systems.

How does your agency integrate this principle into daily practice?

How might your agency more fully integrate practices related to this principle?

7. Healing Happens in Relationships:
Believing that establishing safe, authentic and positive relationships can be corrective and restorative to survivors of trauma.

How does your agency integrate this principle into daily practice?

How might your agency more fully integrate practices related to this principle?

8. Recovery is Possible:
Understanding that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for consumer involvement at all levels of the system and establishing future oriented goals.

How does your agency integrate this principle into daily practice?

How might your agency more fully integrate practices related to this principle?

Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings

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Abstract: It is reasonable to assume that individuals and families who are homeless have been exposed to trauma. Research has shown that individuals who are homeless are likely to have experienced some form of previous trauma; homelessness itself can be viewed as a traumatic experience; and being homeless increases the risk of further victimization and retraumatization. Historically, homeless service settings have provided care to traumatized people without directly acknowledging or addressing the impact of trauma. As the field advances, providers in homeless service settings are beginning to realize the opportunity that they have to not only respond to the immediate crisis of homelessness, but to also contribute to the longer-term healing of these individuals. Trauma-Informed Care (TIC) offers a framework for providing services to traumatized individuals within a variety of service settings, including homelessness service settings. Although many providers have an emerging awareness of the potential importance of TIC in homeless services, the meaning of TIC remains murky, and the mechanisms for systems change using this framework are poorly defined. This paper explores the evidence base for TIC within homelessness service settings, including a review of quantitative and qualitative studies and other supporting literature. The authors clarify the definition of Trauma-Informed Care, discuss what is known about TIC based on an extensive literature review, review case examples of programs implementing TIC, and discuss implications for practice, programming, policy, and research.

Keywords: Homelessness, trauma, trauma-informed, systems change.

INTRODUCTION

Trauma-Informed Care: A Paradigm Shift for Homeless Services

> *"Homelessness deprives individuals of...basic needs, exposing them to risky, unpredictable environments. In short, homelessness is more than the absence of physical shelter, it is a stress-filled, dehumanizing, dangerous circumstance in which individuals are at high risk of being witness to or victims of a wide range of violent events"* [1].

Homelessness is a traumatic experience. Individuals and families experiencing homelessness are under constant stress, unsure of whether they will be able to sleep in a safe environment or obtain a decent meal. They often lack a stable home and also the financial resources, life skills, and social supports to change their circumstances. In addition to the experience of being homeless, an overwhelming percentage of homeless individuals, families, and children have been exposed to additional forms of trauma, including: neglect, psychological abuse, physical abuse, and sexual abuse during childhood; community violence; combat-related trauma; domestic violence; accidents; and disasters. Trauma is widespread and affects people of every gender, age, race, sexual orientation, and background within homeless service settings.

Early developmental trauma—including child abuse, neglect, and disrupted attachment—provides a subtext for the narrative of many people's pathways to homelessness [2]. Violence continues into adulthood for many people, with abuse such as domestic violence often precipitating homelessness [3-5], and with homelessness leaving people vulnerable to further victimization. The impact of traumatic stress often makes it difficult for people experiencing homelessness to cope with the innumerable obstacles they face in the process of exiting homelessness [6], and the victimization associated with repeated episodes of homelessness. Research has found that people who experienced repeated homelessness were more likely than people with a single episode of homelessness to have been abused, often during childhood [6].

Trauma refers to an experience that creates a sense of fear, helplessness, or horror, and overwhelms a person's resources for coping. The impact of traumatic stress can be devastating and long-lasting, interfering with a person's sense of safety, ability to self-regulate, sense of self, perception of control and self-efficacy, and interpersonal relationships. Some people have minimal symptoms after trauma exposure or recover quickly, while others may

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develop more significant and longer-lasting problems such as Posttraumatic Stress Disorder (PTSD) and Complex Trauma.

Trauma reactions are not the only psychiatric issue facing people who are homeless; many people experiencing homelessness also suffer from depression, substance abuse [7-10], and severe mental illness [8, 10]. These issues leave individuals even more vulnerable to revictimization [11], interfere with their ability to work, impair their social networks [8], and further complicate their service needs.

These findings suggest that we will be unable to solve the issue of homelessness without addressing the underlying trauma that is so intricately interwoven with the experience of homelessness. Those working in homeless services have the opportunity to reach many trauma survivors who are otherwise overlooked. Providers in these settings address the immediate crisis by offering food, shelter, and clothing; but they can also contribute to longer-lasting changes by helping an individual or family develop supportive connections in the community and begin to heal from past traumas. Despite this fact, few programs serving homeless individuals and families directly address the specialized needs of trauma survivors. Homeless services have a long history of *serving* trauma survivors, without being *aware of* or *addressing* the impact of traumatic stress [12]. Overwhelmed by the daily needs of their clients, providers in these settings often have few resources to address issues of long-term recovery.

With increasing recognition of the pervasiveness of traumatic stress among people experiencing homelessness, awareness is growing of the importance of creating Trauma-Informed Care within homeless services settings. Trauma-Informed Care (TIC) involves "understanding, anticipating, and responding to the issues, expectations, and special needs that a person who has been victimized may have in a particular setting or service. At a minimum, trauma-informed services endeavor to do no harm—to avoid retraumatizing or blaming [clients] for their efforts to manage their traumatic reactions" [13]. Implementing TIC requires a philosophical and cultural shift within an agency, with an organizational commitment to understanding traumatic stress and to developing strategies for responding to the complex needs of survivors.

Despite its importance, the implementation of TIC within homelessness service settings is still in its infancy. Currently, the nature of TIC remains ill-defined. Strategies for implementation are obscure, few program models exist, and there is limited communication and collaboration among programs implementing TIC. The descriptive and research literature in this area is sparse, with only a handful of studies examining the nature and impact of TIC. More clarification is needed about what exactly defines TIC, what changes should be made within systems wishing to offer TIC, and how these changes should be implemented.

The purpose of this paper is to review the evidence base that supports the use of TIC for individuals and families experiencing homelessness. In this review, we have attempted to:

- Establish a consensus-based definition of TIC
- Discuss what is known about TIC based on our literature review
- Describe models and case examples of what is being done in the field to implement TIC within homeless service settings

We conclude by summarizing implications of our current state of knowledge for practice, programming, policy, and research and by highlighting next steps for developing evidence-based, trauma-informed homeless services.

What is Trauma-Informed Care (TIC)?

What is meant by TIC? Although there is agreement that "trauma-informed" refers generally to a philosophical/ cultural stance that integrates awareness and understanding of trauma, there is no consensus on a definition that clearly explains the nature of TIC.

TIC supports the delivery of Trauma-Specific Services (TSS). TSS refers to interventions that are designed to directly address the impact of trauma, with the goals of decreasing symptoms and facilitating recovery. TSS differs from TIC, in that TSS are specific treatments for mental disorders resulting from trauma exposure, while TIC is an overarching framework that emphasizes the impact of trauma and that guides the general organization and behavior of an entire system. TSS may be offered within a trauma-informed program or as stand-alone services [12].

Based on the literature review, we summarized the basic principles of TIC proposed by various workgroups, organizations, expert panels, and researchers. (see Table **1**). Each of these sources posited a unique definition of TIC. We identified and highlighted common cross-cutting themes and then synthesized them into a single definition. Themes include:

- **Trauma awareness:** Trauma-informed service providers incorporate an *understanding of trauma* into their work. This may involve altering staff perspectives, with providers understanding how various symptoms and behaviors represent adaptations to traumatic experiences. *Staff training, consultation,* and *supervision* are important aspects of organizational change towards TIC and organizational practices should be modified to incorporate awareness of the potentially devastating impact of trauma. For example, agencies may implement routine screening for histories of traumatic exposure, may conduct routine assessments of safety, and may develop strategies for increasing access to trauma-specific services. Dealing with *vicarious trauma* and *self-care* is also an essential ingredient of trauma-informed services. Many providers have experienced trauma themselves and may be triggered by client responses and behaviors.
- **Emphasis on safety**: Because trauma survivors often feel unsafe and may actually be in danger (e.g., victims of domestic violence), TIC works towards building *physical and emotional safety for consumers and providers*. Precautions should be taken to ensure the physical safety of all residents. In addition, the organization should be aware of *potential triggers* for consumers and strive to avoid retraumatization. Because interpersonal trauma often involves boundary violations and abuse of power, systems that are aware of trauma dynamics should establish *clear roles and boundaries* that are an outgrowth of collaborative decision-making.

Privacy, confidentiality, and *mutual respect* are also important aspects of developing an emotionally safe atmosphere. Additionally, *cultural differences and diversity* (e.g., gender, ethnicity, sexual orientation) must be addressed and respected within trauma-informed settings.

- **Opportunities to rebuild control:** Because control is often taken away in traumatic situations, and because homelessness itself is disempowering, trauma-informed homeless services emphasize the *importance of choice* for consumers. They create *predictable environments* that allow consumers to re-build a sense of *efficacy and personal control* over their lives. This includes involving consumers in the design and evaluation of services.
- **Strengths-based approach**: Finally, TIC is *strengths-based*, rather than deficit-oriented. These service settings assist consumers to identify their own strengths and develop coping skills. TIC service settings are *focused on the future* and utilize *skills-building* to further develop resiliency.

These principles form a standard for programs wishing to develop TIC within homeless service settings. Based on these combined principles, we developed a consensus-based definition of TIC:

Consensus-Based Definition

> "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."

Trauma-informed approaches are designed to respond to the impact of trauma. The principles described above target the specialized needs of trauma survivors and describe how services can be delivered through the lens of trauma.

METHODS

This paper reviews the evidence base supporting the effectiveness of TIC for people experiencing homelessness. To date, most determinations of what constitutes evidence-based practice have relied on outcome-based quantitative research. However, this approach neglects qualitative analyses that examine the nature and process of the intervention, as well as a wealth of information that reflects what is occurring in practice. In fact, corroborative evidence, including clinical wisdom about "what works," is often the starting point for developing both qualitative and quantitative studies. In the homelessness field, corroborative evidence may be the primary body of knowledge we have about a particular intervention.

For this review, we utilized a comprehensive framework that was developed by the Homelessness Resource Center (HRC) for assessing the level of evidence of an emerging, promising or best practice [15]. The goal of this framework is not to decide whether a practice qualifies as evidence-based, but rather to synthesize all that we currently know about the intervention. Thus, our review included peer-reviewed quantitative and qualitative studies, as well as corroborative literature (e.g., program evaluations and unpublished pilot studies).

The literature on TIC is significantly greater in mental health and substance use fields than within the homelessness field. Thus, we also reviewed the current evidence base for trauma-informed practices in these areas since there is a large overlap in the difficulties faced by many individuals with mental health/substance use issues and those in homeless service settings. In fact, in the Women, Co-Occurring Disorders, and Violence Study (WCDVS), a large multi-site study examining trauma-informed services for women with co-occurring disorders and trauma exposure, 70.4% of participants had been homeless at some point in their lives [16]. We reviewed evidence for trauma-informed services within all these settings, applying this broader knowledge base to our understanding of TIC within homeless service settings.

We conducted our literature review by searching two databases, PsycInfo and Medline (PubMed), for peer-reviewed articles published in major journals. In addition, we used the Google search engine to locate web-based literature and program information. Our search terms included: homeless, homelessness, housing, shelters, trauma, trauma-informed, PTSD, services, abuse, violence, domestic violence, psychological, substance use, and mental health. We also completed more specialized searches on unique populations (using search terms such as youth, men, ethnicity, veterans), authors of note (e.g., Harris, Fallot, Bassuk, and van der Kolk), models (e.g., Attachment, Self-Regulation and Competency [ARC] and Sanctuary), programs (e.g., Community Connections, the STAR program, and the Community Trauma Treatment Center for Runaway and Homeless Youth), and research studies (e.g., the Women, Co-Occurring Disorders, and Violence Study).

In addition to reviewing the literature, we contacted various programs directly, by telephone or email, including: the National Center on Family Homelessness (Moses, Guarino); Homelessness Resource Center (Olivet); Community Connections (Fallot); the Institute for Health and Recovery (Markoff & Dargon-Hart); CT State Department of Mental Health and Addiction Services (Leal); the Domestic Violence & Mental Health Policy Initiative (Brashler, Hall); the Community Trauma Treatment Center for Runaway and Homeless Youth (Schneir); the Trauma Center at JRI/ Youth on Fire, developers of Phoenix Rising (Spinazzola); Kinniburgh and Blaustein, developers of ARC; Cincinnati Children's Hospital Medical Center, developers of CARE (Pearl); University of Connecticut Department of Psychology and the CT Department of Mental Health and Addiction Services Research Division (Marra). Many of these programs sent unpublished program evaluation reports, manuals, or self-assessment tools, for inclusion in this review.

RESULTS

Organizational Needs Assessments: Do We Need Trauma-Informed Care?

Needs assessments can be used to identify needs and to detect gaps in service within a system. We began by reviewing results of needs assessments conducted by several agencies regarding the relevance of trauma within their service system and the need for TIC. These needs

Table 1. Principles of Trauma-Informed Care

Common Principles Across Definitions		Example Definitions of Trauma-Informed Care				
		Community Connections: Five Guiding Principles for Trauma-Informed Services [12]	**NASMHPD*: Criteria for Building a Trauma-Informed Mental Health Service System**	**NCTSN**: Principles of Trauma-Informed Care for Children**	**NCFH***: Operating Principles for Trauma-Informed Organizational Self-Assessment**	**WCDVS****: Trauma-Informed or Trauma-Denied: Principles & Implementation of Trauma-Informed Services for Women [14].**
Consensus-Based Principles Across Definitions		**Theory-Based**	**Expert Trauma Panel**	**Experts**	**Theory-Based**	**Research-based**
1. Trauma Awareness	**a. Program philosophy and mission**		Trauma function/ focus, trauma policy or position, financing for best practices, trauma-informed services, clinical practice guidelines for people with trauma histories, trauma-informed disaster planning, systems integration, research & data on trauma & evidence-based & best-practice treatment models, access to evidence-based & best-practice trauma treatment		Trauma awareness; basic understanding of trauma & triggers; includes staff training & supervision, educating consumers about trauma	Recognize the impact of trauma on development and coping
	b. Staff education, training, and consultation		Workforce orientation, training, support, competencies and job standards related to trauma; promote education of professionals in trauma			Emphasize trauma recovery as a primary goal
	c. Practices		Trauma screening and assessment; Trauma-specific services, including evidence-based and emerging best-practice treatment models		Integration (symptoms such as adaptive coping, integrating services, trauma-specific services)	
	d. Recognition of vicarious trauma and staff self-care					
2. Safety	**a. Physical and emotional safety**	Safety (physical and emotional)		Maintaining clear and consistent boundaries	Safety, basic needs, consistency, and predictability	Create an atmosphere of safety, respect, and acceptance
	b. Relationships: authentic, respectful, clear boundaries	Trustworthiness (clear tasks, consistent practices, staff-consumer boundaries)		[see Delivering services below]	Engagement: respectful nonjudgmental relationships, clear boundaries	Utilize a relational collaboration model. Growth is fostered by mutual, respectful, authentic relationships
	c. Avoid retraumatization		Procedures avoid retraumatization and reduce impacts of trauma			Minimize retraumatization

(Table 1) contd.....

Common Principles Across Definitions		Example Definitions of Trauma-Informed Care				
		Community Connections: Five Guiding Principles for Trauma-Informed Services [12]	**NASMHPD*: Criteria for Building a Trauma-Informed Mental Health Service System**	**NCTSN**: Principles of Trauma-Informed Care for Children**	**NCFH***: Operating Principles for Trauma-Informed Organizational Self-Assessment**	**WCDVS****: Trauma-Informed or Trauma-Denied: Principles & Implementation of Trauma-Informed Services for Women** [14].
Consensus-Based Principles Across Definitions		**Theory-Based**	**Expert Trauma Panel**	**Experts**	**Theory-Based**	**Research-based**
	d. Acceptance of and respect for diversity		Trauma policies and services that respect culture, race, ethnicity, gender, age, sexual orientation, disability, and socio-economic status	Delivering services in a nonjudgmental and respectful manner	Cultural competence	Work towards cultural competence, understand contextual factors
3. Choice & Empowerment	**a. Choice and control**	Choice: maximize consumer choice and control	Consumer/Trauma Survivor/ Recovering person involvement and trauma-informed rights	Maximizing choice and control for participants	Consumer control, choice and autonomy	Underscore consumers' choice and control over recovery
	b. Empowerment model	Empowerment: prioritize consumer empowerment, skill-building, and growth		Avoiding provocation and power assertion	Open communication: provide information openly to consumers	Use an empowerment model
	c. Consumers involved in service development and evaluation	Collaboration: maximize collaboration and sharing of power between staff and consumers		Sharing power in the running of shelter activities	Shared power and governance	Involve consumers in design and evaluation of services
4. Strengths-based	**Focus on strengths, resiliency**	[see Empowerment above]			Healing, instilling hope	Highlight consumers' strengths, adaptations, and resiliencies

* NASMHPD= National Association of State Mental Health Program Directors.
** NCTSN = National Child Traumatic Stress Network.
*** NCFH = National Center on Family Homelessness.
**** WCDVS = Women, Co-Occurring Disorders and Violence Study.

assessments were generally designed as a first step, prior to initiating a more formal organizational self-assessment or to beginning programmatic shifts. Several findings emerged from a review of these needs assessments:

- **Providers feel that they need to be better informed about trauma and violence** [17, 18]. Directors and staff within state domestic violence coalitions reported that many shelters are unprepared to deal with the complex needs of the women they serve, many of whom have few resources and have been victimized as children and as adults. Domestic violence advocates reported an increasing awareness of the need for services appropriate for women with mental health issues, substance abuse problems, and histories of abuse. They also expressed a need for guidance and resources in improving their responses to survivors of domestic violence who have experienced multiple abuses throughout their lives [18]. A multi-site program implementing trauma-informed services found that prior to implementation, sites had little knowledge about trauma, how to facilitate recovery, or how services might help or retraumatize survivors [19].
- **Many providers do not have systematic ways of assessing for trauma-related issues.** In a study examining PTSD screening and referral practices in VA addiction treatment programs, they found that although one-half to two-thirds of clinicians did routinely screen for trauma exposure and posttraumatic stress symptoms, assessments were generally not conducted systematically and did not utilize validated measures [20].
- **Consumers want services that are empowering.** Qualitative research has suggested that homeless individuals and families need and want trauma-informed services, including desire for autonomy, prevention of further victimization, and assistance in restoring their devalued sense of identity [21]. A provider guidebook, written from a consumer perspective, notes the need for accessible and effective programs for trauma survivors [22].

- **Mental health services are an important need for many homeless families and individuals.** In a multi-site research study on trauma-informed services for homeless families, researchers examined current service needs, including families' need for social capital (educational or employment-related interventions), physical health, and mental health/substance use treatment. Among the families, they found that "mental health needs were the most prevalent of all the intervention needs components across sites (62%)," with many facing multiple challenges, signaling the need for comprehensive intervention [23].

The results of these needs assessments supported the central importance of dealing with trauma within homelessness service settings and the perceived need for TIC.

Trauma-Informed Care within Homelessness Services Settings: Attitudes, Implementation, and Outcomes

Once the perceived need for trauma services is established, we can begin to explore the development of a TIC framework within homelessness service settings. We reviewed available quantitative, qualitative, and corroborative evidence regarding trauma-informed services.

Prochaska's stages of change model [24] highlights the fact that change is a process for individuals, who progress through precontemplation, contemplation, action, and maintenance of change. Similarly, systems change is a multi-step process. Our review of the literature highlighted three areas of evidence: attitudes, implementation, and outcomes. "Attitudes" refers to the beliefs of consumers and providers (at all levels, from management to front-line workers) of the need for a paradigm shift, confidence in ability to institute a paradigm shift, and belief that such a shift will lead to positive outcomes. "Implementation" coincides with Prochaska's action stage of change. It is a process variable, and is concerned with *how* changes are made. Implementation requires a clear definition of what is meant by Trauma-Informed Care, in order to translate these principles into concrete changes that will be instituted within the system. Finally, "outcomes" refers to the impact of a paradigm shift to TIC within homelessness service settings. Measurable objectives help to assess the efficacy of systems change. Outcomes may include measurable quantitative outcomes, such as a decrease in recidivism in homelessness, or qualitative outcomes, such as self-esteem or satisfaction with services.

Review of the Evidence: What Do We Know About TIC?

In our review of the evidence for TIC, several salient points emerged:

1. Attitudes

- **Programs attempting to implement TIC have encountered some concerns and resistance on the part of providers.** Providers may be afraid that addressing trauma will open a "Pandora's box" of reactions. They may lack confidence in their ability to manage and address trauma reactions and may be concerned that they will encounter triggers of their own trauma histories [19]. They may also worry that they will not have the resources to adequately respond to the complex needs of survivors.
- **Because of these concerns, taking the time to build "buy-in" is particularly important.** Recognizing the importance of commitment in organizations, some programs have developed committee structures geared towards obtaining "buy-in" from administration, program staff, and consumers. Building strong relationships also aided buy-in and integration of services [19]. After building agency-wide commitment, programs have found strong support from staff members for implementing a trauma-informed model [25].
- **Consumers want providers who are empathic and caring, who provide validation, and who offer emotional safety—characteristics of trauma-informed providers.** Consumers have emphasized the benefits of working with trauma-informed providers. Some have suggested that programs could benefit from having more trauma services, that practitioners need to remain patient, and that consumers themselves need to be invested in actively addressing their own issues [26]. However, even within trauma-informed systems, consumers sometimes struggle to feel empowered within a larger service system [27].

2. Implementation

- **Training is central to implementing TIC.** The majority of programs working to build TIC utilized staff training to increase awareness of and sensitivity to trauma-related issues. A large multi-site study of trauma-informed models found that "training on trauma for non-trauma providers was the first and most important step in making services more trauma-informed" [19].
- **Ongoing supervision, consultation, and support are needed to reinforce trauma-based concepts.** One lesson from WCDVS was the importance of ongoing supervision and support to ensure that the environment is trauma-informed and that staff members practice appropriate self-care. Many programs also used external trauma consultants and ongoing training to reinforce knowledge and commitment to building trauma-informed services [19].
- **Assessment and screening are important aspects of trauma-informed services.** Research documenting high prevalence rates of trauma among people experiencing homelessness has led to the conclusion that screening for trauma is important within homeless service settings [28]. Although providers have at times expressed concern that inquiring about trauma histories will lead to traumatic stress responses, findings indicate that there are few adverse reactions to screening and assessment. Instead, most people benefit from this type of assessment [29]. Several pilot studies show that providers refined their intake processes to include screening for trauma exposure [28, 30]. Additionally, screening and assessment tools should be revised and refined with consumer and provider feedback [29].

- **Because homeless individuals often have a multitude of service needs, comprehensive and integrated services are essential.** Studies have found that service settings offering integrated counseling—addressing trauma, mental health, and substance use issues—had better results than settings that were not integrated [31].
- **Integrating trauma-informed services for children is also important.** Children of parents who are dealing with trauma, mental illness, substance abuse, and/or homelessness may be at greater risk for adverse outcomes. A number of programs working to integrate trauma-informed services have also highlighted the importance of parallel services for children. In WCDVS, a subset of sites offered specialized children's programs, including assessment, groups, and resource coordination/advocacy for children to build coping skills, strengthen interpersonal relationships, and develop positive identity and self-esteem [32].
- **Many factors challenge implementation of trauma-informed services.** Various reports highlighted the logistical difficulties of systems change. Change, especially within larger systems, can be time-consuming and requires a great deal of commitment across all levels of an organization. Organizational resistance and stress can be a barrier to larger systems change [33]. Moses highlighted challenges to systems change across a number of sites working to implement integrated, trauma-informed services for women with co-occurring disorders. These challenges included philosophical differences between mental health and substance use treatment approaches, differences around issues of trauma, resistance at the service and administrative levels, limited resources, difficulties in achieving consistent participation in trauma groups, staff turnover, and the difficulty of change in general [13].
- **Implementing a trauma-informed model can lead to changes in how an organization functions.** In a program implementing a trauma-informed model, staff reported a number of changes within their programs, including increased awareness and sensitivity about trauma, intake that incorporates questions about trauma, more freedom and choice given to consumers regarding their treatment, and environmental changes that led to increases in safety, confidentiality, and a more welcoming atmosphere [30].
- **Including consumers in developing and evaluating trauma-informed services is important.** Although there has not yet been research that examines differences in services that include or do not include consumers in program development and evaluation, current wisdom in the field stresses the importance of including consumers in all aspects of programming [34, 35]. This wisdom is consistent with theories on empowerment, which suggest that survivors should be given agency in effecting their own outcomes [36]. The WCDVS found that integrating consumers into the design and evaluation of services had a profound impact on the systems involved [19], and that "integral to the... group's personal and professional growth was the development and expression of their individual and collective voices" [27].
- **Cultural competence is important in developing TIC.** Because trauma may have different meanings in different cultures, and because traumatic stress may be expressed differently within different cultural frameworks, it is important for providers within a trauma-informed system to work towards developing cultural and linguistic competence [13].

3. Outcomes

- **Trauma-informed service settings, with trauma-specific services available, have better outcomes than "treatment as usual" for many symptoms.** We know from a variety of studies [31, 37] and pilot programs [38] that setting that utilize a trauma-informed model report a decrease in psychiatric symptoms and substance use. Some of these programs have shown an improvement in consumers' daily functioning and a decrease in trauma symptoms, substance use, and mental health symptoms. These findings suggest that integrating services for traumatic stress, substance use, and mental health leads to better outcomes [16].
- **TIC for children lead to better outcomes, such as better self-esteem, improved relationships, and increased safety.** A subset of programs within WCDVS examined the impact of a standardized, trauma-informed intervention for children, consisting of a clinical assessment, coordination of resources and advocacy, and a psycho-educational skills-building group. One year later, children in the intervention group had more positive self-identity, increased tools for building healthy relationships, and improved safety. These changes were particularly striking for children who had witnessed violence [32, 39].
- **Early indications suggest that TIC may have a positive effect on housing stability.** A multi-site study of TIC for homeless families found that, at 18 months, 88% of participants had either remained in Section 8 housing or moved to permanent housing [23]. An outreach and care coordination program that provided family-focused, integrated, trauma-informed care to homeless mothers in Massachusetts found that the program led to increased residential stability [38].
- **TIC may lead to a decrease in crisis-based services.** Some studies have found decreases in the use of intensive services such as hospitalization and crisis intervention following the implementation of trauma-informed care [40].
- **Trauma-informed, integrated services are cost-effective.** Because trauma-informed integrated services have improved outcomes but do not cost more than standard programming, they are judged to be cost-effective [41].
- **Qualitative results find that providers report positive outcomes in their organizations from**

implementing TIC. Providers report greater collaboration with consumers, enhanced skills, and a greater sense of self-efficacy among consumers, and more support from their agencies. Supervisors report more collaboration within and outside their agencies, improved staff morale, fewer negative events, and more effective services [40].

- **Qualitative results indicate that consumers respond well to TIC.** Within the D.C. Trauma Collaboration study, consumers reported an increased sense of safety, better collaboration with staff, and a more significant "voice." Eighty-four % of consumers rated their overall experience with these trauma-informed services using the highest rating available [42]. Survey results suggest that consumers were very satisfied with trauma-informed changes in service delivery [25].

These results reinforce the need for TIC, assist in further defining TIC, clarify the process of implementation, and suggest the efficacy of TIC for certain outcomes. However, in our review, we found that various questions were *not* addressed by available evidence. These gaps in the available evidence are important in highlighting the additional work that remains to be done to implement TIC in homelessness service settings.

Review of the Evidence: What Do We Not Know About TIC?

Our review of the literature highlighted several directions for future exploration:

1. Attitudes

- **Although providers and consumers alike generally pay lip service to the idea of TIC, we do not know the extent to which their attitude is influenced by demand.** In much of the research to date, providers and consumers were given brief questionnaires or were interviewed—in many cases, by the individuals working to build trauma-informed services. Thus, there may be a tendency to indicate support of implementation plans and strategies in the absence of true commitment.

2. Implementation

- **We do not know exactly what constitutes "trauma-informed care."** Trauma has become a buzz-word recently, with many agencies and workgroups noting the importance of becoming "trauma-informed." However, definitions of "trauma-informed" and how these ideas are implemented vary widely. There is generally a lack of specificity in how agencies are defining "trauma-informed," and how this relates to actual practice.
- **We do not have a clear method for measuring the degree to which a program is trauma-informed.** Because of the lack of definitions and behaviorally-defined changes signifying trauma-informed services, there is no consistent basis for identifying whether or not and to what degrees a program is trauma-informed.
- **We do not know how special populations respond to trauma-informed homelessness services.** Much of the evidence on trauma-informed homelessness systems concerns women and children. We know less about the response of other groups, such as men, veterans, individuals from ethnic/racial minorities or other cultures, and lesbian, gay, bisexual and transgendered (LGBT) individuals.

3. Outcomes

- **We do not know whether differences in outcomes are based on trauma-informed environments, trauma-specific interventions, or both.** Because many service settings that provide TIC also offer trauma-specific services, the extent to which each component contributes to change is difficult for research studies to determine.
- **We do not know whether trauma-informed services are effective specifically within homeless services.** Although the research in other fields suggests that trauma-informed services may be effective for homeless individuals, there have yet to be any rigorous, quantitative studies exploring outcomes within homelessness service settings. The results of the Homeless Families Program, a current multi-site evaluation of trauma-informed homelessness services, may begin to shed some light on this issue.

Our review of the current evidence suggests that TIC is an important area for further exploration. Initial feedback appears to support the assertion that TIC has a positive impact on both the process and outcome of service provision within homelessness service settings. However, the review highlighted as many questions and gaps as it defined results and conclusions.

Because the implementation of TIC within homelessness service settings is in its infancy, it is particularly important to review lessons from the field, including self-assessments and frameworks that are being developed to guide the paradigm shift to TIC, as well as feed back from local, regional, and national programs and initiatives that are implementing TIC. Lessons from the field highlight clinical insights, new practice initiatives, and areas in need of further qualitative and quantitative research.

Corroborative Evidence: Lessons from the Field on Building TIC in Homelessness Service Systems

When we look to the field for best practices and clinical wisdom, we find a wealth of information about current theories, practices, programming, and policy initiatives. This information tells us that although we do not yet have substantial outcome-based research supporting the effectiveness of TIC, there is considerable activity in the field that is awaiting additional documentation. Many homeless service systems are beginning to address this issue—administrators, providers, consultants, and consumers are working together to transform programs into environments that offer TIC.

After recognizing the pervasiveness of traumatic stress among people experiencing homelessness, various programs are taking steps to become more trauma-informed. We have

selected several case examples to describe the ways in which homeless service settings are striving to become more trauma-informed. This is not a comprehensive list of trauma-informed resources and programs. Instead, it is intended to illustrate various creative ways that programs are implementing trauma-informed models within homeless service systems, and some of the tools that are available to aid this transition.

Selected Promising Models

To foster the development of trauma-informed homeless service settings without reinventing the wheel within each individual program, innovators have developed frameworks and models that can serve as guides for implementing TIC. Various models have been proposed that support organizational change towards a model of TIC and that guide trauma-informed service delivery. Some of these models are:

- Attachment, Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth (ARC) [43]
- Child Adult Relationship Enhancement (CARE)
- *A Long Journey Home* [44]
- Phoenix Rising [45]
- Sanctuary Model [46]
- Using Trauma Theory to Design Service Systems [12]

Table 2 describes each of these models, the applications of the models, and available evidence supporting their effectiveness. These models of TIC emphasize staff education, involving consumers, and transforming systems to be responsive to the needs of trauma survivors. Several models, including ARC, CARE, and Sanctuary, have an evidence base (e.g., outcomes-based quantitative research) in the mental health field (including inpatient and outpatient settings) and are considered to be promising practices in trauma-informed care [46]. Others, such as *A Long Journey Home* and Phoenix Rising, were developed specifically for homeless service settings. Most of these models have been implemented within homeless service settings, and process and outcome evaluation data are currently being collected.

HOW TRAUMA-INFORMED ARE WE? ORGANIZATIONAL SELF-ASSESSMENTS

The models described above highlight the need for a framework that provides the foundation for a paradigm shift within homelessness service systems. Once a model for TIC has been identified, an organizational self-assessment can be utilized as a starting point for systems change.

Self-assessment targets specific areas for change and indicates how a service delivery model might be adapted to an organization's unique needs. As the model is implemented, a self-assessment is a useful reminder about important aspects of trauma-informed care that facilitate self-monitoring and program evaluation. Organizational self-assessments can also be conducted after implementation of a paradigm shift in order to evaluate the effectiveness of the systems change.

Several trauma-informed organizational self-assessments are currently available or/are in development. They include:

- The Collaboration on Trauma-Surviving Homeless Children, a partnership between the National Center on Family Homelessness and the Trauma Center at Justice Resource Institute (JRI), has developed the ***Trauma-Informed Organizational Self-Assessment for Programs Serving Homeless Families*** [50] to help programs assess the degree to which their services are trauma-informed and to highlight areas for change. The self-assessment addresses organizational issues such as delineating program mission, guidelines, and policies; reviewing services and policies; establishing a safe and trauma-informed physical environment; respecting consumer needs and differences; protecting consumer privacy and information; encouraging internal and external community-building; and involving consumers in program development and evaluation. The instrument evaluates staff issues, including hiring practices, staff training and education, and supervision and support. It also assesses consumer issues, including procedures for arrival and intake; safety-planning and crisis prevention; goal setting; and availability of services, including trauma-specific interventions.
- The Trauma Center at JRI has developed the ***Trauma-Informed Facility Assessment*** [49], a brief instrument assessing the degree to which an organization's physical space is trauma-informed. This assessment defines several characteristics that are of primary importance for trauma-informed organizations, including physical safety, absence of triggering material, privacy/ confidentiality, and structure and predictable/consistent response. Other areas measured by the instrument include accessibility; organization and hygiene; the ability to meet the basic needs of consumers and provide links to resources; the availability of personal/quiet space; the communication of positive messages; and the creation of a sense of community, with consumer ownership of the space and the program.
- Community Connections has developed a ***Trauma-Informed Program Self-Assessment Scale and Planning Protocol*** [51]. This tool allows organizations to evaluate the degree to which program activities and settings are consistent with five guiding principles: safety, trustworthiness, choice, collaboration, and empowerment. Six major domains are evaluated, including: program procedures and settings; formal services policies; trauma screening, assessment, and service planning; administrative support for program-wide trauma-informed services; staff trauma training and education; and human-resource practices. Each domain is evaluated on the basis of review of program policies, standard program activities, review of physical space, staff ratings, and consumer ratings.
- As part of a larger study examining integrated trauma-informed treatment for women with

Table 2. Models of Trauma-Informed Care

Model	Developers	Description	Key Principles	Applications	Research Evidence	Strengths	Limitations
The ARC Model (Attachment, Self-Regulation, and Competency): A Comprehensive Framework for Intervention with Complexly Traumatized Youth	Kinniburgh and Blaustein [48]	• ARC is a flexible framework for intervention with children/families who have experienced complex trauma. ARC has been adapted for use within various milieus. • It has been applied within homeless settings for runaway and homeless youth.	• 10 building blocks, based on three basic principles: *Attachment, Regulation, and Competency.* • *Attachment:* Caregiver affect management, attunement, consistent responses, routines and rituals. • *Regulation:* Affect identification, modulation, and expression. • *Competency*: Executive functions, self-development & identity, & developmental tasks.	Therapeutic Procedures: • Psycho-education; • Relationship strengthening; • Social skills; • Parent-education training. • ARC principles adapted for use with homeless adolescents. • ARC Agency Inventory for homeless/ runaway youth has been developed.	• Pilot data: ARC is effective in outpatient settings. • Quasi-experimental research studies: conducted in outpatient and milieu settings in MI, IL, CA, AL, & MA. Outcomes: decreased trauma symptoms, PTSD, and internalizing/ externalizing symptoms. • ARC concepts-adapted for use in homeless settings but not yet been evaluated.	• Very strong theoretical basis. • Addresses developmental trauma. • Offers a comprehensive framework for milieu change; provides a model for trauma-specific interventions. • Well-defined, with an extensive manual and comprehensive training • NCTSN calls it a "promising practice" Collecting evidence on effectiveness at multiple sites.	• Although evaluated in multiple outpatient and milieu settings, it has yet to be formally evaluated in homeless settings.
CARE (Child Adult Relationship Enhancement)	Trauma Treatment Training Center (TTTC). Revised for homeless populations by NCFH & the Trauma Center.	• Trauma-informed modification of Parent Child Interaction Therapy (PCIT). • Skill-based model for use in milieu settings. • Being modified for homeless settings.	CARE guides caregivers in child-directed and parent-directed interactions: • Caretakers' competence in managing child's problematic behaviors; • Caretakers' competence reinforcing + behaviors; • Reduce parent-child conflict; and • Enhance positive parent-child interactions.	• Trauma education component. • Live coaching. • Practice of 3 P Skills (Praise, Paraphrase, and Point-Out Behavior) to guide parent-child interactions.	• CARE is empirically informed but has not yet been evaluated. • PCIT, the foundation for CARE, has been empirically supported by numerous studies. • Piloted in shelters	• Modified PCIT-Strong theoretical & research base • Effective for building + caregiver/child relationships & building caregiver competence. • NCTSN calls it a promising practice	• Limited scope in terms of systems change. • Does not yet have an evidence base within homelessness.
A Long Journey Home	Prescott, L. and NCFH [44]	A Guide for Creating Trauma-Informed Services for Homeless Mothers and Children	Offers guidance on: • Changing the environment • Trauma-informed policies and procedures • Trauma-informed services & support • Client representation & staff development • Training and supervision • Developing sustainability	•Guide offers concrete suggestions for organizational shift towards TIC •Includes concrete examples, exercises, & suggestions for staff training.	• In the final stages of development; has not been piloted in homeless service settings.	• Practical guide for making concrete changes within systems. • Developed specifically for trauma-informed systems change within homeless service settings.	• Still in development --does not yet have a research or practice evidence base.

(Table 2) contd.....

Model	Developers	Description	Key Principles	Applications	Research Evidence	Strengths	Limitations
Phoenix Rising	Youth on Fire and the Trauma Center at JRI	Phoenix Rising is an adaptation of ARC concepts for use with homeless adolescents and young adults.	Four main components: • Staff training & ongoing consultation • Trauma-informed milieu changes based on the Trauma-Informed Facility Self-Assessment [49] • Comprehensive Risk Counseling and Services • Group activities (expressive art therapies and community-building)	Designed for non-clinical staff in shelters for homeless youth. Offers guidance on: • Training and philosophy-shift; • Self-assessment • Organizational and physical space issues • Staff issues • Consumer issues (skill-building, development of a cohesive environment)	• Being piloted at a drop-in program for homeless adolescents and young adults in Cambridge, MA.	• Practical guidebook for concrete systems change. • Modification of a strong theoretical model (ARC) for use at a drop-in center for homeless youth.	Manual under development and being piloted in a homeless service system.
The Sanctuary Model	Bloom, S. [46]	• Framework for intervening with trauma survivors and facilitating organizational change. • Originally developed for traumatized adults in inpatient units, adapted for DV shelters.	• Culture of nonviolence. • Emotional intelligence. • Inquiry & social learning. • Shared governance. • Open communication. • Social responsibility. • Growth and change. Shared intervention language: SAGE (Safety, Affect Management, Grief, Emancipation) for adults, SELF (Safety, Emotions, Loss, Future) for children.	Concrete tools for intervention include: • Community meetings • Red flag reviews • Psychoeducation • Self-care planning • Safety plans • Team meetings • Treatment planning conferences	• Program evaluation within inpatient units: reduced PTSD symptoms & use of restraints/ seclusion, improved patient satisfaction, improved staff retention. • Additional pilot trials underway.	• Theoretical base. • Research evidence in multiple settings-inpatient and outpatient • NCTSN calls it a promising practice	• Although evaluated within multiple outpatient and milieu settings, it has yet to be formally evaluated in homeless settings.
Using Trauma Theory to Design Service Systems	Harris and Fallot [12]	• Short edited book describes trauma-informed systems & the application of trauma theory to systems change. Applies concepts to various settings, such as shelters. Forms guide systems change.	• Systems change approach. • Self-Assessment and Planning Protocol ensures that all levels of the organization have an understanding of trauma, its sequelae, and the impact of trauma in shaping a consumer's responses.	• Book describing the model: Using Trauma Theory to Design Service Systems • Trauma-Informed Self-Assessment and Planning Protocol. • Trauma-Informed Self-Assessment Scale • Implementation Form.	• Piloted in DC, ME, & CT. Most pilot projects within mental health & substance abuse settings. • Initial pilot project data: support for this model from organizations, staff, and consumers.	• Theoretical base. • Self-Assessment and Planning protocol offers concrete steps for intervention. • Training and consultation is available.	• Evidence base comes from unpublished pilot studies. • Not yet evidence on this model in homeless service settings.

co-occurring disorders, the W.E.L.L. Project of the Institute for Health and Recovery (IHR) developed a toolkit for developing trauma-informed organizations. This self-assessment tool, entitled ***Developing Trauma-informed Organizations: A Toolkit*** [52], includes principles of trauma-informed treatment, a self-assessment for provider organizations, and an organizational assessment for non-provider organizations.

Although these self-assessment tools—like the service delivery models—are still in development and refinement stages, they reflect advances towards the development of TIC.

INNOVATIVE PROGRAMS AND INITIATIVES UTILIZING TIC

The development of these models and self-assessment tools has facilitated the progress of a number of innovative

programs that are working to build TIC within homelessness service systems. We selected various programs that illustrate lessons from the field with diverse populations experiencing homelessness.

Trauma-Informed Family Shelters

- The *Collaboration on Trauma-Surviving Homeless Children*—a partnership among the National Center on Family Homelessness, the Trauma Center at Justice Resource Institute, and other agencies—has worked with various shelters within the Boston metropolitan area to build trauma-informed homeless services. Experts in trauma and homelessness worked jointly to develop trauma-based training and consultation targeted specifically to the needs of homeless families. Trauma training was offered to all levels of program staff, from administrators to clinical case managers to family advocates. Staff participated in regular trauma team meetings that focused on both trauma-informed organizational change and trauma-focused case consultation. Trauma-informed programming was also instituted within shelter settings. This included community-building activities, an expressive music program, and self-care activities for residents. The goal of this program was to increase the staff's knowledge of traumatic stress, their skill level in responding to trauma-related issues, their self-efficacy about working with individuals and families who have been traumatized, and their awareness of issues related to vicarious trauma and burnout, and self-care. Initial evaluation results indicated positive outcomes, with high levels of support for the organizational shift to trauma-informed programming, increased staff confidence, fewer resident conflicts, better relationships among staff and residents, and fewer resident terminations.

Trauma-Informed Domestic Violence Shelters

- The *Domestic Violence (DV) and Mental Health Policy Initiative* in Chicago is working with the Department of Public Health, the Mayors Office, and several domestic violence shelters to create three "Centers of Excellence" for trauma and domestic violence. This pilot program will evaluate changes among organizations, providers, and survivors. The initiative is also developing a DV-Trauma Core Curriculum to assist providers in offering more trauma-informed services within domestic violence programs.

Trauma-Informed Homeless Outreach Programs

- *The Women's Violence Prevention Project Alliance* at the Friends of the Shattuck shelter in Boston is an outreach program for homeless men and women that is working towards becoming more trauma-informed. This program developed a manual to help providers and outreach workers build their understanding of trauma and learn how to respond appropriately to survivors. The manual also includes a safety-planning guide for use with individuals who are living on the streets.

Trauma-Informed Programs for Homeless Youth

- *Youth on Fire* is a drop-in center for homeless adolescents and young adults in Cambridge, Massachusetts. This program utilizes the Phoenix Rising model, an adaptation of ARC (Attachment, Self-regulation, and Competency model) for homeless and at-risk youth. Program staff members have received trauma training and continue to receive trauma consultation from the Trauma Center at Justice Resource Institute. They are working to modify their environment to become more trauma-informed. This program also offers trauma-specific group interventions.
- The *Community Trauma Treatment for Runaway and Homeless Youth* is a partnership among several agencies in the Los Angeles area that provides outreach and services to homeless youth. This program has utilized the ARC model to institute a philosophical shift towards becoming trauma-informed. They developed an ARC-based organizational self-assessment in order to target areas for change within participating agencies. They have also instituted trauma-informed case conference meetings in which ARC concepts are used for case review. Trauma-specific interventions have also been instituted within this program.
- *The Homeless Children's Network* is a consortium of fifteen homeless and domestic violence programs in San Francisco, California. This program provides therapy and case management to homeless children and their families. Their theoretical framework considers homelessness to be a traumatic stressor for children.

Trauma-Informed Treatment Programs for Homeless People with Co-Occurring Mental Health and Substance Use Problems

- The *Seeking Treatment and Recovery (STAR) Program* in Florida provides treatment for homeless people who are suffering from co-occurring mental illness and substance abuse. After determining that 79.5% of the homeless individuals served by their program acknowledged a history of physical or sexual abuse, this program began to make changes to become more trauma-informed. The program instituted a formal process of screening for trauma exposure. Based on the high level of trauma exposure reported by men, they expanded the trauma-specific services to include treatment for male survivors. The program also incorporated various training activities to raise trauma awareness and to build trauma-informed services [28].

Programs Utilizing a Trauma Framework for Veterans

- *Mary E. Walker House* is a transitional-living program for homeless women veterans in Coatesville, Pennsylvania, that focuses on recovery from trauma and substance abuse. This program includes a trauma framework and also offers trauma-specific services.

- The *Renew program* is a V.A. program in Long Beach, California, which serves both homeless and non-homeless women veterans who have experienced military sexual trauma, and often pre-military sexual trauma.
- *New Directions* is a V.A. program in Los Angeles, California, that offers substance abuse and mental health treatment utilizing a trauma framework. Its Women's Program offers trauma counseling, with 100% of clients reporting abuse. The Executive Director noted, "Most of our clients have experienced multiple traumas, including physical trauma as a child, military trauma and years of abuse on the streets and in prisons. Since veterans are known to have a higher degree of trauma than the general public, it would be most cost effective to begin to *treat trauma as the core disability* rather than separate and apart from all other symptoms" [53].

These program examples illustrate the beginning of a paradigm shift in which homeless services sites are recognizing the central role of trauma in the lives of consumers. These programs are being implemented in diverse settings including family-based shelters, domestic violence programs, outreach programs, dual diagnosis programs for homeless individuals, and programs for homeless youth and veterans. However, this shift is only beginning. Many programs do not yet recognize the central role of trauma. Guidance from state and federal initiatives is likely to facilitate broader awareness of the need for TIC within behavioral health systems and, more specifically, within homelessness services settings.

SELECTED STATE AND FEDERAL INITIATIVES TO ESTABLISH TIC

Over the past ten years, various state and federal policies have focused on the importance of establishing trauma-informed services within mental health and substance abuse settings. In 1998, the National Association of State Mental Health Program Directors (NASMHPD) issued a position statement on services and supports for trauma survivors, recognizing that "the psychological effects of violence and trauma in our society are pervasive, highly disabling, yet largely ignored." The statement articulated a commitment to address the issue of trauma. The report, *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services,* defined "trauma-informed" and described programs that have implemented trauma-informed models on a statewide or local level [54]. NASMHPD also developed a Trauma Services Implementation Toolkit for State Mental Health Agencies [42] that describes products being used by various state agencies to work towards building trauma-informed systems. Although these policy documents are not directed towards homeless service systems, they provided momentum in the social-services fields towards incorporating knowledge of trauma into service systems.

Regional and national initiatives regarding the need for TIC within the homelessness field are even more recent. Within the past ten years, a number of homeless service organizations and coalitions have begun to emphasize the importance of addressing the impact of trauma among individuals experiencing homelessness, and several training and technical assistance centers have emerged that are actively promoting trauma-informed homelessness services.

The ***Homelessness Resource Center*** (HRC), a SAMHSA-funded program, provides resources, training, and technical assistance on issues affecting people who are homeless. Its mission is to improve the lives of people who are homeless and have been impacted by trauma, substance abuse, and mental health issues. One of HRC's guiding principles is to foster trauma-informed recovery systems. Through its website, the HRC disseminates tips, tools, and knowledge-based products that can be used by programs interested in implementing trauma-informed care. See www.homeless.samhsa.gov.

The ***National Center for Trauma-Informed Care***, funded by SAMHSA's Center for Mental Health Services (CMHS), offers educational materials, technical assistance, and training to social services systems to build an understanding of the impact of trauma and effective trauma-based interventions. In collaboration with the Homelessness Resource Center, the National Center for Trauma-Informed Care offers trauma-informed training to providers in the Gulf Coast recovery area. In addition, training in trauma-informed care has been offered to Projects for Assistance in Transition from Homelessness (PATH) programs.

The ***National Child Traumatic Stress Network*** (NCTSN), another SAMHSA-supported program, has focused on the impact of traumatic stress in the lives of children. The Network has been active in promoting trauma-informed care, including trauma awareness within homeless service settings for youth. ***The Homelessness and Extreme Poverty Working Group*** is a branch of NCTSN that devotes itself to the intersection of trauma, poverty, and homelessness in children.

The ***Department of Veterans Affairs*** offers specialized services to homeless veterans, and is increasingly addressing sexual trauma among female veterans. However, the ***National Coalition for Homeless Veterans*** noted that "with greater numbers of women in combat operations, along with increased identification of and a greater emphasis on care for victims of sexual assault and trauma, new and more comprehensive services are needed." The Coalition's 2007 public policy priorities include increasing homeless veterans' access to comprehensive, high-quality and affordable health care, including substance abuse and mental health care. Limitations still exist in the VA's policy on trauma-informed care for homeless veterans, particularly around the treatment of trauma (not necessarily combat-related) among male veterans.

The work of these initiatives has been integral to raising awareness of the need for trauma-informed homeless service systems. However, a large gap still remains between the recognition of trauma and the implementation of programs and policies that ensure available and accessible trauma-informed care for homeless individuals and families. Further advances in practice, programming, policy, and research are needed to develop evidence-based, trauma-informed care within homeless services across the country.

DISCUSSION

Our review of the current evidence suggested that, while there are challenges to implementing trauma-informed services, Trauma-Informed Care appears to be effective. We can conclude from research in other fields that, with necessary buy-in, TIC is well-received by consumers and providers, most likely leads to better outcomes, and does not cost significantly more than treatment as usual. Despite these promising findings, this review also highlighted what we *do not* yet know about TIC within homelessness services settings. There is a dearth of research on trauma-informed approaches specifically within homeless service settings. Most organizations that are working towards building trauma-informed homelessness service settings are collecting minimal or no information for evaluation purposes. The Homeless Families Program, a large quasi-experimental study examining trauma-informed services within homeless services, is an exception.

Initiated by the Substance Abuse and Mental Health Services Administration (SAMSHA) in 1999, the Homeless Families Program is the first large research study to examine integrated, trauma-informed care for homeless families with psychiatric disorders, substance use problems, and trauma histories. Each of the eight sites focuses on helping consumers understand the connection between their own trauma histories and their current issues; this education lays the groundwork for assisting consumers in developing new coping strategies and working to improve their parenting skills and relationships. The program also focuses on staff issues, including team-building, staff support, and self-care.

Although evaluation of the Homeless Families Program is still in progress, and final results are not yet available, preliminary findings have identified several factors that seem to be important for implementing trauma-informed services: 1) the trauma intervention approach should fit into the overall model and philosophy of the program; 2) programs should utilize strengths-based approaches in working with trauma survivors; 3) programs should encourage mutual respect and trustworthy behavior (e.g., following through on commitments); 4) programs should avoid punitive approaches, limiting rules and regulations to those ensuring safety; 5) staff should be encouraged to have realistic expectations about the progress that can be expected; 6) programs should engage survivors in the process of helping others (e.g., normalizing, empathizing, assisting, allowing transformative experiences); and 7) programs should maintain a nonjudgmental approach, while encouraging personal responsibility and the possibility of making better choices [55].

Clearly, although initial investigations are promising, the research to date is inadequate for evaluating the effectiveness of trauma-informed models within homeless service settings. Additional quantitative and qualitative research is needed to further explore trauma-informed practices specifically within homeless service settings. This research can be used to establish empirically-based best practices and will be the springboard for policy that can drive systems change in programs nationwide. Because the field is only beginning to generate research-based evidence on trauma-informed homelessness services, we have looked to the field for best practices and clinical wisdom in developing and implementing trauma-informed theories and practices.

RECOMMENDATIONS

This review documents the high rates of traumatic stress among people who experience homelessness and supports the need for developing trauma-informed services. While considerable progress has been made in increasing awareness of the impact of traumatic stress, the implementation of a widespread system of trauma-informed homeless services is in its early stages. Although this review highlights various innovative practices and programs that have been created in a wide array of settings for various subgroups of homeless people, they are relatively limited given the enormous need. Many program strategies and models are still being developed and piloted. Preliminary feedback from the homelessness arena and other service settings suggests that these approaches may be effective in producing better outcomes and promoting systems change. However, the evidence base supporting the effectiveness of these practices and programs is largely drawn from the corroborative literature.

The research base supporting the effectiveness of trauma-informed services within homeless settings is limited. Over the past decade, trauma-informed services have begun to be implemented in other fields, including mental health and substance use programs. With this implementation has come some robust quantitative and qualitative research. Quantitative research from these fields indicates that trauma-informed services are associated with improved outcomes, such as decreased mental health, trauma-related, and substance abuse symptoms and behaviors. Qualitative research from these fields has better described the meaning of trauma-informed care and has found that its implementation can be a challenging process, but that it can lead to systems changes that have positive impacts on both providers and consumers. Findings from these studies can inform best practices within the homelessness field.

Even with significant limitations in the research literature, we have learned important lessons about how we can best move ahead to make the homelessness service system more trauma-informed.

Practice

Despite the prevalence of trauma among individuals experiencing homelessness, many homeless service systems are not yet adequately addressing this issue. Greater uniformity and consistency of trauma-informed services for homeless individuals will aid in our understanding of the effectiveness of those practices.

Practice recommendations for building trauma-informed homeless services include the following:

1. Although a number of homeless services settings may be beginning to implement trauma-informed services, there is great variability in how these services are implemented. *Utilization of a theory-based model or framework* would help to ensure consistency across sites and help to begin to build evidence-based practices.

2. Programs should strive to *avoid any practices that may be retraumatizing.* This applies to all levels of the system, including administrative, provider, and consumer levels.
3. Homeless service systems should implement *universal systematic screening for trauma histories*, using standardized measures.
4. Program intake and evaluation should include an *assessment of consumer strengths and resources.* This contributes to the development of a strengths-based model and supports the further development of coping resources.
5. Because research has found that integration of services is a key factor in improving outcomes, it is recommended that *substance abuse, mental health, and trauma services be integrated.*
6. Programs implementing integrated trauma-informed treatment approaches should also include *trauma-informed services for children*, in order to increase resiliency in children and youth.
7. Because the majority of consumers in homeless service settings are trauma survivors, additional *trauma-specific services* should be made available for consumers who wish to receive targeted treatment.
8. Building on empowerment-based trauma theories emphasizing the importance of actively participating in service programs and rebuilding a sense of control, programs should support and encourage *consumer involvement.* Examples of consumer involvement include active goal-setting and crisis planning, peer-led services, leadership roles for consumers, and involvement in program design, evaluation, and refinement.
9. All trauma-informed services should be *culturally and linguistically competent.*

Programming

Our review of the theory, study, and practice of trauma-informed services underscored six steps that are essential when implementing a trauma-informed model, including:

1. Obtaining "buy-in" at multiple levels within the system
2. Conducting a needs assessment to identify areas for change
3. Reviewing the organization's environment, procedures, and services and revising them to become more aligned with the principles of trauma-informed care
4. Providing training on trauma
5. Offering ongoing trauma-based consultation and supervision
6. Providing access to trauma-specific interventions

These principles and implementation strategies are a starting point for any program wishing to implement trauma-informed services.

Beyond offering services that have a trauma-based framework, programming efforts are needed to establish agency-wide commitment to building trauma-informed services. Programming builds continuity among providers to establish the overall shift in program philosophy necessary for building trauma-informed services.

1. Homeless programs should integrate trauma awareness and responsiveness into their *program missions.*
2. There is a need to *operationalize the principles* of trauma-informed services, and to link these principles to quantitative, measurable changes that can be tracked and evaluated.
3. Guidelines should be developed for implementing a *trauma-informed model or framework* in homeless service settings.
4. Programs working for larger systems change towards a trauma-informed model should start with an *organizational self-assessment* in order to identify strengths and target areas for change.
5. Organizations should institute regular *internal and/or external reviews* to assess the degree to which their programs are trauma-informed.
6. Despite the fact that they work with trauma survivors on a daily basis, most staff members within homeless services are not trained about the impact of trauma or strategies for working with trauma survivors. Homeless services should implement *standardized training on understanding traumatic stress and working with trauma survivors.* Because these concepts are complex and cannot be adequately covered in one training, regular follow-up trainings should be offered.
7. A *consultation model* that is ongoing and responsive to specific needs should be utilized to reinforce concepts learned in trainings, as well as to help providers apply what they have learned to actual situations in their service settings.
8. *Regular supervision* should be offered in order to assist staff members in understanding the impact of trauma in particular situations, and to aid staff in recognizing and managing their own reactions.
9. Homeless services should design *trauma-informed environments*, including attention to issues of physical space, triggering materials, privacy/ confidentiality, and structure/ predictability.
10. *Policies and protocols* should be reviewed to ensure that they are consistent with a trauma-informed model and are not inadvertently retraumatizing.
11. Homeless service organizations should be *aware of and responsive to issues of job stress, burnout, and vicarious trauma* in providers. Programs need to have structures in place for prevention of, and early intervention for, vicarious trauma. In terms of prevention, it is recommended that organizations institute policies, programs, or activities that encourage *staff self-care and support.*

12. *Consumer involvement* is an integral part of a trauma-informed system. It is recommended that consumers of homeless services participate as active members in program development, operation, and evaluation. Some possibilities for this involvement include: *Town Hall meetings, consumer advisory boards, and peer-led groups*. Prescott [22] offers guidelines for integrating consumers into trauma-informed programs.

13. Services and programs should *promote cultural diversity and competency.*

Policy

The evidence on trauma-informed services in homeless settings is limited and there is a lack of clearly defined principles, definitions, and methods for establishing trauma-informed services. More research is needed to evaluate the process of developing trauma-informed services and to evaluate the effectiveness of trauma-informed services for homeless individuals. State and federal funding should be appropriated for examining evidence for trauma-informed interventions. The National Association of State Mental Health Program Directors (NASMHPD) has taken a first step in this direction by recommending that states establish financing criteria and mechanisms for funding best-practice trauma treatment models and services. However, these policy efforts should be expanded to include federal and local funding, and to include a focus on homeless service settings.

The current review of trauma-informed homeless services suggests a number of policies whose adoption is necessary to move the field further:

1. Policies should support homeless services that employ strategies to *prevent trauma exposure*, including the elimination of practices that are retraumatizing.

2. Policies should support increased capacity for *early detection of trauma* within homeless service settings.

3. *Mainstream services should be available and accessible* to individuals experiencing homelessness and should be responsive to the needs of trauma survivors.

4. Policies should guide the development and offering of *comprehensive, integrated, trauma-informed treatment* within homeless service settings.

5. Policies should prescribe and define *consumer involvement* in developing and evaluating homeless services.

6. Policies should ensure that *funding is available to develop and sustain trauma-informed care.*

7. Policies should ensure that services are designed to be *developmentally-appropriate,* and *culturally and linguistically competent.*

8. Trauma-informed homeless service policies need to be supported by larger systems guiding services for homeless individuals and families, including national, state, and local governmental, community-based groups, and non-profit organizations. Some of these systems include: the *U.S. Department of Health and Human Services, the U.S. Department of Veterans Affairs, the U.S. Departments of Housing and Urban Development, the U.S. Interagency Council on Homelessness, state-level councils to end homelessness, the National Alliance to End Homelessness, the National Health Care for the Homeless Council, the National Law Center on Homelessness and Poverty, the National Center on Family Homelessness,* and *the Homelessness Resource Center.*

Research

There is a paucity of research examining the effectiveness of trauma-informed services for homeless individuals and families. Most programs that have begun to institute trauma-informed practices have not tested their models for effectiveness. This may be due to financial constraints and to the fact that many programs are focused on direct service, as opposed to research.

1. Although research on trauma-informed services in the mental health and substance use fields is promising, *further research is needed on developing trauma-informed services within homeless service settings.*

2. Researchers and providers need to establish a *greater consensus about what constitutes a "trauma-informed service system."* Clearly defining what is meant by a "trauma-informed system" will create greater uniformity in research, increasing the ability to compare strategies for implementing trauma-informed systems.

3. *Methods to achieve trauma-informed systems* also need to be more clearly established. The conceptual framework established by a set of guiding principles should be behaviorally defined within a system. This allows fidelity measurements, indicating the degree to which a program is meeting the general standards for a trauma-informed program. Clearly defining methods will also lead to the possibility of a classification system delineating *varying levels of trauma-informed systems.*

4. Although a number of models or frameworks for building trauma-informed services have been developed, more evidence is needed to evaluate and refine these approaches. Thus, additional research is needed to *evaluate trauma-informed models* within homeless settings. It is recommended that additional research within the homelessness arena be conducted using models such as ARC, CARE, A Long Journey Home, Sanctuary, and Using Trauma Theory to Design Service Systems.

5. The *corroborative evidence* that is available offers a clear starting point for future research on trauma-informed homeless services. Additional *qualitative research* is needed to more clearly define the process of offering trauma-informed services, while *quantitative studies* should follow after models have been clearly defined and described. These should examine the outcomes of trauma-informed interventions.

6. Additional research is needed to distinguish the *relative contribution of trauma-informed care, versus trauma-specific services*. The majority of the research to date on trauma-informed care has also included trauma-specific services. While clinically this makes intuitive sense, research is needed to evaluate what specific factors are leading to change within these systems.

7. Additional research is required on the needs of *special populations* who are homeless. For instance, additional research is needed to determine how trauma-informed care should be adapted to meet the unique issues faced by youth, veterans, individuals from other countries, individuals of different ethnic backgrounds, and LGBT individuals who are experiencing homelessness.

Trauma-informed homeless services offer a promising new area for increasingly effective and sensitive service approaches for highly vulnerable people. Because many, if not all, homeless individuals have been exposed to high levels of traumatic stress, it is essential that homeless service systems develop sensitivity and responsiveness to post-trauma responses among the people they serve. More efforts are needed in terms of practice, programming, policy, and research to continue to build empirically-based, effective models of trauma-informed care for people who are struggling daily to exit homelessness.

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CONFLICT OF INTEREST

Authors work within organizations that developed some of the models reviewed (e.g. organizational assessments, ARC model, Phoenix Rising).

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APPENDIX 1

Traumatic Stress and Homelessness

> "*Homelessness deprives individuals of...basic needs, exposing them to risky, unpredictable environments. In short, homelessness is more than the absence of physical shelter, it is a stress-filled, dehumanizing, dangerous circumstance in which individuals are at high risk of being witness to or victims of a wide range of violent events*" [1].

Researchers have documented that the rates of traumatic stress are extremely high, and may even be normative, among those experiencing homelessness. Individuals who are homeless may have been exposed to neglect, psychological abuse, physical abuse, or sexual abuse during childhood; community violence; sexual assault; combat-related traumas; domestic violence; and accidents or disasters. A literature review found consistent and well-documented evidence of high levels of multiple forms of traumatic stress within individuals and families who are homeless. It is clear that trauma affects people of every gender, age, race, sexual orientation, and background within homeless service settings. No one is immune. The following data highlight this point:

Men

- More than 2/3 of men in a dual-diagnosis treatment program for homeless people reported a *history of trauma -- either physical or sexual abuse* [28].
- More than 1/4 of homeless men were *assaulted in the past year* [56].
- Homeless men within substance treatment programs have a high prevalence of *depression, family dysfunction, trauma, and multiple previous treatment experiences* [57].
- Despite the fact that men comprise the majority of homeless people and are frequently exposed to trauma, homeless men are *less likely to receive social services* than homeless women [58], with less effort directed towards understanding the impact of trauma for this population.

Women/Mothers

- Although many people think of men when they consider the issue of homelessness, families—typically single mothers with young children—now comprise up to 40% of the overall homeless population [59].
- Trauma is extremely prevalent among homeless women: *over 90% of homeless mothers report having experienced severe physical or sexual assault* during their lifetimes [60].
- The majority of homeless mothers were *abused during childhood,* with nearly 2/3 reporting severe physical abuse and 42% reporting sexual abuse; 60% were abused before the age of twelve [2].
- More than 70% of homeless mothers have at least one *childhood risk factor*, including: severe physical abuse, unwanted sexual contact, having a parent who was mentally ill or who abused substances, running away for a week or more, or being in foster care [61].
- Homeless mothers are also frequently the *victims of abuse during adulthood,* with 61% reporting a history of domestic violence and 32% acknowledging recent domestic violence [2].
- Homelessness puts women *at risk for assault*; being homeless was associated with more than three times the risk of sexual assault for women [56].
- Homelessness and victimization are associated with adverse mental health outcomes: more than 50% of homeless mothers reported *depression*, and more than 40% reported *posttraumatic stress disorder* (PTSD)

[62], and were three times as likely as housed women to suffer from PTSD [63].

Children and Youth

- *Child abuse* is associated with high-risk behaviors in adolescents, such as truancy and running away, that may lead to homelessness [64]. Almost 3/4 of girls on the streets report that they were *forced to run away from violence at home* [65].
- Homeless children and youth are *at risk for further victimization*, such as repeated abuse, exposure to violence, and forced prostitution [66].
- *86% of homeless youth report exposure to trauma*, with almost 2/3 reporting exposure to multiple traumatic events; physical assaults are prevalent for young men, while sexual/physical abuse is common among young women [67].
- Homeless children are at increased risk for *medical, emotional, behavioral, and academic problems*, including post-trauma responses, insecure attachments, and difficulty learning [60, 68, 69].

Elderly

- The elderly make up a relatively lower percentage of the homeless population, only 2% [70]; however, elderly homeless persons are *more vulnerable to victimization*, have *more health problems*, and may be *less likely to receive needed social services and protection from law enforcement* [71].
- In 2006, 27% of the homeless victims of violent crimes were between 50-59 years of age [9].

Veterans

- Veterans are disproportionately represented in the homeless population, with veterans making up 23% of all homeless people in the U.S. [72].
- The *majority of women in homeless veteran programs have serious trauma histories*, including being physically harassed, sexually harassed, or raped while in the military [73].
- One-quarter or more of homeless veterans manifest *symptoms of PTSD*; 76% experience *alcohol, drug, or mental health problems* [74].
- *Trauma and related distress are related to relapse and rehospitalization* of homeless veterans who have substance abuse problems, particularly for female veterans [75].

Minorities

- *Minorities are over-represented* among the homeless population, with almost half being African-American [4].
- Families of color also *disproportionately experience trauma* [50].

Lesbian, Gay, Bisexual, & Transgendered (LGBT) Individuals

- 40% of homeless youth identify as LGBT.
- One-third of LGBT youth are *assaulted after disclosing their sexual orientation*; 40% to 60% of homeless youth cited *physical abuse as a reason for leaving home* [76].
- Thirty-three percent of transgendered individuals reported that they had been *physically or sexually assaulted in the past year* [56].

These statistics suggest that it is reasonable to assume that the majority of homeless individuals have been exposed to traumatic stress. Most people experiencing homelessness have been victimized one or more times in their lives. For many people, abuse began during childhood; in fact, developmental trauma with disrupted attachments may provide the subtext for the stories of many people's pathways towards homelessness [2]. Violence continues into adulthood for many people, with abuse such as domestic violence often precipitating homelessness [3-5], and with homelessness leaving people vulnerable to further victimization. In fact, homelessness has been suggested to be a traumatic event in and of it, compounding the psychological impact of the myriad risk factors often experienced by people who are homeless [77]. Based on this assumption, we can conclude that individuals experiencing homelessness are, by definition, trauma survivors, demonstrating the urgency of addressing trauma within this population.

Another reason that it is important to address trauma within homelessness service settings is that victimization is associated with repeated episodes of homelessness. Research has found that people who experienced repeated homelessness were more likely than people with a single episode of homelessness to have been abused, often during childhood. First-time homeless mothers who experienced domestic violence were more than three times as likely to become homeless again [6]. These findings suggest that we will be unable to solve the issue of homelessness without addressing the underlying trauma that is so intricately interwoven with the experience of homelessness.

As can be seen from this description, the relationship between trauma and homelessness is complex, with traumatic stress being a possible core factor increasing vulnerability to homelessness, and with homelessness leaving individuals more vulnerable to further victimization. There is also a complex and multi-directional relationship between trauma, substance abuse, mental illness, and homelessness. All these factors need to be addressed in services for homeless men, women, children and youth, the elderly, minorities, veterans, LGBT individuals, and other people.

APPENDIX 2

The Impact of Trauma

Traumatic stress can be devastating and long-lasting. To develop an understanding about how to build trauma-sensitive services, we need to first clearly understand that the impact of traumatic stress can be devastating and long-lasting, interfering with a person's sense of self, and sense of safety, leading to feelings of helplessness, terror, and disempowerment. Traumatic exposure may lead to responses

Table 3. How Common Trauma Reactions May Explain Some "Difficult" Behaviors or Reactions Within Homeless Service Settings

"Difficult" Behaviors or Reactions within Homeless Service Settings	Common Trauma Reactions
Has difficulty getting motivated to get job training, pursue education, locate a job, or find housing	Depression and diminished interest in everyday activities
Complains that the setting is not comfortable or not safe, appears tired and poorly rested. Is up roaming around at night.	Nightmares and insomnia
Perceives others as being abusive, loses touch with current-day reality and feels like the trauma is happening over again	Flashbacks, triggered responses
Avoids meetings with counselors or other support staff, emotionally shuts down when faced with traumatic reminders	Avoidance of traumatic memories or reminders
Isolates within the shelter, stays away from other residents and staff	Feeling detached from others
Lacks awareness of emotional responses, does not emotionally respond to others	Emotional numbing or restricted range of feelings
Is alert for signs of danger, appears to be tense and nervous	Hyper-alertness or hypervigilance
Has interpersonal conflicts within the shelter, appears agitated	Irritability, restlessness, outbursts of anger or rage
Has difficulty keeping up in educational settings or job training programs	Difficulty concentrating or remembering
Becomes agitated within the shelter. Is triggered by rules and consequences. Has difficulty setting limits with children.	Feeling unsafe, helpless, and out of control
Has difficulty following rules and guidelines within the shelter or in other settings. Is triggered when dealing with authorities. Will not accept help from others.	Increased need for control
Feels emotionally "out of control." Staff and other residents become frustrated by not being able to predict how he or she will respond emotionally	Affect dysregulation (emotional swings -- like crying and then laughing)
Seems spacey or "out of it." Has difficulty remembering whether or not they have done something. Is not responsive to external situations.	Dissociation
Complains of aches and pains like headaches, stomachaches, backaches. Becomes ill frequently.	Psychosomatic symptoms, impaired immune system
Cuts off from family, friends, and other sources of support	Feelings of shame and self-blame
Has difficulty trusting staff members; feels targeted by others. Does not form close relationships in the service setting.	Difficulty trusting and/or feelings of betrayal
Complains that the system is unfair, that they are being targeted or unfairly blamed	Loss of a sense of order or fairness in the world
Puts less effort into trying--does not follow through on appointments, does not respond to assistance	Learned helplessness
Invades others' personal space or lacks awareness of when others are invading their personal space	Boundary issues
Has ongoing substance abuse problems	Use of alcohol or drugs to manage emotional responses
Remains in an abusive relationship or is victimized again and again	Revictimization (impaired ability to identify danger signs)

including Posttraumatic Stress Disorder (PTSD) and Complex Trauma.

Posttraumatic Stress Disorder (PTSD) refers to a group of symptoms that some individuals experience after overwhelming, frightening, or horrifying life experiences that exceed their capacity to cope. PTSD includes intrusive symptoms such as triggered memories or nightmares, avoidance symptoms such as social withdrawal, constriction, and emotional numbing, and symptoms of hyperarousal such as concentration problems, irritability, and constant alertness for danger.

Exposure to chronic interpersonal trauma such as child abuse or domestic violence may have an even more extensive impact on the survivor, sometimes referred to as "Complex PTSD," or "Disorders of Extreme Stress, Not Otherwise Specified" (DES-NOS). Survivors with Complex PTSD have difficulty regulating their internal states, including their emotional states and their physiological reactions. Their emotions sometimes shift rapidly, leaving them feeling helpless in the face of overwhelming emotion. Their bodies are easily activated, resulting in anxiety, panic, or terror. At other times, they have dissociative responses in which their bodies or emotions shut down and they become numb. Triggered responses, reactions to reminders of the trauma, are also common. In Complex PTSD, the traumatic experiences impact the survivor's sense of self; survivors often blame themselves for their abuse, feeling damaged and ashamed. Individuals who have experienced chronic interpersonal trauma often have problems sustaining supportive relationships, such as difficulty trusting others or problems establishing clear boundaries and setting limits with others. This increases their vulnerability to retraumatization, and interferes with the development of adequate social networks for support in times of crisis. Individuals with Complex PTSD may have impaired

immune system functioning and may experience poor physical health. They often have difficulty maintaining attention and concentration and may have memory problems. Their belief systems about the world are also altered and they often feel unsafe [78-80].

In describing the link between trauma exposure and homelessness, Browne [2] wrote, "it seems probable that, for some homeless women, the effects of early violence or molestation by intimates decreased their supportive networks and increased their risk of becoming homeless later in life." Thus, exposure to traumatic stress may increase people's vulnerability to becoming homeless in certain situations, and conversely, traumatic stress reactions may make it more difficult to cope with the stresses inherent in being homeless.

Homeless service providers who lack a basic knowledge of trauma will not have a context for understanding trauma-based reactions. Table **3** illustrates behaviors sometimes seen in homeless service settings that can be confusing or frustrating for providers or other consumers; column two of the chart demonstrates how each of these behaviors may be explained in the context of common reactions to traumatic stress. This chart highlights the need for understanding trauma within homeless service settings.

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CAPE COD AND ISLANDS
BEHAVIORAL HEALTH SUMMIT

OCTOBER 4, 2013

Presenter: Kappy Madenwald, LISW-S
Madenwald Consulting, LLC
Columbus, Ohio

Bridging the Gap

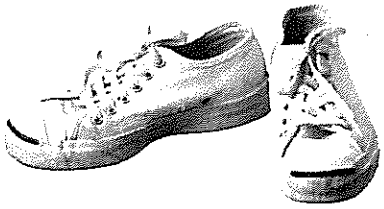
We are hospitalizing you for your safety

Bridging the Gap

Stand in the shoes of a person who is in crisis and describe your reaction to hearing that news

Bridging the Gap

- What are you thinking?
- What are you feeling?



The Essence of Effective Crisis Resolution

QUESTION:

Is admission to a psychiatric hospital an example of crisis resolution?

Bridging the Gap

Person and family-centered centered Crisis Systems of Care create an opportunity to bridge the gap between how crisis services have been historically delivered and what is useful to you if you are the person experiencing the crisis. The goal is:

- Resolution.
- As comfortably as possible.
- As soon as possible.
- Preserving as much choice as possible.
- All while minimizing harm.

The Essence of Effective Crisis Resolution

Think back to a time when you experienced a personal crisis…

Without detailing the facts, describe the essence of the crisis?

- What were the thoughts you had?
- What were the accompanying emotions?
- What were the accompanying behaviors?
- What would others have noticed about you at that time?

The Essence of Effective Crisis Resolution

Now think forward from the peak of the crisis to the point where you felt relief…

- What changed that resulted in relief?
- What were the thoughts you had?
- What were the accompanying emotions?
- What were the accompanying behaviors?
- What would others have noticed about you at the point of relief?

The Essence of Effective Crisis Resolution

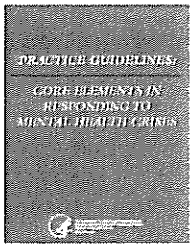
Question:

If the facts haven't changed, can there be resolution?

Core Elements for Responding to Mental Health Crises

10

- Issued by SAMHSA in 2009 these practice guidelines address
  - 10 Essential Values
  - Principles
  - Infrastructure needs



Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009.

SAMHSA Core Elements: 10 Essential Values

11

1. Avoiding harm

- Sometimes mental health crises place the safety of the person, the crisis responders or others in jeopardy.
- An appropriate response establishes physical safety, but it also establishes the individual's psychological safety.
- Precipitous responses to individuals in mental health crises—often initiated with the intention of establishing physical safety—sometimes result in harm to the individual.
- An appropriate response to mental health crises considers the risks and benefits attendant to interventions and whenever possible employs alternative approaches, such as controlling danger sufficiently to allow a period of "watchful waiting."
- In circumstances where there is an urgent need to establish physical safety and few viable alternatives to address an immediate risk of significant harm to the individual or others, an appropriate crisis response incorporates measures to minimize the duration and negative impact of interventions used.

10 Essential Values...

12

2. Intervening in Person-centered ways.

- Mental health crises may be routine in some settings and, perhaps, have even come to be routine for some people with serious mental health or emotional problems.
- Nevertheless, appropriate crisis assistance avoids rote interventions based on diagnostic labels, presenting complaint or practices customary to a particular setting.
- Appropriate interventions seek to understand the individual, his or her unique circumstances and how that individual's personal preferences and goals can be maximally incorporated in the crisis response.

10 Essential Values...

3. Shared responsibility

- An acute sense of losing control over events or feelings is a hallmark of mental health crises.
- In fact, research has shown "feeling out of control" to be the most common reason consumers cite for being brought in for psychiatric emergency care.
- An intervention that is done to the individual— rather than with the individual—can reinforce these feelings of helplessness.
- One of the principal rationales for person-centered plans is that shared responsibility promotes engagement and better outcomes.
- While crisis situations may present challenges to implementing shared, person-centered plans, ultimately an intervention that considers and, to the extent possible, honors an individual's role in crisis resolution may hold long-term benefits.
- An appropriate crisis response seeks to assist the individual in regaining control by considering the individual an active partner in—rather than a passive recipient of—services.

10 Essential Values...

4. Addressing trauma

- Crises, themselves, are intrinsically traumatic and certain crisis interventions may have the effect of imposing further trauma—both physical and emotional.
- People with serious mental illness have a high probability of having been victims of abuse or neglect.
- It is essential that once physical safety has been established, harm resulting from the crisis or crisis response is evaluated and addressed.
- There is also a dual responsibility relating to the individual's relevant trauma history and vulnerabilities associated with particular interventions; crisis responders should appropriately seek out and incorporate this information in their approaches, and individuals should take personal responsibility for making this crucial information available (for instance, by executing advance directives).

10 Essential Values...

5. Establishing feelings of Personal safety

- An individual may experience a mental health crisis as a catastrophic event and, accordingly, may have an urgent need to feel safe.
- What is regarded as agitated behavior may reflect an individual's attempts at self-protection, though perhaps to an unwarranted threat.
- Assisting the individual in attaining the subjective goal of personal safety requires an understanding of what is needed for that person to experience a sense of security (perhaps contained in a crisis plan or personal safety plan previously formulated by the individual) and what interventions increase feelings of vulnerability (for instance, confinement in a room alone).
- Providing such assistance also requires that staff be afforded time to gain an understanding of the individual's needs and latitude to address these needs creatively.

10 Essential Values...

6. Based on strengths

- Sharing responsibility for crisis resolution means understanding that an individual, even while in crisis, can marshal personal strengths and assist in the resolution of the emergency.
- Individuals often understand the factors that precipitated a crisis as well as factors that can help ameliorate their impact.
- An appropriate crisis response seeks to identify and reinforce the resources on which an individual can draw, not only to recover from the crisis event, but to also help protect against further occurrences.

10 Essential Values...

7. The whole Person

- For individuals who have a mental illness, the psychiatric label itself may shape—even dominate—decisions about which crisis interventions are offered and how they are made available.
- An individual with a serious mental illness who is in crisis is a whole person, whose established psychiatric disability may be relevant but may—or may not—be immediately paramount.
- That the individual may have multiple needs and an adequate understanding of the crisis means not being limited by services that are compartmentalized according to healthcare specialty.
- An individual's emergency may reflect the interplay of psychiatric issues with other health factors.
- And while the individual is experiencing a crisis that tends to be addressed as a clinical phenomenon, there may also be a host of seemingly mundane, real-world concerns that significantly affect an individual's response: the whereabouts of the person's children, the welfare of pets, whether the house is locked, absence from work, and so on.

10 Essential Values...

8. The Person as credible source

- Assertions or complaints made by individuals who have been diagnosed with a serious mental illness tend to be viewed skeptically by others.
- Particularly within the charged context of mental health crises, there may be a presumption that statements made by these individuals are manifestations of delusional thinking.
- Consequently, there is a risk that legitimate complaints relating to such matters as medical illness, pain, abuse or victimization will go unheeded.
- Even when an individual's assertions are not well grounded in reality and represent obviously delusional thoughts, the "telling of one's story" may represent an important step toward crisis resolution.
- For these reasons, an appropriate response to an individual in mental health crisis is not dismissive of the person as a credible source of information—factual or emotional—that is important to understanding the person's strengths and needs.

10 Essential Values...

9. Recovery, resilience and natural supports

- Certain settings, such as hospital emergency departments, may see individuals only transiently, at a point when they are in acute crisis and in a decidedly high-stress environment.
- Even when not occurring within hospitals, mental health emergency interventions are often provided in settings that are alien to the individual and the natural supports that may be important parts of his or her daily life.
- It is important not to lose sight of the fact that an emergency episode may be a temporary relapse and not definitional of the person or that individual's broader life course.
- An appropriate crisis response contributes to the individual's larger journey toward recovery and resilience and incorporates these values.
- Accordingly, interventions should preserve dignity, foster a sense of hope, and promote engagement with formal systems and informal resources.

10 Essential Values...

10. Prevention

- Too often, individuals with serious mental illnesses have only temporary respite between crises.
- An appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse.
- Hence, an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvements.

Under-developed Crisis Systems

Easy to say. Hard to do.

There is a staggering degree of difference (state to state and community to community) in how mental health/substance use crisis services developed over time and how they are delivered day to day

Under-developed Crisis Systems

In under-developed crisis systems you can expect to see high volume usage of one or more of the following

- 911
- Law enforcement
- Jail/detention
- Court
- Hospital emergency departments
- Hospital Inpatient units

Under-developed Crisis Systems

- When data is cross-matched it is often the case that multiple systems are interfacing with a critical subset of individuals who have frequent crisis events
- However each agency/department is bearing the load, largely on its own…
  - Incurring considerable cost
  - Expending considerable time, and
  - Managing considerable risk

Under-developed Crisis Systems

If you are a safety net provider interfacing with a high volume of individuals in crisis (sometimes seeing the same people over and over again)…

- It can look like an ignored or neglected task by some "other system"
- It can feel like a "dump"

Under-developed Crisis Systems

- But it really isn't an ignoring/neglecting/dumping issue.
- It is more accurate to say that the community strategy and structure for addressing behavioral health crises is:
  - Under-developed
  - Under-defined
  - Under-assigned

Under-developed Crisis Systems

- In under-developed systems there is to varying degrees a disconnect between:
  - Behavioral Health providers
  - Emergency Departments
  - Jails
  - Law Enforcement
  - Hospitals
  - Primary Care
  - Other Social Services

Under-developed Crisis Systems

- This results in:
  - Silos of service delivery
  - Insufficient referral pathways (both into and out of crisis service)
  - Blind spots in understanding and addressing health outcomes, risks, costs
  - Narrow understanding about who are the crisis "experts" /who has the crisis "expertise"

Under-developed Crisis Systems

For others in the community, roles tend to be under-defined and under-assigned and providers may feel uncertainty about what to do or may feel their hands are tied to directly intervene. Digging deeper, common explanations emerge:

- It's not my job
- I don't have permission
- I don't have the competency
- I don't have the time
- I can't get paid for it
- It could put me or my agency at risk

The inertia here leads to overuse of "default" systems and solutions

Under-developed Crisis Systems

The default systems are often the ones that are available 24/7 and that generally cannot say no

Under-developed Crisis Systems

- Law Enforcement, jail and hospital emergency departments are all examples of big "I" interventions. They are:
  - Intensive
  - Intrusive, and often
  - Involuntary
- Though, each is used with good intention and in an effort to ensure safety, none are without risk of harm to the person in crisis.

Under-developed Crisis Systems

Big "I" interventions can:

- Be traumatizing
- Be shaming, embarrassing and stigmatizing
- Have lasting legal, financial, health and social repercussions

And they can have a negative impact on

- Trust
- Change-readiness
- Health activation
- Treatment involvement

Under-developed Crisis Systems

In an under-developed system stigmatization is compounded by:

- Routine involvement of law enforcement
  - Draws attention
  - Upsets neighbors, family members, landlords
  - Blurs the line between criminal justice and treatment services
- Fear of consequences of disclosing symptoms
  - No-win situation
  - Loss of choice
  - Loss of freedom
  - Sense of isolation—"who can I safely tell?"

Under-developed Crisis Systems

Big "I" interventions may compound—but do little to address—the essence of the initial crisis, which at its core is likely related to one or more common, human conditions:

Fear	Grief/Loss
Sadness	Pain
Anger	Exhaustion
Loneliness/isolation	Hunger
Restlessness/Boredom	Lack

Where are the opportunities for resolution in the crisis definitions below?

- A personal difficulty or situation that disables a person. It is also a hardship that can prevent one from controlling his or her life (Belkin, 1984, p. 424).
- An event as that is viewed as unbearable; it is also one that exceeds a person's usual resources and coping mechanisms (Gilliland & James, 1997, p.3).
- "A state of disorganization in which people face frustration of important life goals or profound disruption of their life cycles and methods of coping with stressors" (Brammer, 1985, p.94)

Where are the opportunities for resolution in the crisis definitions below?

- Perceiving a precipitating event as being meaningful and threatening...
- Appearing unable to modify or lessen the impact of stressful events with traditional coping methods (previously successful coping strategies are ineffective)
- Experiencing increased fear, tension, and/or discomfort
- Exhibiting a high level of subjective discomfort
- Proceeding rapidly to an active state of crisis—a state of disequilibrium.
- (A. Roberts, 2000)

Under-developed Crisis Systems

Sometimes big "I" Interventions are indicated, but in a well developed Crisis System of Care they become exception rather than rule:

- Use of law enforcement only when engagement efforts have not worked and risk is high
- Use of emergency department for crisis intervention when medical or risk factors contraindicate a community-based intervention
- Use of inpatient hospitalization when community-based services, natural and informal supports and/or individualized treatment strategies are insufficient

Under-developed Crisis Systems

Community attention to crisis practices is often driven by some common themes:

- Community tragedy
- Dissatisfaction of/advocacy by those who have experienced crises and their families
- High inpatient admission rates/insufficient bed capacity
- Crowding/boarding in emergency department
- Jail cost/overcrowding
- Heavy use of 911
- Law enforcement concerns: time spent transporting, 'sitting' in ED, enforcing involuntary evaluations

Under-developed Crisis Systems

But even when there are clear reasons to do so, crisis response patterns can seem unchangeable, because…

- The hospital is where the doctor is
- The hospital is where the timely access is
- The hospital is where the quick medication resource is
- The hospital/jail is open 24/7/365
- The hospital/jail is where the safety/security is
- The hospital/jail is where the bed is
- The Law Enforcement Officer has the transport vehicle

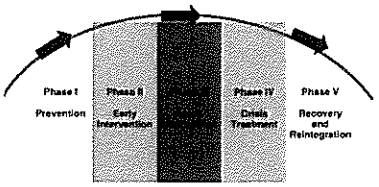
Under-developed Crisis Systems

The shift away from default interventions does not happen overnight. It can require:

- Radically new ways of looking at things
- New and even unexpected partnerships
- Cross-sector policy shifts
- Cross-sector data analysis
- Talking in depth to and involving people and families who use crisis services

40

Framing a Crisis System of Care



Framing a Crisis System of Care

41

So, what is a "Crisis System of Care?"

It is the organized whole of a behavioral health crisis system. It is made up of an infrastructure of services, systems, processes and pathways that promote early, in-community planning for, response to, and management of behavioral health crises. It is a public health framework that is inclusive of the services provided by primary care physicians, hospitals, law enforcement entities, schools, congregate care facilities, social services systems and the actions of consumers, family members and the general public."

Source: Madenwald/Day

Framing a Crisis System of Care

42

Crisis Systems of Care is a cross service/sector framework and strategy that can increasingly:

1. Eliminate gaps in the safety net
2. Reduce duplication
3. Reinforce a coordinated, systemic (rather than agency-centric) approach in planning, delivery, policy and outcome-management practices
4. Deliver person/family centered care
5. Promote local solutions
6. Reduce criminal justice system involvement
7. Diminish need for emergency department and inpatient/residential treatment services
8. Enhance the community's ability to strategically plan for, compete for and effectively utilize new funds, resources and programs and to assure that any new initiative is mission consistent.

Source: Madenwald/Day

Crisis Systems of Care: Five Phases

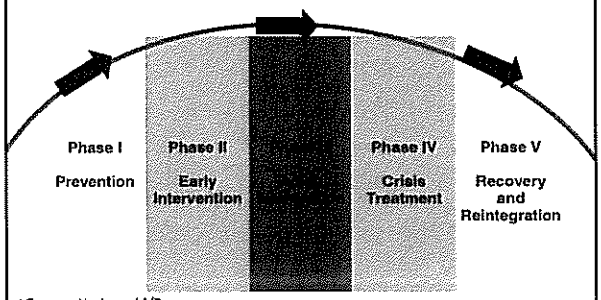
43

The framework promotes broad, cross-sector investment and planning in each of 5 crisis phases

- Crisis Prevention
- Early Intervention
- Acute Intervention
- Crisis Treatment
- Recovery and Reintegration

Source: Madenwald/Day

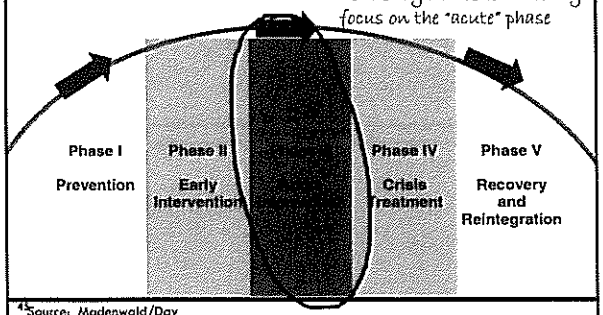
Crisis Continuum



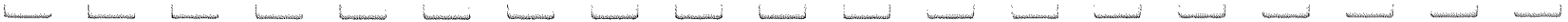
44Source: Madenwald/Day

Crisis Continuum

Tendency can be to narrowly focus on the "acute" phase



45Source: Madenwald/Day



Crisis Systems of Care: Four Key Elements

- The **Players** (consumers and family members, policy-makers, providers, agencies, systems, strategic partners)
- The **Logistics** (access, movement/pathways, supply/demand, information exchange, protocols)
- The **Competencies** (resolution-oriented, recovery-consistent, family-centered, strengths-based, trauma-informed, population-informed)
- The **Parts** (inpatient beds, respite, mobile crisis teams, CIT-trained police officers, WRAP Planning, Mental Health First Aid, peer to peer support, warm line, urgent care appointments)

Source: Madenwald/Day

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Tendency can be to narrowly focus on the "parts"

Source: Madenwald/Day

Framing a Crisis System of Care

- This is not a "McDonalds" franchise kind of model
- While there is much to learn about successful practices elsewhere it is equally if not more important to look at community-specific 'goodness of fit'
- Crisis system services must consider local needs, resources, values, cultures, characteristics, geography, service mix

Most transferable from locale to locale:
Philosophy of care

Framing a Crisis System of Care

Effective systems:

- Promote care "upstream"
- Are strength-based, and person-centered
- Are resolution-focused
- Minimize "handoffs"
- Strive to bring relief at earliest possible point
- Use formal, informal and natural solutions and supports

Framing a Crisis System of Care

Effective systems:

- Attend to all levels of the crisis continuum
- Include non-traditional partners
- Include non-traditional services
  - INCLUDING: PEER-DELIVERED SERVICES
- Include effective processes, efficiencies, logistical strategies that streamline, bridge services, aid in continuity…
- Include technological tools
- Collect and analyze systems-level data

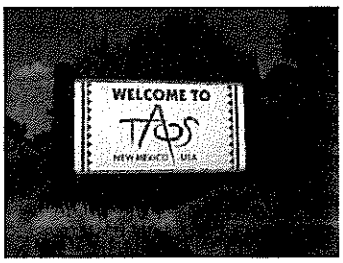
Framing a Crisis System of Care

- Essential to recognize that even with abundant capacity, a critical number of individuals will not seek traditional services.
- Expanding the safety net means looking beyond traditional services/traditional providers to other means of harm reduction.
- This includes increasing the awareness and competency of experts in other systems who may be likely to intersect with persons at risk.

Framing a Crisis System of Care

- Experts in local crisis services live in every community. They are the people and the family members of the people who have experienced both a behavioral health crisis and the "systems" response to that crisis.
- We won't get it right if we don't know the story—
  - What helps
  - What doesn't help

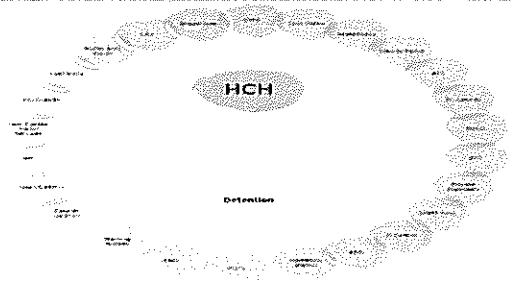
53 Taos, New Mexico



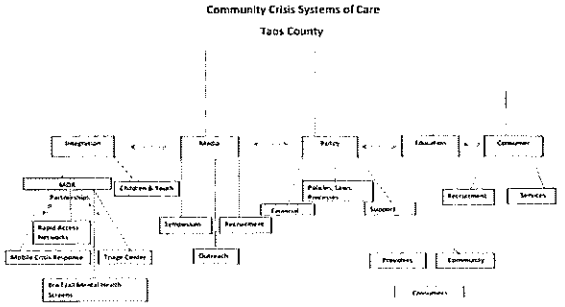
Taos, New Mexico

- Disproportionate number of arrests of persons with a mental health or substance use condition
- High volume of mental health/substance use-related crises in hospital emergency department
- High rate of suicide
- Considerable degree of stigma
- Seasonal population surges
- Geographic challenges
  - Distance to inpatient facilities
  - Weather
  - Consumer comfort with leaving community

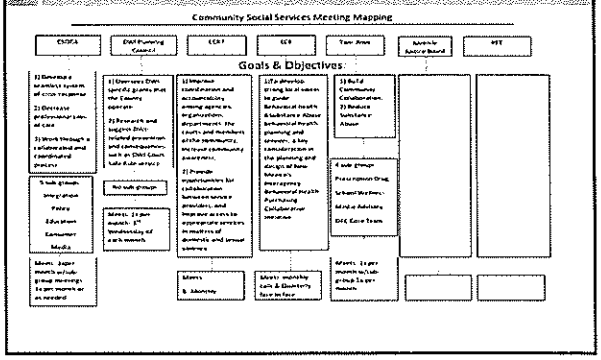
Community Partners/Stakeholders



Structure



Community Mapping



Community Mapping Continued

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Taos County, New Mexico: Crisis System of Care Framework				
Phase I Prevention	Phase II Early Intervention	Phase III Acute Intervention	Phase IV Crisis Treatment and Stabilization	Phase V Recovery and Reintegration
[illegible] E	Mental Health First Aid: E	[illegible] E	[illegible] P	ACT Team: E
Wellness Recovery Action Plan (WRAP) Training: E	[illegible] Mobile Crisis Intervention Team: G	[illegible] E	[illegible] G	[illegible] G
[illegible] E	[illegible] G	[illegible] E	[illegible] E	[illegible] E
[illegible] E	Primary Care protocol for first line crisis response: G	Law Enforcement [illegible] G		[illegible] E
[illegible] E	[illegible] G	[illegible] G		[illegible] E
[illegible] G	Community Against Violence [illegible] E			
Emergency Department [illegible] E	24/7 [illegible] E			

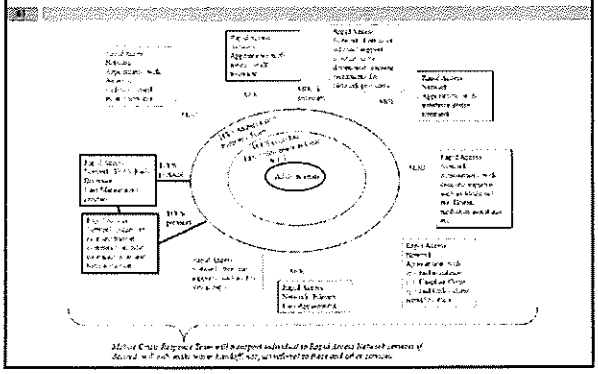
Codes: E Existing service/practice—fully operational P Partial implementation F Future expansion G Grant-proposed expansion

59

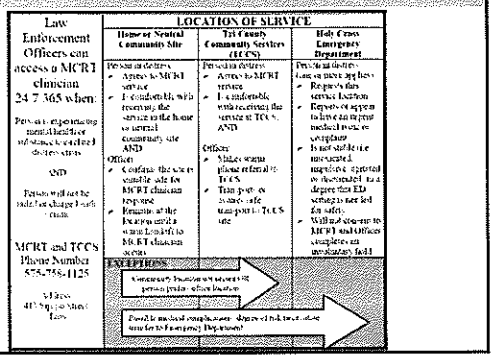
Taos County, New Mexico: Sequential Intercept Model Services for Adults				
Intercept 1: Law Enforcement	Intercept 2: Initial detention/Initial court hearings	Intercept 3: Jails/Courts	Intercept 4: Re-entry	Intercept 5: Community corrections
Crisis Intervention Training (CIT) for law enforcement officers: F	Jail-based intervention and pre-court diversion: F	Adult Drug Court, Eighth Judicial District: E	Jail-based case manager providing transitional care for inmates: P	TCCS outpatient services as conditions of probation/parole E
Mobile Crisis Response Team G	Magistrate Court court-ordered treatment in lieu of prosecution or incarceration E	Mental Health Court: F	TCCS federal probation contract for re-entry services: E	
Rapid Access Network to treatment and services: G		Medication services at Detention Center E		
TCCS Early Diversion G, funded by claims		DWI jail diversion program E		

60

Vision for Taos County



Taos, New Mexico: MH/LEA Location of Crisis Service Decision Tool



63 Mobile Crisis Intervention

CBHI
Children's Behavioral Health Initiative

Children's Behavioral Health Initiative: Mobile Crisis Intervention

- Adherence to guiding principles
  - Wraparound
  - Stage-based interventions
  - Shared Decision-Making
- Direct care by persons with lived experience (Family Partners)
  - Specific attention to the experience of parents when their child is in crisis
  - Consult to and collaboration with the crisis clinician
  - Consult to the greater agency on embedding family-centered principles into practice

Children's Behavioral Health Initiative: Mobile Crisis Intervention

- Re-think on "purpose"
  - Resolution NOT Screening
- Re-think on "time"
  - No rush to disposition
  - Think "longitudinally" for the person in crisis
  - Earliest safe relief/resolution
- Re-think on "location"
  - Non-Emergency Department
  - Natural when possible (home, school)
  - Mobile to facilities (group home, detention center)
- Re-think on "disposition"
  - Natural
  - Informal
  - Shared Decision-Making

Children's Behavioral Health Initiative: Mobile Crisis Intervention

- Broad expectancy around crisis response and safety planning—not limited to Emergency Service Programs (ESPs)
  - Across mental health services
  - Across child-serving systems
- Meaningful safety planning
  - Youth and family-centered
  - Nothing cookie cutter
  - It is the youth's plan not the agency's plan and there is only one of them
  - Mechanisms for safety plans to be filed with and accessed by ESP/MCI teams as needed

Children's Behavioral Health Initiative: Mobile Crisis Intervention

- Focus on relationships and partnerships
- Expectation that the ESP/MCI will promote development of Crisis System of Care (but not that they "own" it)
  - In coordination with youth System of Care initiatives
  - By establishing/strengthening relationships and coordinating with key stakeholders
    - Hospitals
    - Schools
    - Departments of Mental Health, Youth Services, Developmental Disabilities,
    - Law Enforcement Agencies
- Fewer "audience members" more active partners

Children's Behavioral Health Initiative: Mobile Crisis Intervention

- Incremental improvements:
  - Technologies that promote efficient, mobile activities
  - Cross-sector crisis competency
    - Promoting enhanced first response within other systems
  - Cross-sector strategies and solutions
    - communication channels
    - Information exchange mechanisms
    - Protocols/memorandums of understanding
  - Meaningful use of cross-sector data

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Panel Discussion

PRACTICE GUIDELINES:

CORE ELEMENTS IN RESPONDING TO MENTAL HEALTH CRISES

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

PRACTICE GUIDELINES:

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I. INTRODUCTION

CRISES HAVE A PROFOUND IMPACT ON PEOPLE WITH SERIOUS MENTAL HEALTH OR EMOTIONAL PROBLEMS.

Adults, children and older adults with a serious mental illness or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization.

Homelessness, police contact, institutionalization and other adverse events are in themselves crises, and may also contribute to further crises. The statistics below paint a sobering picture of how crises affect the lives of people who have mental or emotional disabilities:

- From one third to one half of homeless people have a severe psychiatric disorder.[1]
- Approximately 7 percent of all police contacts in urban settings involve a person believed to have a mental illness.[2]
- The likelihood of mental illness among people confined in state prisons and local jails is three to four times higher than in the general population[3] and, compared with other inmates, it is *at least twice as likely* that these individuals will be injured during their incarceration.[4]
- About 6 percent of all hospital emergency department visits reflect mental health emergencies.[5]
- Due to a lack of available alternatives, 79 percent of hospital emergency departments report having to "board" psychiatric patients who are in crisis and in need of inpatient care, sometimes for *eight hours or longer.*[6]
- Almost one in 10 individuals discharged from a state psychiatric hospital will be readmitted within 30 days; more than one in five will be readmitted within 180 days.[7]
- About 90 percent of adult inpatients in state psychiatric hospitals report histories of trauma.[8]
- About three quarters of youth in the juvenile justice system report mental health problems and one in five has a serious mental disorder.[9]
- Mothers with serious mental illnesses are *more than four times as likely* as other mothers to lose custody of their children.[10]
- People with serious mental illnesses die, on average, *25 years earlier* than the general population.[11]

These statistics are incomplete; they reflect just a sampling of scenarios that, while commonplace, constitute significant life crises for individuals with serious mental illnesses.

Many such individuals experience a cascade of crisis events that place them in more than one of these statistical groups. For instance, readmission to a psychiatric institution—a high probability for adults who have been discharged from a state psychiatric hospital, based on these data—may feature a series of crisis events for the individual: the psychiatric emergency itself; forcible removal from one's home; being taken into police custody, handcuffed and transported in the back of a police car; evaluation in the emergency department of a general hospital; transfer to a psychiatric hospital; a civil commitment hearing; and so on. And at multiple points in this series of interventions, there is a likelihood that physical restraints, seclusion, involuntary medication or other coercion may be used. Intense feelings of disempowerment are definitional of mental health crises, yet as the individual becomes the subject of a "disposition" at each juncture, that person may experience a diminishing sense of control.

In the wake of rare but highly publicized tragedies attributed to people with mental illnesses, there is often a temporary surge in political concern about mental healthcare and expanding crisis interventions. Sadly, the more commonplace crises endured every day by many thousands of adults, older adults and children with serious mental or emotional problems tend to generate neither media attention nor political concern.

While no one with a mental or emotional disorder is immune from crises, people with what are termed serious mental illnesses—defined as schizophrenia, bipolar disorder and major depression—may be most reliant on public systems. They also may be at great risk of recurrent crises and interventions that exacerbate their clinical and social problems. These guidelines focus most specifically on individuals with serious mental or emotional problems who tend to encounter an assortment of governmental or publicly funded interveners when they are in crisis. Nevertheless, the values, principles and strategies embedded in the guidelines that follow are applicable to all individuals with mental healthcare needs, across populations and service settings.

Individuals whose diagnoses do not fit "serious mental illnesses" may be vulnerable to serious mental health crises that can have devastating outcomes. Interventions on their behalf are more likely to occur within the private healthcare sector, which mirrors public mental health systems' problems in providing early and meaningful access to help. Within these parallel systems, crisis services are provided in a broad array of settings that ultimately will require translation of the guidelines presented here into specific protocols that break cycles of crises and advance the prospects of recovery for people with mental illnesses.

WHAT IT MEANS TO BE IN A MENTAL HEALTH CRISIS

Too often, public systems respond as if a *mental health crisis* and *danger to self or others* were one and the same. In fact, *danger to self or others* derives from common legal language defining when involuntary psychiatric hospitalization may occur—at best, this is a blunt measure of an extreme emergency. A narrow focus on dangerousness is not a valid approach to addressing a mental health crisis. To identify crises accurately requires a much more nuanced understanding and a perspective that looks beyond whether an individual is dangerous or immediate psychiatric hospitalization is indicated.

While behaviors that represent an imminent danger certainly indicate the need for some sort of an emergency response, these behaviors may well be the culmination of a crisis episode, rather than the episode in its entirety. Situations involving mental health crises may follow trajectories that include intense feelings of personal distress (e.g., anxiety, depression, anger, panic, hopelessness), obvious changes in functioning (e.g., neglect of personal hygiene, unusual behavior) or catastrophic life events (e.g., disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters).

Because only a portion of real-life crises may actually result in serious harm to self or others, a response that is activated only when physical safety becomes an issue is often too little, too late or no help at all in addressing the root of the crisis. And a response that does not meaningfully address the actual issues underlying a crisis may do more harm than good.

THE NEED FOR CRISIS STANDARDS

Individuals experiencing mental health crises may encounter an array of professionals and non-professionals trying to intervene and help: family members, peers, healthcare personnel, police, advocates, clergy, educators and others. The specific crisis response offered is influenced by a number of variables, among them:

- where the intervention occurs,
- at what time of day it occurs,
- when it occurs within the course of the crisis episode,
- the familiarity of the intervener with the individual or with the type of problem experienced by the individual,
- interveners' training relating to crisis services,
- resources of the mental health system and the ready availability of services and supports, and
- professional, organizational or legal norms that define the nature of the encounter and the assistance offered.

The guidelines presented here define appropriate responses to mental health crises across these variables. They were developed by a diverse expert panel (see below) that includes individuals with and without serious mental illnesses who are leaders within mental health professions and mental health advocacy.

This report of the panel's findings is not intended to be an exhaustive resource on crisis services and best practices, but rather an explanation of factors essential to any response to mental health emergencies. In organizations that may already have protocols for responding to individuals in mental health crises (for instance, police departments, hospitals and mental health clinics), these guidelines offer an opportunity to assess the adequacy of current practices based on a set of underlying values and principles. In foster care, schools or other settings where protocols may not currently exist, the guidelines can serve as a framework for examining current activities and the need for more explicit standards. In either instance, these crisis guidelines promote two essential goals:

1. Ensuring that mental health crisis interventions are guided by standards consistent with recovery and resilience and
2. Replacing today's largely reactive and cyclical approach to mental health crises with one that works toward reducing the likelihood of future emergencies and produces better outcomes.

II. RESPONDING TO A MENTAL HEALTH CRISIS

TEN ESSENTIAL VALUES

Ten essential values are inherent in an appropriate crisis response, regardless of the nature of the crisis, the situations where assistance is offered or the individuals providing assistance:

1. **Avoiding Harm.** Sometimes mental health crises place the safety of the person, the crisis responders or others in jeopardy. An appropriate response establishes physical safety, but it also establishes the individual's psychological safety. For instance, restraints are sometimes used in situations where there is an immediate risk of physical harm, yet this intervention has inherent physical and psychological risks that can cause injury and even death. Precipitous responses to individuals in mental health crises—often initiated with the intention of establishing physical safety—sometimes result in harm to the individual. *An appropriate response to mental health crises considers the risks and benefits attendant to interventions and whenever possible employs alternative approaches, such as controlling danger sufficiently to allow a period of "watchful waiting." In circumstances where there is an urgent need to establish physical safety and few viable alternatives to address an immediate risk of significant harm to the individual or others, an appropriate crisis response incorporates measures to minimize the duration and negative impact of interventions used.*

> **"To promote patient-centered care, all parties involved in health care for mental or substance-use conditions should support the decision-making abilities and preferences for treatment and recovery of persons with mental/substance use problems and illnesses"**
>
> Institute of Medicine (2006) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Recommendation 3-1, p. 126

2. **Intervening in Person-Centered Ways.** Mental health crises may be routine in some settings and, perhaps, have even come to be routine for some people with serious mental health or emotional problems. Nevertheless, appropriate crisis assistance avoids rote interventions based on diagnostic labels, presenting complaint or practices customary to a particular setting. *Appropriate interventions seek to understand the individual, his or her unique circumstances and how that individual's personal preferences and goals can be maximally incorporated in the crisis response.*

3. **Shared Responsibility.** An acute sense of losing control over events or feelings is a hallmark of mental health crises. In fact, research has shown "feeling out of control" to be the most common reason consumers cite for being brought in for psychiatric emergency care.[12] An intervention that is done *to* the individual—rather than *with* the individual—can reinforce these feelings of helplessness. One of the principal rationales for person-centered plans is that shared responsibility promotes engagement and better outcomes. While crisis situations may present challenges to implementing shared, person-centered plans, ultimately an intervention that considers and, to the extent possible, honors an individual's role in crisis resolution may hold long-term benefits. *An appropriate crisis response seeks to assist the individual in regaining control by considering the individual an active partner in—rather than a passive recipient of—services.*

Personal Safety Plan

Some state mental health systems encourage consumers to complete a form intended to help staff understand an individual's preferred ways of addressing emerging crises. The following is the introduction presented from Florida's adaptation of the Massachusetts form; it affirms the perspective of a partnership between staff and the individual.

"This form will allow you to suggest calming strategies IN ADVANCE of a crisis. It will allow you to list things that are helpful when you are under stress or are upset. It will also allow you to identify things that make you angry. Staff and individuals receiving services can enter into a 'partnership of safety' using this form as a guide to assist in your treatment plan. The information is intended only to be helpful; it will not be used for any purpose other than to help staff understand how to best work with you to maintain your safety or to collect data to establish trends. This is a tool that you can add to at any time. Information should always be available from staff members for updates or discussion. Please feel free to ask questions."

Massachusetts Department of Mental Health (1996) *Task Force on the Restraint and Seclusion of Persons who have been Physically or Sexually Abused*, Report and Recommendations.

Florida Department of Children and Families, Form CF-MH 3124, http://www.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx

4. **Addressing Trauma.** Crises, themselves, are intrinsically traumatic and certain crisis interventions may have the effect of imposing further trauma—both physical and emotional. In addition, people with serious mental illness have a high probability of having been victims of abuse or neglect. *It is essential that once physical safety has been established, harm resulting from the crisis or crisis response is evaluated and addressed without delay by individuals qualified to diagnose and initiate needed treatment. There is also a dual responsibility relating to the individual's relevant trauma history and vulnerabilities associated with particular interventions; crisis responders should appropriately seek out and incorporate this information in their approaches, and individuals should take personal responsibility for making this crucial information available (for instance, by executing advance directives).*

5. **Establishing Feelings of Personal Safety.** An individual may experience a mental health crisis as a catastrophic event and, accordingly, may have an urgent need to feel safe. What is regarded as agitated behavior may reflect an individual's attempts at self-protection, though perhaps to an unwarranted threat. *Assisting the individual in attaining the subjective goal of personal safety requires an understanding of what is needed for that person to experience a sense of security (perhaps contained in a crisis plan or personal safety plan previously formulated by the individual) and what interventions increase feelings of vulnerability (for instance, confinement in a room alone). Providing such assistance also requires that staff be afforded time to gain an understanding of the individual's needs and latitude to address these needs creatively.*

6. **Based on Strengths.** Sharing responsibility for crisis resolution means understanding that an individual, even while in crisis, can marshall personal strengths and assist in the resolution of the emergency. Individuals often understand the factors that precipitated a crisis as well as factors that can help ameliorate their impact. *An appropriate crisis response seeks to identify and reinforce the resources on which an individual can draw, not only to recover from the crisis event, but to also help protect against further occurrences.*

7. **The Whole Person.** For individuals who have a mental illness, the psychiatric label itself may shape—even dominate—decisions about which crisis interventions are offered and how they are made available. *An individual with a serious mental illness who is in crisis is a whole person, whose established psychiatric disability may be relevant but may—or may not—be immediately paramount.* That the individual may have multiple needs and an adequate understanding of the crisis means not being limited by services that are compartmentalized according to healthcare specialty. An individual's emergency may reflect the interplay of psychiatric issues with other health factors. And while the individual is experiencing a crisis that tends to be addressed as a clinical phenomenon, there may also be a host of seemingly mundane, real-world concerns that significantly affect an individual's response: the whereabouts of the person's children, the welfare of pets, whether the house is locked, absence from work, and so on.

8. **The Person as Credible Source.** Assertions or complaints made by individuals who have been diagnosed with a serious mental illness tend to be viewed skeptically by others. Particularly within the charged context of mental health

crises, there may be a presumption that statements made by these individuals are manifestations of delusional thinking. Consequently, there is a risk that legitimate complaints relating to such matters as medical illness, pain, abuse or victimization will go unheeded. Even when an individual's assertions are not well grounded in reality and represent obviously delusional thoughts, the "telling of one's story" may represent an important step toward crisis resolution.[13] *For these reasons, an appropriate response to an individual in mental health crisis is not dismissive of the person as a credible source of information—factual or emotional—that is important to understanding the person's strengths and needs.*

9. **Recovery, Resilience and Natural Supports.** Certain settings, such as hospital emergency departments, may see individuals only transiently, at a point when they are in acute crisis and in a decidedly high-stress environment. Even when not occurring within hospitals, mental health emergency interventions are often provided in settings that are alien to the individual and the natural supports that may be important parts of his or her daily life. It is important not to lose sight of the fact that an emergency episode may be a temporary relapse and not definitional of the person or that individual's broader life course. *An appropriate crisis response contributes to the individual's larger journey toward recovery and resilience and incorporates these values. Accordingly, interventions should preserve dignity, foster a sense of hope, and promote engagement with formal systems and informal resources.*

10. **Prevention.** Too often, individuals with serious mental illnesses have only temporary respite between crises. An appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse. *Hence, an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvements.*

The National Consensus Statement on Mental Health Recovery identifies *recovery* as an individual's journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. It also cites 10 fundamental components for systems:

- Self-Direction
- Individualized and Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-Based
- Peer Support
- Respect
- Responsibility
- Hope

US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (2004) National Consensus Statement on Mental Health Recovery. For the complete report, see: http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

PRINCIPLES FOR ENACTING THE ESSENTIAL VALUES

Several principles are key to ensuring that crisis intervention practices embody these Essential Values:

1. **Access to supports and services is timely.** Ready access to assistance is important not only because it holds the promise of reducing the intensity and duration of the individual's distress, but also because as a crisis escalates, options for interventions may narrow. Timely access presupposes 24-hour/7-days-a-week availability and a capacity for outreach when an individual is unable or unwilling to come to a traditional service site.

2. **Services are provided in the *least restrictive* manner.** Least-restrictive emergency interventions not only avoid the use of coercion, but also preserve the individual's connectedness with his or her world. Individuals should not be unnecessarily isolated from their routine networks of formal and natural supports and should be encouraged to make contact with outside professionals, family and friends who can provide assistance through the crisis event and beyond.

Staff Behaviors that Consumers Feel Are Most Important to Individuals in a Mental Health Crisis

- Having the staff listen to me, my story and my version of events
- Being asked about what treatment I want
- Trying to help me calm down before resorting to forced treatment
- Being asked about what treatments were helpful and not helpful to me in the past

Allen, M., Carpenter, D., Sheets, J, Miccio, S., & Ross, R. (2003) What do consumers say they want and need during a psychiatric emergency? Journal of Psychiatric Practice (9) 1, 39-58.

3. **Peer support is available.** Services should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand. In addition, peers can offer opportunities for the individual to connect with a supportive circle of people who have shared experiences—an option that may have particular relevance given feelings of isolation and fear that may accompany a mental health crisis.

4. **Adequate time is spent with the individual in crisis.** In settings such as hospital emergency departments, there may be intense pressure to move patients through quickly.[14] People who provide assistance must have an adequate understanding of the crisis situation, not only objectively, but also as it is being experienced by the individual who is in crisis. Unfortunately, individuals in acute crisis—particularly following involuntary transport to an evaluation setting—may not be in a position to discuss their presenting complaints clearly and concisely. Personnel in healthcare and similar settings must regard face-to-face time with the individual not as a distraction, but as a core element of quality crisis care. Settings that cannot accommodate the individual in this way may not be appropriate venues for psychiatric crisis intervention; as is discussed elsewhere in these guidelines, such a determination should be regarded as a problem in care and drive performance improvement at both the organizational and systemic levels.

5. **Plans are strengths-based.** It may be fairly routine for professional staff to concentrate on clinical signs and other deficits to be addressed, particularly when an individual is in a crisis state and, therefore, "symptomatic." Yet appropriate crisis intervention gives at least equal attention to the individual's immediately available and potentially available assets. A strengths-based plan helps to affirm the individual's role as an active partner in the resolution of the crisis by marshalling his or her capabilities. A strengths-based approach also furthers the goals of building resilience and a capability for self-managing future crises.

6. **Emergency interventions consider the context of the individual's overall plan of services.** Many individuals with serious mental illnesses go into mental health crises while receiving some sort of services and supports. Appropriate crisis services consider whether the crisis is, wholly or partly attributable to gaps or other problems in the individual's current plan of care and provide crisis measures in ways that are consistent with services the individual receives (or should receive) in the community. In addition, appropriate crisis services place value on earlier efforts by the individual and his or her service providers to be prepared for emergencies, for instance, by having executed psychiatric advance directives or other crisis plans. Incorporating such measures in a crisis response requires that interveners be knowledgeable about these approaches, their immediate and longer-term value, and how to implement them. Appropriate crisis interventions also include post-event reviews that may produce information that is helpful to the individual and his or her customary service providers in refining ongoing services and crisis plans.

7. **Crisis services are provided by individuals with appropriate training and demonstrable competence to evaluate and effectively intervene with the problems being presented.** Crisis intervention may be considered a high-end service, that is high-risk and demanding a high level of skill. Within the course of a psychiatric emergency, various types of crisis interventions may occur—some by healthcare professionals, some by peers and some by personnel (such as police) who are outside of healthcare. Throughout, the individual experiencing a mental health crisis should be assured that all interveners have an appropriate level of training and competence. What that means may vary considerably between scenarios. For instance, a significant number of instances of police involvement with individuals in mental health crises result in injuries or even death.[15] Accordingly, some police departments have taken special measures to train officers in identifying and de-escalating mental health crises. Many have also established links with mental health professionals who can provide timely on-site assistance. These efforts have required police and health care professionals to connect across traditional bureaucratic boundaries.

8. **Individuals in a self-defined crisis are not turned away.** People who seek crisis services but do not meet the service criteria of an organization should receive meaningful guidance and assistance in accessing alternative resources. This is particularly applicable in organizations or programs that carry out a screening or gatekeeping function. For instance, it is not sufficient, upon determining that an individual fails to meet the criteria for hospitalization, to tell the individual or family members to make contact again if the situation worsens. Such practices tacitly encourage the escalation of crises. Individuals and their families should be assisted in accessing services and supports that resolve issues early on, and an organization providing screening or gatekeeping services should be fluent with alternatives for when service thresholds are not met. When these alternatives are lacking, the organization should consider this a problem in care and take action accordingly. Likewise, an organization providing early intervention that routinely receives referrals from hospital gatekeepers might consider improving its outreach so that individuals seeking help are more likely to access their services directly, without placing demands on programs designed for late-stage emergencies.

9. **Interveners have a comprehensive understanding of the crisis.** Meaningful crisis response requires a thorough understanding of the issues at play. Yet, for people with serious mental illnesses, interventions are commonly based on a superficial set of facts: behaviors are seen to present a safety issue, the individual has reportedly failed to take medications as prescribed, or an encounter with the police has occurred. An appropriate understanding of the emergency situation not only includes an appreciation for what is happening at the moment, but also *why* it is happening and how an individual fares when he or she is *not* in crisis. Crises—particularly recurrent crises—likely signal a failure to address underlying issues appropriately. When crisis intervention occurs outside of the individual's customary setting, such as in a hospital emergency department or a psychiatric inpatient unit, it may be challenging to gain a good picture of the individual's circumstances.

An Alternative Approach

"The Hospital Diversion Program at the ROSE HOUSE is currently available to residents of Orange and Ulster counties [New York State]. This peer-operated house is designed to assist fellow peers in diverting from psychiatric distress, which may lead to a hospitalization. The program is located in a three-bedroom home set up and furnished for comfort. The house is equipped with a variety of traditional self-help and proactive tools to maintain wellness. Trained peer companions are the key ingredients in helping others learn self-help tools. Peer companions are compassionate, understanding and empowering. We exist to fill a gap in the mental health system that can brake the cycle of going from home to crisis to hospital.

The ROSE HOUSE offers a stay of up to five days to take control of your crisis or potential crisis and develop new skills to maintain your wellness. Peer companions staff the house 24 hours a day to address the needs of guests as they arise. Participation in the program is completely voluntary and free of charge. You are free to come and go as you please. We also will maintain contact and support for you, at your request, after you finish your stay. We have found that occasional calls and visits reinforce recovery and self determination."

From the website of Projects to Empower and Organize the Psychiatrically Labeled (PEOPLe, Inc.) at: http://www.projectstoempower.org

Mobile outreach services, which have the capacity to evaluate and intervene within the individual's natural environment, have inherent advantages over facility-based crisis intervention, especially when an individual who has personal experience with mental illness and mental health crises is a part of the intervention team. Such mobile outreach capacity is even more meaningful when it is not restricted to a special crisis team, but rather when staff and peers familiar with the individual have the ability to literally meet the individual where he or she is. When intervention within an individual's normal living environment is not feasible, hospitalization is not the inevitable alternative; for many individuals facing civil commitment, consumer-managed crisis residential programs can represent a viable, more normalized alternative that produces good outcomes.[16]

10. **Helping the individual to regain a sense of control is a priority.** Regaining a sense of control over thoughts, feelings and events that seem to be spinning out of control may be paramount for an individual in mental health crisis. Staff interventions that occur without opportunities for the individual to understand what is happening and to make choices among options (including the choice to defer to staff) may reinforce feelings that control is being further wrested away. The individual's resistance to this may be inaccurately regarded as additional evidence of his or her incapacity to understand the crisis situation. Incorporating personal choice in a crisis response requires not only appropriate training, but also a setting with the flexibility to allow the exercise of options. Informed decision-making in this context is not a matter of simply apprising the individual of the empirically derived risks and benefits associated with various interventions; it also includes an understanding among staff that an ostensibly sub-optimal intervention that is of the individual's choosing may reinforce personal responsibility, capability and engagement and can ultimately produce better outcomes. The specific choices to be considered are not limited to the use of medications, but also include the individual's preferences for what other approaches are to be used where crisis assistance takes place, involving whom and with what specific goals. While the urgency of a situation may limit the options available, such limitations may also highlight how earlier interventions failed to expand opportunities to exercise personal control. Post-crisis recovery plans or advance directives developed by the individual with assistance from crisis experts are important vehicles for operationalizing this principle.

11. **Services are congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual being served.** Given the importance of understanding how an individual is experiencing a crisis and engaging that individual in the resolution process, being able to effectively connect with the individual is crucial. A host of variables reflecting the person's identity and means of communicating can impede meaningful engagement at a time when there may be some urgency. Establishing congruence requires more than linguistic proficiency or staff training in cultural sensitivity; it may require that to the extent feasible, an individual be afforded a choice among staff providing crisis services.

National Resource Center on Psychiatric Advance Directives

Psychiatric advance directives (PADs) are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment, in preparation for the possibility that the person may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

Almost all states permit some form of legal advance directive (AD) for healthcare, which can be used to direct at least some forms of psychiatric treatment. In the past decade, 25 states have adopted specific PAD statutes.

http://www.nrc-pad.org

12. **Rights are respected.** An individual who is in crisis is also in a state of heightened vulnerability. It is imperative that those responding to the crisis be versed in the individual's rights, among them: the right to confidentiality, the right to legal counsel, the right to be free from unwarranted seclusion or restraint, the right to leave, the right for a minor to receive services without parental notification, the right to have one's advance directive considered, the right to speak with an ombudsman and the right to make informed decisions about medication. It is critical that appropriately trained advocates be available to provide needed assistance. Correctly or not, many individuals with serious mental illnesses have come to regard mental health crisis interventions as episodes where they have no voice and their rights are trampled or ignored. Meaningfully enacting values of shared responsibility and recovery requires that the individual have a clear understanding of his or her rights and access to the services of an advocate. It is also critical that crisis responders not convey the impression that an individual's exercise of rights is a hostile or defiant act.

13. **Services are trauma-informed.** Adults, children and older adults with serious mental or emotional problems often have histories of victimization, abuse and neglect, or significant traumatic experiences. Their past trauma may be in some ways similar to the mental health crisis being addressed. It is essential that crisis responses evaluate an individual's trauma history and the person's status with respect to recovery from those experiences. Similarly, it is critical to understand how the individual's response within the current crisis may reflect past traumatic reactions and what interventions may pose particular risks to that individual based on that history. Because of the nature of trauma, appropriately evaluating an individual requires far more sensitivity and expertise than simply asking a series of blunt, potentially embarrassing questions about abuse and checking off some boxes on a form. It requires establishing a safe atmosphere for the individual to discuss these issues and to explore their possible relationship to the crisis event.

14. **Recurring crises signal problems in assessment or care.** Many organizations providing crisis services—including emergency departments, psychiatric hospitals and police—are familiar with certain individuals who experience recurrent crises. They have come to be regarded as "high-end users." In some settings, processing these individuals through repeated admissions within relatively short periods of time becomes so routine that full reassessments are not conducted; rather, clinical evaluations simply refer back to assessments and interventions that were conducted in previous (unsuccessful) episodes of care. While staff sometimes assume that these scenarios reflect a patient's lack of understanding or willful failure to comply with treatment, recurrent crises are more appropriately regarded as a failure in the partnership to achieve the desired outcomes of care. And rather than reverting to expedient clinical evaluations and treatment planning that will likely repeat the failed outcomes of the past, recurrent crises should signal a need for a fresh and careful reappraisal of approaches, including engagement with the individual and his or her support network.

"Confounding and complicating the prevalence of trauma in public mental health service recipients is the fact that mental health services themselves are often experienced as traumatic. The use of coercive interventions such as seclusion and restraint, forced involuntary medication practices, and philosophies of care based on control and containment vs. empowerment and choice often cause unintentional re-traumatization in already vulnerable populations."

National Association of State Mental Health Program Directors (2005) NASMHPD Position Statement on Services and Supports to Trauma Survivors

15. **Meaningful measures are taken to reduce the likelihood of future emergencies.** Considering the deleterious impact of recurrent crises on the individual, interventions must focus on lowering the risk of future episodes. Crisis intervention must be more than another installment in an ongoing traumatic cycle. Meaningfully improving an individual's prospects for success requires not only good crisis services and good discharge planning, but also an understanding that the crisis intervener—be it police, hospital emergency department, community mental health program, or protective service agency—is part of a much larger system. Performance-improvement activities that are confined to activities within the walls of a single facility or a specific program are sharply limited if they do not also identify external gaps in services and supports that caused an individual to come into crisis. Although addressing certain unmet needs may be beyond the purview of one facility or program, capturing and transmitting information about unmet needs to entities that have responsibility and authority (e.g., state mental health programs, housing authorities, foster care and school systems) is an essential component of crisis services.

"Most performance measurement efforts tend to operate in isolation from one another to meet the specific needs of their sponsors. Frequently, data collection efforts are particular to specific care settings—such as hospitals or ambulatory care organizations—or to particular payers, whether private or public... Since data are collected and used in fragmented ways, they rarely provide a picture of the overall quality of performance for a specific clinician or organization, or how well patients fare, or the state of the public's health at large."

Health Care at the Crossroads: Development of a National Performance Measurement Data Strategy. The Joint Commission, 2008, p.8.

III. INFRASTRUCTURE

An organization's infrastructure should support interventions consistent with the values and principles listed above. Given the nature of crises affecting individuals with serious mental or emotional problems, these values and principles are applicable to a very broad array of organizations—hospital emergency departments, psychiatric programs, foster care, education, police, schools, and courts. While needed infrastructure will necessarily vary by setting, population served and the acuteness of crises being addressed, there are some important common denominators:

- **Staff that is appropriately trained and that has demonstrated competence** in understanding the population of individuals served, including not only a clinical perspective, but also their lived experiences.
- **Staff and staff leadership that understands, accepts and promotes the concepts of recovery and resilience,** the value of consumer partnerships and consumer choice, and the balance between protection from harm and personal dignity.
- **Staff that has timely access to critical information,** such as an individual's health history, psychiatric advance directive or crisis plan. Such access is, in part, reliant on effective systems for the retrieval of records, whether paper or electronic.
- **Staff that is afforded the flexibility and the resources,** including the resource of time, to establish truly individualized person-centered plans to address the immediate crisis and beyond.
- **Staff that is empowered to work in partnership with individuals being served** and that is encouraged, with appropriate organizational oversight, to craft and implement novel solutions.
- **An organizational culture that does not isolate its programs or its staff** from its surrounding community and from the community of individuals being served. This means that the organization does not limit its focus to "specific" patient-level interventions, but also positions itself to play a meaningful role in promoting "indicated" strategies for the high-risk population it serves and "universal" strategies that target prevention within the general population. The intent here is not to dissipate the resources or dilute the focus of an organization, but to assure recognition that its services are a part of a larger spectrum and that it actively contributes to and benefits from overall system refinements.
- **Coordination and collaboration with outside entities** that serve as sources of referrals and to which the organization may make referrals. Such engagement should not be limited to service providers within formal networks, but should also include natural networks of support relevant to the individuals being served.
- **Rigorous performance-improvement programs** that use data meaningfully to refine individuals' crisis care and improve program outcomes. Performance improvement programs should also be used to identify and address risk factors or unmet needs that have an impact on referrals to the organization and the vulnerability to continuing crises of individuals served.

IV. MAKING IT HAPPEN

The need for major improvements in crisis services for adults, children and older adults with serious mental or emotional problems is obvious. The statistics presented in the introduction to these guidelines make a clear case that people with mental illnesses are vulnerable to repeated clinical and life crises that can have deleterious effects on the individual, families and social networks, and communities. Many interventions could have a significant, positive impact on the frequency and severity of mental health crises, but they are not readily available to most of the individuals who need them.[17]

Properly applied, these guidelines should work to improve the quality of services for people who are in or are vulnerable to mental health crises. Embedded in the guidelines is the notion that crisis services should not exist in isolation; crises are a part of an individual's life experiences and the assistance provided during crisis periods is part of a larger set of services and supports provided to the individual. While the values, principles and infrastructure recommendations presented here focus on crises affecting people with serious mental illnesses, they also have wider application; they reflect generally accepted approaches to working with individuals who have mental or emotional problems, whether or not they are in crisis. Stated differently, these guidelines challenge any disjuncture between responses to mental health crises and routine mental healthcare. They demonstrate how appropriate emergency mental health responses should affirm the principles of recovery and resilience that are the benchmarks for appropriate mental healthcare even though crisis scenarios may test the application of these values.

From a practice standpoint, these guidelines may be most effectively enacted when they are embedded in the various quality-control and performance-improvement mechanisms that operate within an organization. When appropriately conducted, quality control and performance-improvement processes should be data-driven and attuned to demonstrating not only what segments of the service population are prone to mental health crises, but also what factors underlie their vulnerability. An adequate understanding of these factors requires much more than the "encounter" data now routinely collected by both healthcare organizations and police. Data collection should clearly reflect the premise that mental health crises represent problems in care (whether individual or systemic) and should facilitate the root-cause analyses that are required when significant problems in care occur. Similarly, data should be used as tools for identifying gaps, developing remedies and monitoring the impact of these remedies. Providers and provider organizations should have access to these data for purposes of ensuring the quality of care and the appropriate use of resources. To the extent that the causes of mental health crises extend beyond the domains of an emergency department, a hospital, a mental health system, a police department, and/or a housing authority, data without personal identifiers should be routinely shared across systems. Entities having oversight responsibility should ensure that these performance-improvement activities are being carried out and that opportunities exist for cross-agency/cross-system analysis of information and the implementation of strategies to reduce mental health crises. And the partnerships between providers and consumers that are appropriate in the context of individual crises should be mirrored at the performance-improvement level.

In addition to the human case for improving crisis services, a strong business case can be made and data should be collected accordingly. Current approaches to crisis services needlessly perpetuate reliance on expensive, late-stage interventions (such as hospital emergency departments) and on settings that have inherent risks for harm for people with mental health needs (for instance, jails and juvenile justice facilities). Resources and personnel that might otherwise be available for more effective, less risky and less expensive interventions are now channeled into these costly and suboptimal settings. The factors that sustain late-stage crisis interventions may be linked to reimbursement practices and political considerations, yet in some ways the service system is itself complicit. Performance-improvement data derived from on-the-ground case experience can paint a compelling story of how "the right services at the right time" would look for individuals who are currently at high risk for future crises. These data can also set the stage for concrete discussions of the costs and the benefits of changes in policies governing the provision and funding of services and supports.

In short, the approach to crisis services must be forward-looking rather than merely reactive, with success seen as the ability of the individual served to return to a stable life in the community. Rather than leading merely to an increase in the number of beds available for mental health care, it must have as its goal a reduction in the number of crises among people with mental illnesses and therefore a reduced need for emergency services.

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Taos County, New Mexico: Crisis System of Care Framework				
Phase I Prevention	Phase II Early Intervention	Phase III Acute Intervention	Phase IV Crisis Treatment and Stabilization	Phase V Recovery and Reintegration
Walk-in Mental Health Clinic Services: M-F 9AM-11AM. All payers and uninsured (Tri County Community Services, Inc): E	Mental Health First Aid: E	Hospital-based specialized intervention in ER for BH emergencies. hospital-employed LISW. M-TH days E	12-24-48 hour follow-up protocol for individuals seen in the emergency department at Tri-County Community Services: P	ACT Team: E
Wellness Recover Action Plan (WRAP) Training: E	Bi-disciplinary (Clinician and Peer Specialist) Mobile Crisis Intervention Team: G	After hours on-call response to ER for BH emergencies (Tri-County Community Services, Inc): E	Brief Crisis Stabilization Service: G	Warm hand-off protocol for continuity of care: G
ER High Utilizer program: E	Private BH provider protocol for first tier BH crisis response: G	EHR automatic notification system for ACT and complex patients in the ER: E	Medication assistance program for persons who are uninsured/indigent: E	Medicaid outreach enrollment assistance program: E
12 month media series (radio and newspaper) for Crisis System of Care Alliance (CSOCA): E	Primary Care protocol for first tier crisis response: G	Law Enforcement / Hospital/Mobile Crisis mutual protocol for acute crisis response: G		Peer-run 12-step programs: E
Taos Alive Website: Portion available for CSOCA use: E	Taos and Picuris Pueblos protocol for first tier BH crisis response G	Taos and Picuris Pueblos mobile crisis team collaborative protocol: G		TCCS offers EBP Seeking Safety group: E
System competency development: Effective crisis prevention and safety planning: G	Community Against Violence services for victims of domestic violence: E			
Emergency Department Protocol for Opiate Prescribing: E	24/7/365 crisis line E			

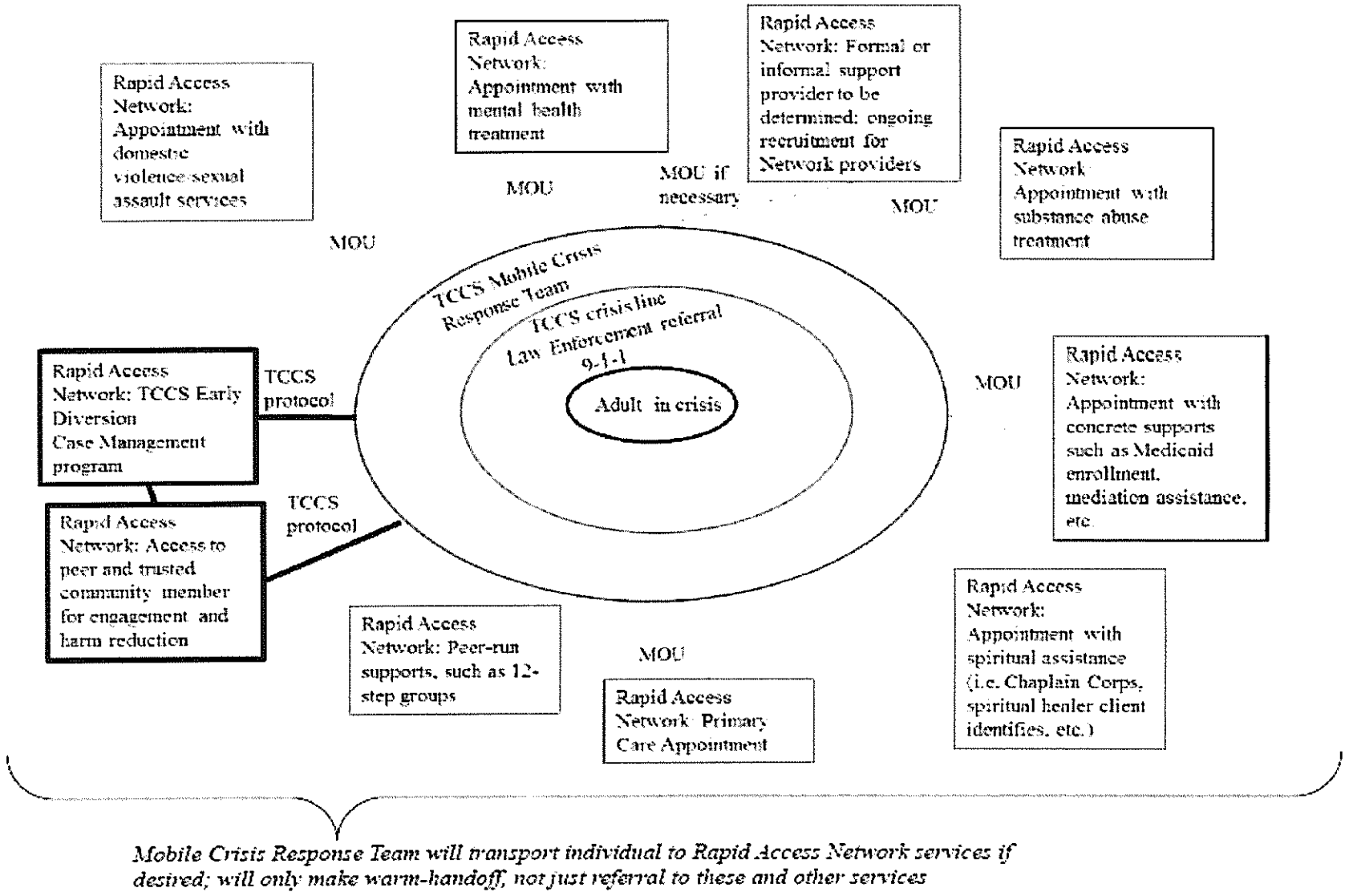
Codes: E: Existing service/practice—fully operational P: Partial implementation F: Future expansion G: Grant-proposed expansion

Source: Taos Community Crisis Systems of Care. Used with Permission.

Taos County, New Mexico: Sequential Intercept Model Services for Adults				
Intercept 1: Law Enforcement	**Intercept 2:** Initial detention/Initial court hearings	**Intercept 3:** Jails/Courts	**Intercept 4:** Re-entry	**Intercept 5:** Community corrections
Crisis Intervention Training (CIT) for law enforcement officers: **F**	Jail-based intervention and pre-court diversion: **F**	Adult Drug Court, Eighth Judicial District: **E**	Jail-based case manager providing transitional care for inmates: **P**	TCCS outpatient services as conditions of probation/parole: **E**
Mobile Crisis Response Team: **G**	Magistrate Court court-ordered treatment in lieu of prosecution or incarceration: **E**	Mental Health Court: **F**	TCCS federal probation contract for re-entry services: **E**	
Rapid Access Network to treatment and services: **G**		Medication services at Detention Center: **E**		
TCCS Early Diversion **G, funded by claims**		DWI jail diversion program: **E**		

Codes: E: Existing service/practice—fully operational P: Partial implementation F: Future expansion G: Grant-proposed expansion

Source: Taos Community Crisis Systems of Care. Used with Permission.



Source: Taos Community Crisis Systems of Care. Used with Permission.

Law Enforcement Officers can access a MCRT clinician 24/7/365 when: Person is experiencing mental health or substance use-related distress/crisis AND Person will not be jailed or charged with a crime MCRT and TCCS Phone Number: 575-758-1125 Address: 413 Sipapu Street, Taos	**LOCATION OF SERVICE**		
	Home or Neutral Community Site	**Tri-County Community Services (TCCS)**	**Holy Cross Emergency Department**
	Person in distress: - Agrees to MCRT service - Is comfortable with receiving the service in the home or neutral community site. AND Officer: - Confirms the site is suitable/safe for MCRT clinician response - Remains at the location until a warm handoff to MCRT clinician occurs	Person in distress: - Agrees to MCRT service - Is comfortable with receiving the service at TCCS. AND Officer: - Makes warm phone referral to TCCS - Transports or assures safe transport to TCCS site	Person in distress: (one or more applies) - Requests this service location - Reports or appears to have an urgent medical issue or complaint - Is not stable (i.e. intoxicated, impulsive, agitated or disoriented) to a degree that ED setting is needed for safety - Will not consent to MCRT and Officer completes an involuntary hold
EXCEPTIONS Community location not secure OR person prefers office location Possible medical complications, degree of risk necessitate transfer to Emergency Department			

Source: Taos Community Crisis Systems of Care. Used with Permission.