Report of the Federal Partners Committee on Women and Trauma

A Federal Intergovernmental Partnership
on Mental Health Transformation

A Working Document

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WOMEN AND TRAUMA

Note:

The views reflected in this report only reflect those of the authors or speakers, and not of their agencies or institutions of employment

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Preface

Background: The Need for a "Women and Trauma Committee"

In the early 1990s, the Substance Abuse and Mental Health Services Administration (SAMHSA) began a series of initiatives to raise awareness regarding the increasing numbers of women seeking services from public mental health and substance abuse programs who had experienced personal histories of violence and trauma, frequently beginning in childhood. Initially, attention focused on the pervasiveness of the problem, with experiences of violence leading to traumatic stress in more than 80-90% of women seeking services. Troubling manifestations of traumatic stress included physical health consequences and precipitous spiritual questioning as well as commonly labeled psychiatric and substance use disorders. For women survivors, addressing the full range of impacts of trauma often required involvement of the entire spectrum of public health services in ongoing trauma resolution and recovery efforts, typically involving the need for supported "safe" housing, supported education and employment assistance, family welfare supports, and possible contact with criminal justice and/or victim assistance programs. Due to the spiraling number of people impacted and the wide range of consequences, trauma is now believed to be a "public health crisis."

Existing providers lacked the capacity to effectively assist women with histories of abuse and trauma. A number of troubling service delivery breakdowns were identified, including widespread lack of screening or assessment for trauma; lack of training in clinical and community-based trauma treatment; and misdiagnosis, under-diagnosis or failure to diagnose trauma as the issue underlying a wide range of problems. Compounding problems further, providers typically offered only the standard regimen of services-as-usual for these women, which often led to a revolving door of treatment and discharge. Even when correctly diagnosed, trauma was typically viewed as one episode or event in the lives of these women, rather than an ongoing series of violent events woven throughout the life cycle. Little or no attention was paid to the inter-generational cycle of trauma that kept recurring within trauma-impacted families.

To address the lack of capacity to effectively serve women who had experienced trauma, SAMHSA sponsored a five-year "Women and Violence" Study (1998-2003) to develop and evaluate new trauma service paradigms. This research study demonstrated that trauma requires a central focus in treatment and needs to be integrated into the provision of related public health and social services. This approach, called "trauma-integrated counseling," has demonstrated efficacy and practicality. New gender-specific group psychosocial empowerment and education counseling models introduced in the "Women and Violence" study are now evidence-based interventions that have been widely applied with significant impact on the recovery of women trauma survivors.

In 2004 SAMHSA's National Center for Trauma-Informed Care (NCTIC) was funded to provide technical assistance to public health programs interested in adopting a "trauma-informed"

organizational and services delivery paradigm that focuses on trauma as the key issue to be addressed in facilitating recovery. Currently, more than 45 State Mental Health Authorities are in the process of implementing trauma-informed systems and services, and trauma-informed care is spreading rapidly to all segments of the public health system. The Women and Trauma Committee will be instrumental in leading and supporting these new movements.

Susan Salasin
Chair, Women and Trauma Federal Partners Committee, and
Director, Trauma and Trauma-Informed Care Program
Center for Mental Health Services
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"Women and Trauma Committee" Operational Development

The Women and Trauma Federal Partners Committee was launched on April 1, 2009. The Committee first developed as a work group within the Federal Partnership on Mental Health Transformation. This partnership was established by one of the nation's health authorities, the Substance Abuse and Mental Health Administration (SAMHSA). SAMHSA was tasked to implement a Presidential Order calling for aggressive actions to develop policy and practice in many priority areas, including suicide prevention, employment, women, youth in transition from school to work, to name just a few. SAMHSA's Center for Mental Health Services was the agency that initiated and coordinated this task.

The Women and Trauma Federal Partners Committee consists of representatives from more than 20 federal agencies and sub-agencies from the Departments of Defense, Education, Health and Human Services, Housing and Urban Development, Justice, Labor, Veterans Affairs, and others. The Committee meets regularly, and continues to seek additional Federal Partner agencies that can provide support, collaboration, and resources on trauma-informed care.

On April 29, 2010, the Committee held a Roundtable on Women and Trauma. The goal of the Roundtable was to initiate a dialogue on the behavioral impacts of trauma affecting women and girls, identify gaps in addressing these impacts, and develop recommendations for an agenda for comprehensive systems change, integration, and collaboration. Approximately 80 participants from federal, state, and nonprofit organizations attended, including two White House staffers—Jennifer Kaplan, Deputy Director of the White House Council on Women and Girls, and Lynn Rosenthal, White House Advisor on Violence against Women. The recommendations from stakeholders at the Roundtable are included in an appendix to this report.

On October 22, 2010, the Committee held a strategic planning retreat to advance the Roundtable's agenda by moving from a focus on providing a common knowledge base among the Federal Partners and collaborators regarding the prevalence of trauma in the lives of women and girls and its behavioral impacts to the development and implementation of an

action agenda to address these issues. The objectives of the planning retreat were to: (1) provide a comprehensive overview of how information from the Roundtable has been used to stimulate a variety of activities among participants; (2) develop specific recommendations for integrating trauma-informed care into prevention, intervention, and treatment activities within each partner agency through education and information dissemination; (3) discuss and begin formulating a strategy to strengthen support for trauma informed care among Federal Partner agencies, and to interest new agencies in participating; and (4) determine whether the Committee can jointly support specific projects and initiatives across agencies, including the development of policy recommendations.

From the discussions at the retreat, the Committee developed a set of priorities that are being integrated into an action agenda to address the impact of trauma on the lives of women and girls at the federal agency and Administration levels. The ultimate goal of the Committee's work is to galvanize the Federal Partners into action in their spheres of influence to address this crucial issue that affects the lives of so many.

Most significant in the Federal Partners' work is that, thus far, more than sixteen trauma-informed actions or initiatives have resulted directly from the Federal Partners Committee and Roundtable efforts.

Carol Boyer
Co-chair, Women and Trauma Federal Partners Committee, and
Policy Advisor
Office of Disability Employment Policy
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Executive Summary

Unaddressed trauma experienced by women, including trauma caused by violence, affects all of us. Advances in the science and practice of behavioral health have helped us to understand that violence against women - and the trauma that results - have a huge impact on the health, economy and even the security of our nation. Trauma occurs whenever an external threat overwhelms a person's coping resources. While concern about trauma is not new, research over the past ten years has provided a stunning picture of the depth and breadth of its consequences. Recognizing that immediate action is necessary and urgent, a group of Federal agencies have been working together for more than a year to highlight the scope of the problem and to develop collective strategies for action. The Federal Partners Committee on Women and Trauma is an outgrowth of the SAMHSA-sponsored "Federal Intergovernmental Partnership on Mental Health Transformation Working Group on Women and Trauma." This report provides background on women and trauma, describes a Roundtable held on April 29, 2010, and presents an outline of what the Committee plans for the coming year.

This report is a call to action, not a comprehensive review. The agencies involved represent only a subset of all agencies whose constituents may be affected by violence and trauma, and many important related issues, such as HIV/AIDS, prevention, housing, and cultural issues, are only touched on in this document. However, the report takes an important first step by describing the level of violence against women and girls in our society and exploring its consequences. Children growing up in the United States today face a surprising level of social violence, including child abuse, witnessing domestic violence, crime, and bullying. Epidemiological research on "adverse childhood experiences" demonstrates convincingly that violence against children is a significant public health issue, and documents strong relationships between adverse childhood experiences and adult health and behavioral health problems, social and economic costs, and early mortality. Women face high rates of domestic violence and sexual assault. Violence is gendered: While men are most likely to experience violence from strangers, women and girls are most likely to be hurt by people they know intimately. For women in the military, the greatest risk of harm is from fellow soldiers; for an adolescent girl, it is from the person she tells that she loves. The Federal Partners Committee has come together with the collective mission of developing strategies to address the consequences of trauma on women.

The report illustrates the importance of listening to and incorporating the voices of people who have been directly impacted by trauma, and describes "trauma-informed care," a new approach to addressing trauma that can be implemented in any setting. Trauma-informed care provides a way for different agencies and groups to come together around a common concern. In a trauma-informed framework, prevention programs, human services, government agencies, and civic groups work together to create healthier, safer, more healing and more productive communities. As individuals, groups, and organizations become aware of trauma and its consequences, new forms of collaboration emerge and people work together to prevent

violence and trauma and to respond effectively when it does occur. Trauma-informed care is an inclusive approach, where everyone has a role to play.

The report also provides an introduction to the key issues facing each participating agency, with statistics documenting the impact of violence against women and girls on their mission and information on how each department is responding. Agencies that participated in the first year of the Federal Partners Committee are the Department of Defense; the Department of Education: Office for Civil Rights; the Department of Health and Human Services: Administration for Children and Families, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, National Institutes of Health, Office of Refugee Resettlement, and Office on Women's Health; the Department of Justice: National Institute of Corrections, Office of Juvenile Justice and Delinquency Prevention, Office for Victims of Crime, and Office on Violence against Women; the Department of Labor: Office of Disability Employment Policy and the Women's Bureau; and the Department of Veterans Affairs. Representatives from several additional federal agencies or offices within agencies have also become active participants, including the Department of Housing and Urban Development, the Rehabilitation Services Administration within the Department of Education, the White House Office on Drug Control Policy, and the Peace Corps.

The Roundtable held in April 2010 brought together more than 80 individuals representing federal and state agencies, advocacy organizations, academic and research institutions, and individuals with direct experience of trauma. A collective momentum emerged from the meeting, and agencies have followed up with concrete actions designed to implement trauma-informed principles and practices. Examples include the development of informational materials and curricula; webinars; prevention toolkits; workforce training programs; university-based training; and conference presentations and workshops. One webinar series on "The Impact of Trauma on Women and Girls across the Lifespan," sponsored by DHHS/SAMHSA, was immediately oversubscribed. Other actions reflect new policies, changes in grant programs, and new research directions. Examples include participation in international and global forums; re-examination of policies on workplace violence, bullying and health education; agency resource mapping; development of new state coalitions; and the development of technical guidance memoranda.

The Women and Trauma Committee continues to meet monthly as a multi-agency workgroup, exchanging information about relevant activities, sharing resources, and planning interagency initiatives. Sub-committees have been formed to focus on: 1) trauma-informed care for front-line community providers; 2) trauma screening and assessment; 3) integration of the first person experience; 4) cross-cultural and diversity issues in trauma; 5) trauma-informed care in the workplace; and 6) military women and trauma-informed care. A second roundtable being planned for December, 2011, will highlight the work of the sub-committees and will focus on effective strategies for prevention and intervention, moving from identifying the problem to discussing effective approaches to implementing trauma informed approaches across the service spectrum.

Introduction and Call to Action

Definition of Trauma

Trauma occurs when an external threat overwhelms a person's coping resources. According to the diagnostic manual used by mental health providers (DSM IV-TR) trauma involves "direct personal experience of an event that involved actual or threatened death or serious injury or other threat to one's physical integrity; or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm or threat of death or injury experienced by a family member or other close associate."

To meet the DSM definition, trauma must also involve "intense fear, helplessness, or horror," or in children "disorganized or agitated behavior." Trauma can result from a wide variety of events, including experiencing or witnessing violent crime, accidents, abandonment (especially for small children), physical or sexual abuse or neglect, cultural dislocation, terrorism, wars, historical violence, institutional trauma, and natural disasters. This monograph focuses primarily on trauma resulting from violence.

Being aware of the pervasive impact of trauma is the first step towards becoming "trauma informed" - integrating knowledge about trauma and recovery into all aspects of organizational culture, including physical environment, policies and procedures and staff attitudes and behaviors. People speak about trauma-informed care, practices, services and systems because it is imperative that this awareness be integrated into organizational culture and settings as well as informing individual practice .

Unaddressed trauma and violence against women affect all of us. Advances in the science and practice of behavioral health have helped us to understand that violence against women - and the trauma that results - have a huge impact on the health, the economy and even the security of our nation. Recognizing that immediate action is necessary and urgent, six Federal agencies have been working together for more than a year to highlight the scope of the problem and to develop collective strategies for action. This report results from the work of the "Federal Partners Mental Health Transformation Committee on Women and Trauma" and from a Roundtable held on April 29, 2010 with Federal, State, tribal, private and community stakeholders working with women and girls affected by trauma across multiple services sectors and settings. While the focus of this report is on women, these issues cannot be discussed without also considering the impact of trauma on men.

While concern about trauma and violence against women is not new, research over the past ten years has provided a stunning picture of the depth and breadth of its consequences. A confluence of biological and epidemiological research, case studies, first person reports, and growing advocacy from survivor groups has made it clear that the time for action is *now*. "Trauma-informed care" - a new approach to violence and trauma based on universal precautions and organizational sensitivity - provides tools for change. Trauma-informed care directly responds to the failures of the current public system to foster safety and transparency in healing and recovery, and it can be implemented in any setting.

Violence against women occurs to women of all ages and in all settings, and it affects all of our social institutions. Public education, prevention, early identification and intervention, and effective trauma treatment are all necessary to break the cycle of violence. A coordinated, multi-level interagency effort is essential. The agencies participating in the Federal Partners Committee recognize that addressing trauma and violence against women can

assist them in meeting their missions.
Addressing violence and trauma against women will help:

- *Department of Defense* to provide the military forces needed to deter war and to protect the security of our country.
- *Department of Education* to ensure access to equal educational opportunities for every individual and to promote improvements in the quality of education.
- *Department of Health and Human Services* to protect the health of all Americans and to provide essential human services, especially for those who are least able to help themselves.
- *Department of Justice* to enforce the law, ensure public safety, and ensure fair and impartial administration of justice for all Americans.
- *Department of Labor* to foster and promote the welfare of the job seekers, wage earners, and retirees of the United States.
- *Department of Veterans' Affairs* to provide veterans the world-class benefits and services they have earned.

At the White House, we have learned that the response (to violence against women) cannot sit with our domestic violence service providers alone. Each federal program that serves families has got to play a part. We need to better understand the intersections that you are talking about at the federal roundtable. And we know that trauma-based care is a very critical part.

Lynn Rosenthal, White House Advisor on Violence against Women

This document is a call to action, not a comprehensive review. Each section provides an introduction to the key issues facing each department. The agencies involved in the Federal Partners Committee represent only a subset of all agencies affected by violence and trauma, and many important issues - such as HIV/AIDS, prevention, housing, and cultural issues – are only touched upon in this document. The work of the Federal Partners Committee is developmental and incremental, and expanding the effort to include new partners is a top priority.

Contextualizing Trauma in the Lives of Women and Girls

Violence against Women and Girls[1]

Children growing up in the United States today face a surprising level of social violence. An estimated 3 to 10 million children witness domestic violence every year.[i] More than a third of adolescents between the ages of 14 and 17 have seen a parent assaulted.[ii] Television programming designed for children has an average of 20-25 violent acts per hour: The typical child will see 8,000 murders by the time they complete elementary school and 40,000 acts of violence by the time they turn 18.[iii] Children are also the victims of violence. Every 35 seconds

[1] Drawn in part from Covington, S. (2010) *Gender Matters: Creating a Trauma-Informed Culture*. Presentation at the Federal Partners Roundtable on Women and Trauma, April 29, Washington, DC.

a child is abused or neglected in the United States, and every six hours a child dies from abuse or neglect.[iv] One in five girls and one in ten boys are sexually abused before adulthood.[v] More than 60% of all children between the ages of 10 and 17 report being exposed to violence in the past year; 50% report being assaulted, and 32% report being bullied.[vi]

While both boys and girls are affected by violence, adolescent girls between the ages of 16-19 are four times more likely than boys to be a victim of rape, attempted rape, or sexual assault.[vii] More than one thousand women are murdered every year by their partner[viii], and one of six women will be sexually assaulted in her lifetime.[ix] Violence is also gendered: While men are most likely to experience violence from strangers, women and girls are most likely to be hurt by people they know intimately. For women in the military, the greatest risk of harm is from fellow soldiers; for an adolescent girl, it is from a person whom she loves.

Given the extent of violence in our country, it is imperative to institute what the medical field refers to as "universal precautions" – making trauma-sensitive services available to everyone. It is also important to 1) identify factors that increase the likelihood of becoming a victim, including relationships with peers, intimate partners, and family members, 2) explore the settings in which social relationships occur (e.g., schools, workplaces, neighborhoods) to identify factors that increase risk, and 3) consider social factors that affect the occurrence of violence. The most effective interventions are gender-responsive – they reflect an understanding of the realities of the lives of women and girls, respond to their strengths and challenges, and use knowledge about female socialization and development to guide all aspects of program and system design.

Violence as a Public Health Epidemic: The ACE Study[2]

The Adverse Childhood Experiences (ACE) Study[x] is an analysis of the relationship between traumatic stress in childhood and the leading causes of morbidity, mortality and disability in the U.S. A collaborative effort between Kaiser Permanente's Department of Preventive Medicine in San Diego and the Centers for Disease Control (CDC), the study includes more than 17,000 middle-class Americans with health insurance. Eighty percent of the participants were white (including Hispanic), 10 percent black, and 10 percent Asian; half were men and half women; and 74 percent had attended college. The average age at entry into the study was 57. In the first wave of the study, subjects were asked whether or not they had experienced any of eight ACE categories during their first 18 years of life (emotional, physical or sexual abuse; domestic violence; substance abuse, mental illness or incarceration of a household member; and parental separation). Two categories of neglect were added in the second wave. The individual's ACE score was calculated by a count of the number of categories reported. Multiple occurrences within a category were not recorded, making this a conservative measure.

[2] Drawn in part from Jennings, A. (2010) *The Tragic Consequences of Unaddressed Childhood Trauma*. Presentation at the Federal Partners Roundtable on Women and Trauma, April 29, Washington, DC. For further information on the ACE study, see Felitti, V.J., Anda, R.F. et al (1998) The relationship of adult health status to childhood abuse and household dysfunction. *American Journal of Preventive Medicine, 14*, 245-258.

Retrospectively reported ACE scores were then matched with the individual's current state of health and well-being and with various measures of health care utilization, cost, and death. Only one-third of the population had an ACE score of zero. One in four had an ACE score of two or more; one in six had an ACE score of four or more; one in nine had a score of five or more. Women were 50 percent more likely than men to report an ACE score of five or more. ACEs did not occur randomly: If any one category was present, there was an eighty-seven percent likelihood that at least one additional category would be present. ACE categories were approximately equal in their impact.

ACE scores are highly correlated with serious emotional problems, health risk behaviors, social problems, adult disease and disability, mortality, high health care and other costs, and worker performance problems. ACE scores are significantly correlated with depression, attempted suicide, hallucinations, the use of antipsychotic medications, the abuse of substances, multiple sex partners, and increased likelihood of becoming a victim of sexual assault or domestic violence. Several measures of worker performance are also related to ACE scores, including absenteeism, serious financial problems, and serious job problems. High ACE scores are significantly related to liver disease, chronic pulmonary obstructive disease, heart disease, autoimmune disease, and lung cancer. Sixty percent of people with an ACE score of 0 live to age 65, but more than 97 percent of those with an ACE score of 4 or more die before 65.

Anna's Story

Anna was not even three years old when the sexual abuse began. It was at the hands of a trusted caregiver, and it continued for 4 years. Her family was unaware that it was happening, and Anna did not have the language to tell them. She was seen by a number of health and human service providers, but no one recognized the signs. No one asked or looked into what might have happened to her. Instead, they focused on what was wrong: Was she learning disabled? Did she have a mental illness? When she "broke" at age 19, she was misdiagnosed as schizophrenic. For 17 years she was in the mental health system, in and out of hospitals, homeless shelters, and clinics. For 17 years, no treatment helped, and some made her worse. When she was 23, she learned from other patients that she was not the only one to have been sexually abused as a child. She diagnosed herself with PTSD. No one listened, understood, or helped her. At that time, no one had trauma training. Anna took her life at the age of 32 in the back ward of a state hospital. The lifetime cost of her care was almost five million dollars. Her story, unfortunately, is not unique.

Ann Jennings, PhD

Women are significantly more likely than men to have a high ACE score, and therefore have a higher risk for all of the above conditions, even without additional risk factors. Women are twice as likely as men to experience depression; fifty-four percent of depression in women can be attributed to childhood abuse.

Adverse experiences in childhood affect the health and behavior of adults through two primary mechanisms. First, they increase conventional risk factors such as smoking, excessive drinking, overeating and engaging in risky sex – behaviors that are often used to cope with the pain of the trauma. Second, childhood trauma affects the developing brain and body and causes

deregulation of the stress response. Biomedical, behavioral and neuroscience research is now confirming these effects.

The costs of untreated trauma are astounding. The cost of chronic illness goes far beyond the actual medical expenses ($277 billion in 2003). According to a 2007 study, the annual financial cost of chronic illness on lost work productivity is $1.1 trillion.[xi] Research on the full cost of violence and abuse to the health and social service systems has not yet been done; however, a study using 2008 health care and population data shows that the predicted incremental cost to the health care system alone ranges between $333 billion and $750 billion annually, or nearly 17 percent to 37.5 percent of the total health care dollar.[xii]

From Trauma to Trauma-Informed Care[3]

The implications of the data on violence and the ACE study are clear. Most, if not all, government agencies are already serving people with trauma histories, whether they know it or not. For those working with particularly vulnerable populations, such as women and children, veterans, people with disabilities, refugees and immigrants, and people who are homeless or in institutions, the numbers are even higher. Staff members themselves may be trauma survivors. In fact, some of the thorniest problems in health and human services today may be the result of undiagnosed trauma among staff and clients. Often, if the problem is named correctly, solutions emerge.

Trauma-informed services don't ask "What's wrong?" They ask "What happened?"

In the past decade, a new understanding of the impact of trauma stemming from violence has begun to fundamentally alter the way services are delivered. The initial work on trauma in the 1970's focused largely on posttraumatic stress disorder (PTSD) in veterans returning from Vietnam. In the 70's and 80's, the domestic violence field was instrumental in bringing attention to violence against women, and the groundbreaking *Violence against Women Act* (VAWA) was passed in 1994. In 1998, the Substance Abuse and Mental Health Services Administration (SAMHSA) launched a five-year study on "women, co-occurring disorders and violence" which highlighted how trauma can become the "central organizing principle" in a person's life, affecting the ability to form relationships, keep a job, or live in stable housing. This study made it clear that many people previously labeled as "mentally ill," "substance abusers" or "criminals" were coping with the results of severe trauma histories. The study raised awareness about how people can be "re-traumatized" by helping professionals who fail to recognize their clients' trauma histories and unintentionally recreate the dynamics of the original abuse. The study also highlighted the strength and resilience of trauma survivors.

[3] Drawn in part from Blanch, A. (2010) *From Trauma to Trauma-Informed Care*. Presentation at the Federal Partners Roundtable on Women and Trauma, April 29, Washington, DC.

Today, human service providers are increasingly making the distinction between "trauma-specific" services, which are behavioral health interventions designed to treat the specific symptoms of trauma, and "trauma-informed" practices, which can be implemented anywhere - in educational settings, in job programs and in the workplace, in housing, in law enforcement, in religious settings, in advocacy programs, and of course, in health and behavioral health settings. In a trauma-informed program, *everyone* – clinical staff, support staff, and clients – is educated about trauma and its consequences. People are alert for ways to make their environments more healing and less re-traumatizing for both clients and staff. They understand that when you have been traumatized, regaining control over the environment is the number one priority, so they emphasize safety, choice, trustworthiness, collaboration, and empowerment.[xiii] Trauma-informed services support resilience, self-care and self-healing. And because violence and healing both occur in a context, trauma-informed programs respect and include culturally specific healing modalities. Trauma-informed care is also an effective platform for building interagency partnerships.

The Importance of Listening to Firsthand Experience

One of the most fundamental values of a trauma-informed system is listening to and incorporating the voices of people who have been directly impacted by trauma. For many, the experience of trauma has been wrapped in secrecy and silence, often for years. Finding and using one's voice – particularly in a way that helps to make change – can be a profound healing experience. In the *SAMHSA Women, Co-Occurring Disorders and Violence Study* (WCDVS), peers moved from "being silent witnesses to the processes and procedures of a complex national study, to being 'allowed' to speak, to being actively engaged in providing information to make the research truly relevant to the lives of the women and children it was intended to affect." [xiv] This process had a deep and lasting impact on the study as well as on the women involved.

> *It is not enough for women to be empowered in their treatment and services. They need to be empowered in their lives. Women and girls impacted by trauma must lead us in designing, implementing and evaluating systems, programs and supports that allow them to heal and build meaningful lives in their communities. At SAMHSA, we are developing new materials and products to help the field move in this direction.*
>
> *Mary Blake, Leader of SAMHSA's Peer Trauma Development Project*

Testimony from women trauma survivors is also one of the most powerful ways to educate the public and to bring the issues to the attention of policymakers. It conveys the reality of violence and trauma in a way that can't be denied, and it provides a role model of strength, resilience and healing. Peers can make critical contributions at all stages of the change process, from educating the public and policymakers to establishing a participatory, collaborative culture in the service setting. [xv] Peer involvement rests on the belief that healing and recovery are possible for everyone, that peer to peer relationships are a tool for healing, and that each of us has something to learn from the other. It requires time to build trust and to engage in difficult conversations, and it rests on a commitment to identifying and supporting natural leaders. The Federal Partners Committee recognizes the importance of peer

involvement, and holds it as the highest value in developing trauma-informed services. The following stories of trauma and survival were shared at the roundtable.

Jacki's Story

It's wonderful to be able to talk about having lived so long and about being strong, because I wasn't always strong. I'm going to put 75 years into 14 minutes today, and I can do it – I do it sometimes before I go to sleep.

I was two years old, that's what the newspaper said, and the newspaper was old and brown like me. There was a man who took the two year old baby. Everyone was a person of color – all brown – all Negroes in those days.- People of color have gone through many names. And the paper said this man took the baby and knocked on people's doors, saying that the baby is wet and sick and hungry, let us in. And they would let him in, and he would abuse them in ways we won't discuss. He would wreck their lives forever, because in the community where I grew up, a man could never let something happen to his wife and still be a man. So the husbands demanded that no matter what had happened, they could never, ever tell anyone. The newspapers called me the "Baby Bandit."

I ended up in a mental hospital at nine years old with all these white people, even the people who cooked and cleaned were white. I had never lived around white people before, and my family was not allowed to visit. I was really traumatized. But no one dealt with what had happened. When I came out of the hospital, it was me and my alter ego that I called "my sister," and we tore up the world wherever we went. By 19, I had 5 kids. Every time I had a kid, my family would take charge.

I took the children and ran away to New York, and the welfare rights people picked me up. They said, "Come on, you can go to school, you can go to work. I got everything together, and eventually I got some of those kids back. Then along came trouble all over again. I had this fine husband. We had a big house. Then one night, I'm walking down the street and I met a man with a gun and an attitude. And when he left me I was not a person anymore. He raped 8 other women in the community. One woman died. And in the courtroom, I heard women screaming. I couldn't talk. Do you know what happened to me because I couldn't testify? I broke inside. I felt like I betrayed all these people who needed me to say that he was the one. So I left my home, my husband, my children, my world, and I lived homeless in the streets. They called me "mad." I was in and out of jail, never prison; in and out of day treatment.

Eventually I ended up in Washington, DC, walking down the streets. It was 90 degrees, but I had a coat and four jackets on. I wonder how people knew I was crazy. There was this little store, and I would go in and take whatever I wanted, because I had an attitude. I figured the world owed me a meal. There were these women that also ate there, and I wouldn't tell them my name, but sometimes they would keep the police from taking me away. I decided one day that I would kick the window in. I would break the glass with my foot. Don't ask me why. They said I was crazy, and they were probably right. I went into the store, and what that man said to me was just unbelievable. He said, "Eat, Momma, eat." It changed my life. The tears came out and I could feel something moving in my chest, something that had been frozen for a long time. And I let those girls take me to the local rape crisis center and to a hospital.

I never went back to say thanks to those women. I didn't know what to say to them. But they – and some of you in this room – have been a blessing not just to me, but to my 17 grandchildren, my 20 great grandchildren that I took out of foster care. I want to you know that my dreams have come true.

Jacki McKinney, Federal Partners Roundtable on Women and Trauma, April 29, 2010

Tonier's Story

At age 9, I believed I would amount to nothing. My mother was an alcoholic. I had 8 brothers and sisters. My mother "entertained" all the time, and when she stopped singing and laughing, I knew I would hear the footsteps coming to my door. There were a lot of sexual assaults, a lot of abuse. Sometimes I couldn't go to school, but no one asked me why. I also started drinking at age 9. When I started to drink, my mother would slap me down, but when the men came, it didn't feel as painful, so I drank.

Eventually someone noticed and they sent out a social worker. She removed us from the family immediately, and put us in foster care. I was given back to my mother, but she needed a place to live, and she had an alcoholic friend of hers who she thought was pretty cute. So I married him, and she moved in. I was pregnant, and every day he beat me. Then I started using crack cocaine, and I didn't have to feel. I thought I never had to feel anything every again. But unfortunately, the cocaine introduced me to the criminal justice system. I stand before you with 86 arrests and 66 convictions. They told me I was going to spend the rest of my life in and out of prison or on the streets. They kept calling me crazy and I didn't know why.

I was a "repeat offender," and every time I was arrested it got worse. One time I told them I was pregnant – I was 5 months pregnant at the time – and they told me no, I had a urinary tract infection. I was called manipulative, attention seeking. I spent time in 20-day programs – just long enough to get some rest and figure out when to get high again. I was raped so many times I can't count them, but they assigned me a male counselor. At one point I was alone with this man, sharing the things that had happened to me, and how despite it all I had graduated the program, and he raped me. And he told me, "No sense telling anyone about it. You're just a convict, a prostitute. He has since been held accountable for his actions, but given my history, maybe a male counselor wasn't the best thing for me.

One of the worst things was being put into seclusion or restraint. I don't care if the room is padded or not, it triggers my issues with my mother. My survival mode kicks in. One time I pushed a tray out my face, and someone got hit with the tray. So they call a code, and then I'm down on the ground being restrained. Restraining a rape victim? Doing more harm, causing more trauma.

I lived under a bridge for 19 years. But then I ended up in the Maryland Correctional Institution for Women, and I got into this program. The first thing they told me was that what had happened to me wasn't my fault. And you know what? After years of everyone telling me that I deserved everything I got, I believed them, and my thought process changed. One of the best things I did was to take a course on how to be a mother. I had lost 4 kids to the system, I knew how to do that, but I didn't know how to take care of a kid. I had been told that when they cry, they're attention-seeking. When you come from abuse, sometimes it takes real work not to be abusive. And I didn't want that for my daughter.

Today I'm a home owner. My daughter goes to a private school. Treating my trauma, you kept me out of your system, and I'm grateful. You also helped me to break that intergenerational curse I had in my family. My daughter will never know what I felt. She doesn't know what it's like to live in the projects, to be hungry. All she knows is that her mom loves her, feeds her. What if, at age 9, someone had recognized my trauma? Is it possible that I could have become the woman I am today without the substance abuse, the homelessness, the mental health diagnoses? And I have one last question. When I was in prison – 83 times in and out – when you looked across your desk and saw me, would you have seen the woman I am today? Would you have been able to see a woman who would be speaking to all of you at a federal roundtable meeting? Do you truly believe in the people you serve? Treat the trauma. I promise you, you're going to get different results.

Tonier Cain, Federal Partners Roundtable on Women and Trauma, April 29, 2010

Trauma as a Cross-Cutting Issue

U.S. Department of Defense (DOD)

Women make up an increasing percentage of our Armed Services, and play a critical role in the defense of our country. A focus on gender-based research and practice within DOD is therefore essential. However, 85 percent of the military are men, and violence and trauma clearly affect them, as well. Key issues for DOD include implementing a universal precautions and trauma-informed approach in the military healthcare system, addressing trauma experienced by women serving in combat, and military sexual trauma (MST).

- Women in the US military have steadily increased over the past two decades, and currently make up 15 percent of the Armed Services.[xvi]
- Since 9/11/2001, 53 percent of female Service members have been deployed. Of that group, 44 percent deployed two or more times, 85 percent deployed to a combat zone, and 42 percent report being involved in combat operations.[xvii]
- By the end of 2009, 125 women had died in deployment in Iraq and Afghanistan, 68 of them by hostile action.[xviii]
- Women veterans are 9 times more likely to have PTSD if they have a history of military sexual trauma, 7 times more likely if they have a history of childhood sexual assault, and 5 times more likely with a history of civilian sexual assault.[xix]

Given the data on violence in society, as well as the specific nature of the military, implementing a "universal precautions" approach to trauma would be prudent. Assessing for trauma histories as part of a comprehensive medical exam could improve both effectiveness and efficiency of military healthcare, avoid re-traumatization, and guide efforts to prevent MST and PTSD based on identified risk factors. The military healthcare system already has excellent healthcare benefits (for members in uniform, families, and retirees) designed to respond to both gender and age. Preliminary discussions are underway about the potential of adding a universal trauma screening and assessment to this system.

While U.S. policy bans female service members from serving in direct ground combat, women may be attached temporarily to all-male combat units to perform specific functions. As a result, women may engage in the same direct combat actions as men, although they may not have received the same training and may be less likely to be officially or publicly recognized as combatants, potentially impeding the process of healing. Alternatively, women combatants may be stigmatized as "victims" rather than celebrated as warriors. Ensuring that trauma-informed and trauma-specific services are available and easily accessed by women combat vets is a high priority.

Women may also be exposed to sexual assault or harassment, which has the potential to compound combat stress or trauma that occurred prior to enlistment. Some women may be reluctant to seek help for trauma, fearing possible ramifications for career advancement. The

Sexual Assault Prevention and Response Office in the Office of the Secretary of Defense has a number of initiatives designed to prevent sexual assault and to encourage women to get help for trauma-related problems. They have partnered with the civilian community in Sexual Assault Awareness Month, have implemented a comprehensive sexual assault education and prevention strategy, and conduct officer training beginning in college or at one of the three Military Service Academies.

The Family Advocacy Program (FAP), managed by the Office of the Secretary of Defense and implemented by the military Services, provides resources for families experiencing child abuse and domestic abuse, including prevention services, early identification and intervention, support for victims, and treatment for offenders. FAP is responsible for ensuring victim safety and access to support and advocacy services as well as ensuring that offenders receive appropriate intervention and treatment services. FAP programs and services are available to service members, their spouses/intimate partners, and children.

Additional Resources:
Department of Defense Advisory Committee on Women in the Services (DACOWITS). Annual Report 2009.
http://dacowits.defense.gov/annual_reports/DACOWITS%2009%20Final%20Report.pdf
Department of Defense FY 2009 Annual Report on Sexual Assault in the Military
http://www.sapr.mil/media/pdf/reports/fy09_annual_report.pdf
Department of Defense Report to the White House Council on Women and Girls, Sept 1, 2009
http://www.defense.gov/pubs/pdfs/DoD_WHC_on_Women_and_Girls_Report_personal_info_redacted_C82A.pdf
Department of Defense Family Advocacy Program:
http://www.militaryhomefront.dod.mil/portal/page/mhf/MHF/MHF_HOME_1?section_id=20.80.500.188.0.0.0.0

U.S. Department of Education (ED)

The Successful, Safe and Healthy Students program is included in the Administration's Elementary and Secondary Education Act (ESEA) reauthorization proposal. The new program, which builds off of the Safe and Supportive Schools program, would increase the capacity of States, high-need districts, and their partners to provide the resources and supports necessary to ensure that students are safe, healthy, and successful. Further, the program would also provide increased flexibility for States and districts to design and implement strategies that best reflect the needs of their students and communities, which may include activities that ensure schools offer girls a safe and supportive environment. Programs and activities supported by this program would include those that reduce or prevent drug use, alcohol use, bullying, harassment, or violence and promote and support the physical and mental well-being of children.

ED - Office for Civil Rights (OCR)

Sexual harassment of and sexual violence against girls and women is a real and serious problem in education at all levels. It can affect any student, regardless of race or age. Sexual harassment can threaten a student's physical or emotional well-being, influence how well a student does in school, and make it difficult for a student to achieve his or her career goals. A school has a responsibility to respond promptly and effectively to sexual harassment. Lack of education on and ineffective methods of combating sexual harassment and violence may create unsafe learning environments for women and girls, in particular.

- A Department of Justice study estimated that 20 to 25 percent of college women are victims of rape or attempted rape during their time in college and 15.5 percent of women are subjected to sexual violence during an academic year.[xx]
- In 2008, there were nearly 3,300 forcible sex offenses reported by college campuses.[xxi]
- In the 2007-2008 school year, there were 800 reported incidents of rape and attempted rape and more than 3,800 reported incidents of other sexual batteries at public high schools.[xxii]
- A 2001 study that surveyed 2,064 students between 8th grade and 11th grade reports that 83 percent of girls have experienced sexual harassment, and 38 percent of students have been sexually harassed by a teacher or other school employee.[xxiii]

Violence against Girls in Schools

Most people think of Title IX as the law that prohibits discrimination against girls in athletics, but it is much more. Title IX protects individuals from sexual harassment, a form of sex discrimination, and sexual assault, which is a form of sexual harassment. It is all covered. The harassment and discrimination policies and procedures that schools are required to have, must cover not only discrimination and harassment by school employees of a student, but also student-on-student harassment and third-party harassment, such as harassment by a visiting athlete or a volunteer in the program. The law requires that harassment and discrimination policies and procedures address all these issues. Also, the effects of trauma on an individual may result in that individual having a disability. Schools have a responsibility under the disability laws to support students with disabilities, both to protect them from discrimination and to provide them accommodations if necessary.

Kristi Bleyer, Office for Civil Rights

OCR enforces Title IX of the Education Amendments of 1972, which prohibits discrimination on the basis of sex, including sexual harassment, in all public and private educational institutions receiving federal funds. The law protects both male and female students from sexual harassment by school employees, other students, or non-employee third parties. The Department of Education and OCR are committed to ensuring that all students feel safe at school so that they have the opportunity to fully benefit from the school's education programs and activities. OCR helps schools combat sexual harassment and sexual violence in a variety of ways:

- OCR investigates and resolves complaints alleging that schools receiving federal funds have failed to protect students from sexual harassment and sexual violence. Resolution agreements often require schools to adopt effective anti-harassment policies and procedures, train staff and students, and address the incidents in question. Between FY

2007 and FY 2010, OCR has received approximately 170 complaints annually alleging sexual harassment. Approximately 60% of these complaints came from elementary and secondary schools.

- OCR initiates compliance reviews focused on specific issues. Such reviews increase the impact of OCR's resources, complement the complaint resolution process, and can benefit larger numbers of students. Over the past 5 years, OCR has initiated 12 sexual harassment compliance reviews, including 3 in FY 2009. In FY 2010, OCR initiated a sexual harassment/sexual violence review of a school district, and a sexual violence review of a postsecondary institution.
- OCR issues policy guidance to inform schools of their obligation to provide an environment free from sexual harassment.[xxiv] In October 2010, OCR issued guidance to help school districts, colleges, and universities that receive federal funding combat harassment and bullying in schools. The letter explains educators' legal obligations to protect students from student-on-student harassment, including sexual and gender-based harassment.[xxv] In April 2011, OCR issued guidance to help school districts, colleges and universities that receive federal funding address sexual violence in schools. The letter explains that the requirements of Title IX pertaining to sexual harassment also cover sexual violence and lays out the specific Title IX requirements applicable to sexual violence.[xxvi]
- OCR field offices offer schools technical assistance to encourage them to improve their anti-harassment policies and procedures and to assist students and their parents to work with schools to enhance the schools' anti-harassment capability.

In addition, OCR recently modified its requirements for the Civil Rights Data Collection, which collects data on key education and civil rights issues from nearly 7,000 school districts. For the first time, a reporting school district is now required to submit information regarding harassment, including whether it has a sexual harassment and bullying policy, school-level data on reported allegations of harassment or bullying based on sex, and school-level data on students disciplined for harassment or bullying based on sex. ED – Office of Postsecondary Education (OPE)

OPE administers the *Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act*, which requires all colleges and universities that participate in federal financial assistance programs to (1) collect statistics of crimes that occur on or around campus; (2) issue timely warnings to the campus community about crimes that may threaten the safety of students or employees; (3) prepare and disseminate an annual report that contains the crime statistics above and the institution's campus security policies; and (4) maintain a daily log of crimes that occurred on or around campus.

ED – Office of Safe and Drug-Free Schools (OSDFS)

The mission of OSDFS is to create safe schools, respond to crises, address alcohol and drug abuse and violence, and promote the health and well being of students, as well as the development of good character and citizenship. OSDFS administers grants, coordinates

programs, and recommends policy for improving conditions for learning. OSDFS participates in interagency committees specifically focused on gender-based volence prevention. The office regularly posts information about bullying and gender-based violence on its listserv and in weekly newsletters and hosted a gender-based violence summit in April 2011. Two examples of OSDFS grant program that may address gender-based violence as part of their program activities are the Safe Schools/Healthy Students (SS/HS) initiative and the Safe and Supportive Schools (S3) initiative.

The ED Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention, administered by OSDFS, assists institutions of higher education in developing, implanting, and evaluating alcohol, other drug, and violence prevention policies and programs that will foster students' academic and social development and promote campus and community safety. A number of resources are available related to gender-based violence.

ED – Office of Special Education and Rehabilitative Services (OSERS)

The National Institute on Disability and Rehabilitation Research (NIDRR), within OSERS, currently sponsors two research grants that are evaluating interventions aimed at preventing violence against women with disabilities. Both violence prevention programs that are being studied are conducted in collaboration with the Centers for Independent Living, which are administered by the Rehabilitation Services Administration (RSA) within OSERS. The violence prevention programs aim to increase knowledge, safety-promoting behaviors, and self-efficacy of women with disabilities. These research grants are being conducted by Portland State University and the University of Montana**.**

Additional Resources:
Higher Education Center http://higheredcenter.ed.gov
Office for Civil Rights http://www2.ed.gov/about/offices/list/ocr/index.html
Office of Safe and Drug Free Schools http://www2.ed.gov/about/offices/list/osdfs/index.html
Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act
http://www2.ed.gov/admins/lead/safety/campus.html
Studies sponsored by NIDRR
http://www.naric.com/research/record.cfm?search=1&type=all&criteria=violence&phrase=no&rec-1774
http://www.naric.com/research/record.cfm?search=1&type=all&criteria=violence&phrase=no&rec=2254

U.S. Department of Health and Human Services (DHHS)
Administration for Children and Families (ACF)
Family Violence Prevention and Services

The Family Violence Prevention and Services Act (FVPSA) provides the primary federal funding stream dedicated to the support of emergency shelter and related assistance for victims of domestic violence and their dependents. The FVPSA deals with issues of trauma and violence

against women every day, with every person the program serves. In addition to supporting a national network of domestic violence services, The Administration for Children and Families (ACF) funds state domestic violence coalitions, national resource centers, training centers, culturally specific institutes, a national hotline and an institute on trauma and mental health.

Each year, domestic violence programs funded through FVPSA serve more than 1.2 million survivors of domestic violence and their children. Domestic violence has been associated with a wide range of mental health consequences, including depression, post traumatic stress disorder, and a range of behaviors related to trauma reactions. For many survivors, these issues may resolve with increased safety and support, but others may benefit from additional resources and treatment. Survivors of domestic violence, and their children who experience that trauma directly or vicariously, are better served in trauma-informed settings where staff take the trauma into account, avoid triggering reactions, adjust their behavior to accommodate trauma reactions, and allow survivors to manage their trauma through a range of coping strategies.

Domestic Violence: Where Mental Health and Social Justice Meet

Our center was established in 2005 by DHHS to serve as a national resource on domestic violence and mental health. To get a picture of the problem, on any given day in 2009 about 9,000 women were turned away because there weren't enough services.

Integrating (mental health and domestic violence) services has taken a very long time because historically, mental health has been used against women – by the abusers, by the courts, and by the child welfare system. It works because an abuser is more credible than a woman who has had a history of mental health treatment.

We're working on changing the culture of DV programs to become trauma-informed, and the mental health system, to be aware of DV. One small change can make a difference: instead of only asking if you are a danger to yourself or others, asking if you are in danger from another person.

So how do we bring in a social justice lens? We need to think not only about the traumatic effect of abuse, but also about the social realities of ongoing abuse, violence and danger, as well as the social structures that support abuse of power.

Carole Warshaw, MD

- More than 1500 domestic violence programs across the country respond to more than 1.4 million crisis calls annually.[xxvii]
- More than 300,000 adults and children were provided housing in 2005.[xxviii]
- Across studies of battered women, rates of mental health problems are very high: 54-84 percent for PTSD; 63-75 percent for depression; and 38-75 percent for anxiety disorders.[xxix]
- More than half of all women seen in a range of mental health settings are currently or have in the past experienced abuse by an intimate partner.[xxx]
- Three of five discretionary ACF grants targeting the hardest to serve populations focus on abuse survivors with mental health and/or substance abuse problems.
- In a 2008 study of more than 3,400 domestic violence survivors in eight states, 86 percent of participants requested help with obtaining counseling.[xxxi]

- In the same study, 98 percent requested help with safety issues and learning about options, 97 percent with understanding domestic violence and paying attention to their own needs, 95 percent with making connections with others, 93 percent with obtaining emotional support, and 92 percent with dealing with upsetting feelings or stress.

Many domestic violence survivors seek counseling services as an important part of their recovery from trauma. Very limited research exists on evidence-based treatments for addressing mental health issues in the context of ongoing domestic violence. In addition, there are few controlled studies on the treatment of complex trauma for domestic violence survivors. Current best practice approaches involve combining core principles of domestic violence advocacy work with evidence-informed trauma treatment. Research is needed to assess the types of interventions that will be most helpful to survivors of domestic violence.[xxxii]

Currently there is a strong movement across the country for family violence programs to become trauma-informed. Because it is based on "what happened to you not what's wrong with you," the approach is helpful in empowerment-oriented domestic violence programs. Several states have received grants to strengthen the partnership between domestic violence and behavioral health providers and to expand training in trauma-informed care. Trauma-informed care is also being extended to programs for children exposed to domestic violence, teaching mothers to identify and address the impact of trauma on their children and teaching children the skills they need to talk it through.

As part of the network of domestic violence National and Special issue Resource Centers funded through FVPSA, the National Center on Domestic Violence, Trauma and Mental Health is committed to developing comprehensive, accessible, and culturally-relevant responses to the range of trauma- and mental health-related issues faced by domestic violence survivors and their children, promoting advocacy that is survivor-defined and rooted in the principles of justice, and eradicating the social and psychological conditions that contribute to interpersonal abuse and violence across the lifespan. The Center offers information about current practice, model approaches and policies, and successful collaborations as well as individualized training, capacity-building assistance, and consultation. They are leading a six-state initiative to help domestic violence coalitions and programs to implement trauma-informed program practices and services. For more information they can be reached at 312-726-7020 or www.dvmhpi.org.

Additional Resources:
http://www.acf.hhs.gov/programs/fysb/content/programs/fv.htm
National Online Resource Center on Violence against Women http://www.vawnet.org/
National Center on Domestic Violence, Trauma and Mental Health at the Domestic Violence and Mental Health Policy Initiative http://www.dvmhpi.org/Aboutdvmh.htm

DHHS – Agency for Healthcare Research and Quality (AHRQ)

The Agency for Healthcare Research and Quality's (AHRQ) mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans through services research, knowledge synthesis, and development of tools for improving services and practice. Women's health is one of AHRQ's priority areas. Since violence and trauma affect all areas of women's health, healthcare providers need to be informed about and skilled in addressing these issues. Research on the efficacy of trauma-informed care as well as tools to assist in training and implementation would contribute to this goal.

- ACE study researchers believe that women's significantly higher rates of childhood abuse may explain their proneness to ill-defined health problems like fibromyalgia, chronic fatigue syndrome, obesity, irritable bowel syndrome, and chronic non-malignant pain syndromes. [xxxiii]
- Including a trauma assessment as part of a comprehensive medical evaluation led to a 35 percent reduction in doctor office visits during the subsequent year, an 11 percent reduction in emergency visits and a 3 percent reduction in hospitalizations.[xxxiv]
- Only 23 percent of physicians, nurses, physician assistants, and medical assistants believe they have strategies that could assist victims of domestic abuse.[xxxv]
- A study using 2008 health care and population data shows that the predicted incremental cost of violence and abuse to the health care system ranges between $333 billion and $750 billion annually, or 17 to 37.5 percent of the total health care dollar.[xxxvi]

In the late 1990's AHRQ issued an RFA on violence against women, resulting in a number of tools currently available on their website, including an assessment instrument to evaluate domestic violence programs in hospital settings, a manual of evidence-based practices for medical examination and treatment of victims of sexual assault, and a review of programs and tools that improve care for victims of domestic violence. AHRQ works in partnership with other HHS agencies to develop and disseminate knowledge about trauma and trauma-informed care in primary care settings.

Additional Resources:
http://www.ahrq.gov/research/womenix.htm
Academy on Violence and Abuse http://www.avahealth.org/

Dolezi, T., McCollum, D., and Callahan, M. (2009) *Hidden Costs in Health Care: The Economic Impact of Violence and Abuse.* Eden Prairie, MN: Academy on Violence and Abuse.

DHHS – Centers for Disease Control and Prevention (CDC)

Within the CDC mission to promote public health and safety, the National Center for Chronic Disease Prevention and Health Promotion has a strong focus on chronic disease and reproductive health, both profoundly affected by violence against women. The Adverse Childhood Experiences (ACE) study, a partnership between CDC and Kaiser Permanente, has been a major force in bringing the issue of trauma and abuse to public attention.[xxxvii] Next steps include examining the gender implications of the ACE study, researching the link between women's cardiovascular health risks and ACEs, conducting gender-based data analyses, and considering the impact of violence on the developmental trajectory of women. Compared to men:

- Women experience significantly higher rates of abuse in all ACE categories except physical abuse and physical neglect.[xxxviii]
- Women report being victimized by family members significantly more often.[xxxix]
- Women experience significantly higher levels of depression across all ACE scores.[xl]

Starting in 2009, CDC included an optional module on ACEs in their Behavioral Risk Factor Surveillance System (BRFSS) survey, an extensive national telephone survey conducted through state health departments. The first report on findings was released in December 2010.[xli] These findings indicate that ACEs (see list on page 3) were common in a representative sample of adults. Almost two-thirds (59 percent) reported at least one ACE. CDC partnered with the World Health Organization (WHO) and other agencies to develop an ACE instrument designed to be adaptable to persons with a range of economic and cultural differences and to address forms of violence not included in the original ACE questionnaire (*e.g.*, war, disaster, extreme poverty).

Additional Resources:

Addressing Trauma in the Child Welfare System

Child Welfare has an outdated image that does not serve the greater good and the needs of vulnerable children and young women. 67% of abused children are less than 1 year old; 80% are less than 3 years old. Adopted and fostered children can be forced into prostitution, beaten or forced to sell on the street. Child welfare can help to change the picture. There are opportunities that abound, and we must come together. Stop blaming us. When there's a two-month old that's been raped and then brutally murdered, we didn't do that. And the most horrifying thing for a worker in our agency is to take a baby out of a mother's arms. Go and find out what is going on in child welfare. Find out what the workers go through. You want to talk trauma? It's trauma to the 10th power for child welfare workers. Child fatalities? At Christmas time, the rate goes up. Summer is coming, the rate goes up. We will fail girls and also young boys and men if we allow differences in perspective to keep us apart and keep us from protecting children. In modern society, we create things that can be tossed away. We have treated our girls and young women the same way. We think of them as disposable. And that's a tragedy. Let's go with the conservation approach. Let's save our girls. Let's save our planet.

Sharon Cadiz, PhD

The ACE study
http://www.cdc.gov/nccdphp/ace/index.htm
Lifecourse Effects of Trauma in the Life of Women and Girls: Findings from the ACE Study
https://services.choruscall.com/links/womenshealth.html
WHO (2006) *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence*

DHHS – Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Mental Health Services (CMHS)

More than half of the people served by mental health systems across the country are female, and the vast majority have histories of trauma and abuse. Trauma affects how women and girls engage in services, what outcomes are achieved, and the mental health of future generations.

- 85 – 95 percent of women in the public mental health system have histories of physical or sexual abuse, most as children.[xlii]
- Symptoms considered indicative of psychosis and schizophrenia, particularly hallucinations, are strongly related to childhood abuse and neglect. Large-scale general population studies indicate the relationship is causal, with more severe abuse leading to higher symptomatology.[xliii]
- Prospective studies demonstrate an association between child sexual abuse and subsequent increases in rates of both childhood and adult mental disorders.[xliv]
- One out of four adolescent girls exhibits depressive symptoms, a rate that is 50 percent higher than boys. One of ten girls exhibits severe depressive symptoms. Abused girls have twice the number of symptoms of poor mental health as those who have not been abused.[xlv]
- The majority of patients treated for PTSD in randomized trials improve, making these approaches some of the most effective mental health treatments devised to date.[xlvi]

Cultural Concerns and Historical Trauma

To understand trauma means being acutely sensitive to the conditions under which people grew up, to how they live today, to the journeys they have taken along the way, and to the meaning they make of their experiences. Culture can affect what behaviors are seen as legitimate, how distress is expressed, and how healing occurs. Cultural conditions may also affect patterns of behavior for generations. For example, during much of this country's history, a black person put his or her life at risk by antagonizing a white person. Tight control over children's behavior – still common in some African American communities - was a matter of survival.

Women who are not part of the dominant culture face "multiple oppressions," and newcomers (refugees and immigrants) face the added trauma of cultural dislocation. While some of us may see extreme violence as an aberration, for some it is a part of life.

Many groups also carry the wounds of "historical trauma," defined by Maria Yellow Horse Brave Heart as "cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma." Historical trauma can come from many sources. Jews experienced the holocaust, Japanese-Americans were interned in camps during WWII, Hawaiians and Mexicans were colonized by the US. The impact of historical trauma can be especially profound in situations where entire cultures were lost or destroyed, as with enslaved Africans and American Indians/Alaskan Natives (AI/AN).

Historical trauma highlights the need for group as well as individual healing. Overlooking cultural concerns can lead to re-traumization, and inattention to the historical root causes of social epidemics such as violence against AI/AN women and HIV/AIDS among African Americans effectively repeats the social trauma perpetrated against these groups.

Trauma-integrated care - a combination of trauma-specific treatments and trauma-informed environments - has been shown to be effective in providing mental health services and supports for women with complex mental health and trauma histories. Mental health services that are not trauma-informed may inadvertently do serious psychological damage through practices such as seclusion and restraint, housing without adequate privacy provisions, crisis intervention techniques that replicate traumatic dynamics, and forcing parents to lose parental rights in order to access services. The Center for Mental Health Services (CMHS) has promoted trauma-informed services through national centers on adult and children's trauma and is currently working to integrate principles of trauma-informed care throughout their portfolio, including a trauma-informed systems guide, development of trauma-informed peer leadership and training materials, a trauma focus within Mental Health Transformation grants, and an effort to include trauma in the integration of health and mental health. One new project launched as a result of the roundtable involves training almost 200,000 clinical service providers serving more than 6 million adults and children through the National Council of Community Behavioral Health.

Additional Resources:
Najavits, L. M. (2007) Psychosocial treatments for posttraumatic stress disorder. In P.E. Nathan and J.M. Gorman, (Eds.) *A Guide to Treatments that Work* (3rd Edition, pp 513-529) NY: Oxford.
National Center on Trauma-Informed Care http://mentalhealth.samhsa.gov/nctic/
National Child Traumatic Stress Network http://www.nctsnet.org/nccts/nav.do?pid=hom_main
The Anna Institute http://annafoundation.org/ To join listserv, email afj@gwi.net
Action Steps for Improving Women's Mental Health
http://download.ncadi.samhsa.gov/ken/pdf/OWH09-PROFESSIONAL/ActionSteps.pdf

DHHS – SAMHSA
Center for Substance Abuse Treatment (CSAT)

The Center for Substance Abuse Treatment (CSAT) has known since the early 1990's that many women in substance abuse treatment have trauma histories – histories that include but extend far beyond domestic violence. As a partner in the *Women, Co-Occurring Disorders and Violence Study*, CSAT learned that in order to be effective, substance abuse and mental health services must work hand-in-hand to address the trauma underlying the symptoms, and in order to interrupt the intergenerational cycle of violence, services must focus on the entire family. CSAT's current work emphasizes working with all family members and kinship arrangements - including fathers, children, extended family members, foster care families, and others – to stabilize situations and do family healing work.

- Substance abuse can lead to worsened medical and mental health conditions, infectious diseases (*e.g.*, HIV/AIDs), unintentional injuries, low birth weight, premature deliveries, developmental disabilities, domestic violence and child abuse and neglect.[xlvii]
- A high percentage of people who are addicted to substances have experienced trauma as children or adults.[xlviii] More than half of all women seeking substance abuse treatment report one or more lifetime traumas.[xlix]

- Helping clients gain control over trauma-related symptoms greatly improves their chances of recovery. [l]
- Women are more likely than men to meet criteria for PTSD once exposed to trauma.[li]
- Alcohol and drug use can be, for some women, an effort to manage PTSD symptoms. [lii]
- Perpetrators of violent assault are often under the influence of substances. Helping the client protect against future trauma is an important part of treatment.[liii]

Given these statistics, it is of critical importance that substance abuse programs become trauma-informed. A universal precautions approach is essential, staff must be able to work with the person "where he or she is", and environments must clearly demonstrate safety and protection for both mothers and their children. Women can easily be re-traumatized if staff don't focus on relationships or are insensitive to women's trauma histories. For example, when women are separated from their children during an initial assessment, they may become extremely fearful for the safety of the child – especially if they see the child being led away by a male staff person.

CSAT is currently working to ensure that all their grantees in the Women, Children and Family Treatment Program are trauma-informed, including the Residential Treatment for Pregnant and Post-Partum Women (PPT) grantees. PPT is a gender and culturally specific program that targets traditionally underserved populations, especially racial and ethnic minority women and their minor children. A "learning collaborative" approach is being used, emphasizing participatory learning, training and technical assistance, site visits, and action planning. The goal is for all grantees to adopt and implement at least one best practice model for trauma-informed care within the next 12 months.

Additional resources:
National Center on Substance Abuse and Child Welfare http://www.ncsacw.samhsa.gov/
Najavits, L.M. (In press) An implementation guide to Seeking Safety. In: D. Springer, A. Rubin (Eds.), *Substance Abuse Treatment for Youths and Adults from Clinician's Guide to Evidence-Based Practice Series*. Hoboken, NJ: John Wiley.
Najavits, L.M., Gallop, R., and Weiss, R. (2006) Seeking Safety Therapy for Adolescent Girls with PTSD and Substance Use Disorder: A Randomized Controlled Trial. *The Journal of Behavioral Health Services and Research, 33(4)*:453-463.
Center for Substance Abuse Treatment (2009) Substance abuse treatment: Addressing the specific needs of women. *Treatment Improvement Protocol (TIP) Series 51.* HHS Publication (SMA) 09-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration.

DHHS - Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau, Office of Women's Health

The Health Resources and Services Administration (HRSA) is the primary federal agency for improving access to healthcare services for people who are uninsured, isolated or medically vulnerable. The HSRA Office of Women's Health focuses on reducing sex and gender-based[liv] disparities in health care and ensuring that women from all walks of life receive quality health

care. Since 1991, HRSA has been working to address the consequences of the epidemic of intimate partner and family violence through policy development, training, technical assistance, service delivery, education, and research. Efforts include domestic violence service linkages through primary healthcare sites, grants to improve identification and treatment of victims of domestic violence during pregnancy, and training of healthcare professionals. HRSA's Women's Health Databook, currently in its 9th edition, presents current and historical data on some of the most pressing challenges facing women, their families, and their communities; profiles women's health from a variety of data sources; highlights emerging issues and trends in women's health; and highlights racial/ethnic, sex/gender, age and socioeconomic disparities. The health indicators section of the Databook includes information on intimate partner violence. The Bright Futures for Women's Health and Wellness (BFWHW) emotional wellness guides, available in English and Spanish online, focus on achieving better physical, emotional, social and spiritual health by encouraging healthy relationships and behaviors. The guides are based on the latest research on emotional wellness, and include tips and information on coping skills, self-appreciation, finding balance and purpose, and connecting with others.

Several new initiatives address violence prevention and trauma, including a project in collaboration with the National Institute of Justice (NIJ) and other DHHS agencies focusing on teen dating violence. A continued focus on trauma-informed women's health services is planned, starting with the HRSA Women's Health Coordinating Committee as a structure for initiating widespread education and action.

Additional Resources:
Women's Health USA 2010 Databook http://www.hrsa.gov/womenshealth/
Trauma and Disaster Preparedness http://gainscenter.samhsa.gov/atc/
DHHS, HRSA. *One Department: Overview of Activities on Violence Against Women 2008-2009*
http://www.womenshealth.gov/pub/owh/violence-against-women.cfm
Stop Bullying Now http://www.stopbullyingnow.gov/

DHHS – National Institutes of Health (NIH), Office of the Director, Division of Program Coordination, Planning and Strategic Initiatives, Office of Research on Women's Health

Violence against women is a major research priority across the National Institutes of Health (NIH). In FY 09, more than $41 million was spent on 135 research projects on violence against women in 10 different research institutes, centers and offices. The majority of studies were conducted by the National Institutes on Mental Health, Alcohol Abuse and Alcoholism, Drug Abuse, and Child Health and Human Development, and projects on violence against women were also supported through the Institutes on Nursing Research; Heart, Lung and Blood; and General Medical Sciences. Research spans a wide variety of topics, from PTSD and consequences of violence in different populations and age groups, to risk and protective factors and research on services and interventions. Knowing the factors that put women at risk for violence is key to prevention. For example, violence against women is often associated with alcohol, and women are at higher risk for violence when they are pregnant or post-partum.

The Director of Research Programs serves as the coordinator of violence against women programs across NIH. The Office works collaboratively with other federal agencies and with academia to ensure that research data are available and accessible to policymakers, practitioners, and educators. While much progress is being made, further research is needed on the impact of trauma-informed care on health and social outcomes for women.

Additional Resources:
NIH Research Portfolio Online Reporting Tools (RePORT) Categorical Spending.
http://report.nih.gov/rcdc/categories/

DHHS – Administration for Children and Families, Office of Refugee Resettlement (ORR)

Refugees leave their home countries involuntarily and, by definition, cannot return home because of a "well-founded fear of persecution." The trauma experienced by refugee women is likely to have been prolonged and repeated, consciously caused, and exacerbated by forced exile. Sources of trauma for refugees may include war, rape or atrocities, or "disappearance" of friends and family. Trauma for women refugees may also result from previous experiences within the country of origin – domestic violence, rape, honor killings, torture and combat. Women and girl refugees are extremely vulnerable to gender-based violence during migration and in refugee camps, and upon resettlement, women and girls continue to be vulnerable to gender-based violence, discrimination and exploitation.

- More than 2.5 million refugees have been resettled in the US since 1975. Approximately 75 percent of all refugees are women and children.[lv]
- Women refugees have higher levels of PTSD severity and more mental health symptoms than men.[lvi]
- Women and children comprise 80 percent of international war casualties and increasingly serve as combatants.[lvii]
- Women and girls are at high risk for torture due to their small size and in order to retaliate or intimidate family members.[lviii]
- Women and girls are particularly vulnerable to gender-based violence during migration and in refugee settings.[lix]
- Women refugees without employment are at higher risk for sexual exploitation and abuse; those who work may face increased risk for violence at home.[lx]

While the Office of Refugee Resettlement (ORR) is primarily responsible for helping refugees to gain independence, a partnership with SAMHSA provides a focus on the development of trauma-informed services. Such services are essential to ensure safety for refugee women, to avoid re-traumatization, and to recognize trauma-based symptoms that might be misdiagnosed as mental illnesses. In 1995 ORR established the Refugee Women's Network, a national nonprofit dedicated to empowering refugee and immigrant women through leadership training, education and advocacy. ORR also supports women trauma survivors through their Torture Treatment, Assistance for Victims of Human Trafficking, and Ethnic Self-Help programs.

Additional Resources:
Refugee Women's Network http://www.riwn.org/
Women's Refugee Commission (2009). *Peril or Protection: The Link between Livelihoods and Gender-based Violence in Displacement Settings* http://womensrefugeecommission.org/
Blanch, A. (2008*) Transcending Violence: Emerging Models for Trauma Healing in Refugee Communities.* CMHS/SAMHSA.
http://www.theannainstitute.org/RefugeeTraumaPaperJuly212008.pdf

DHHS - Office on Women's Health (OWH)[4]

The Office on Women's Health (OWH) strives to ensure that "all women and girls are healthier and have a better sense of well being" by developing innovative gender-based programs, educating health professionals, and disseminating health information. Violence and trauma affect the health of women and men across the lifespan and across generations. In partnership with other agencies, OWH focuses on breaking the intergenerational cycle of violence through prevention, early intervention and trauma-informed treatment.

- Trauma survivors report more symptoms, have higher rates of both physical and mental health problems,[lxi] use more healthcare services, and have higher health care costs.[lxii]
- Trauma survivors use significantly more costly healthcare services and fewer preventive interventions such as mammograms, cervical cancer screenings, and regular dental care,[lxiii] in part due to re-traumatization (secondary victimization).[lxiv]
- Secondary victimization increases mental health symptoms.[lxv]
- Current healthcare training requires only 2 hours on trauma for medicine and dentistry and 6 hours for nursing, and focuses primarily on mandated reporting.[lxvi]

Health and social service providers interact on a routine basis with women and children who are survivors of domestic violence, sexual assault, childhood sexual abuse, combat, street violence, and natural disasters. Without adequate training in trauma, health care providers can unintentionally re-traumatize patients through procedures such as dental and pelvic exams (for sexual abuse survivors), ER visits (where medical staff may dismiss or ignore the woman's experience), or even surgery (where a person loses control over the situation.) Healthcare providers working in school systems or other child-serving agencies who are not trauma-informed can easily misinterpret trauma symptoms as behavioral problems.

Medical education is one key strategy in developing trauma-informed care. Widespread dissemination of basic knowledge about trauma is another. In order to provide effective healthcare, all health and social service provides, regardless of specialization, must be trained

[4] Drawn in part from Raja, S. (2010*) Interdisciplinary Approaches to Trauma-Informed Care: Survivors and the Healthcare System.* Presentation at Federal Partners Roundtable on Women and Trauma, April 29, Washington, DC

to be trauma-informed. Health care professionals can become trauma-informed by making simple changes such as allowing the patient to take a break if the exam becomes stressful and knowing what types of questions not to ask. Current plans to create a more trauma-informed healthcare system include expanding trauma training to include both a broader array of providers and topics beyond mandated reporting and addressing issues of secondary victimization.

OWH regional offices have the capacity to reach a wide variety of providers through an extensive grassroots network and partnerships with community groups and organizations. Regional offices can also respond to local events like disasters, which often have a disproportionate impact on underserved populations with less access to services. For example, in OWH Region II the impact of 9/11 on women in NYC was profound, particularly on food service workers who were on the site (largely Hispanic women). OWH regional offices are currently providing training in trauma-informed care to faith-based and community groups, particularly front-line workers, bringing different perspectives from the field together for cross-fertilization of ideas and developing a pool of local experts and people with the lived experience of trauma and violence. This initiative includes a series of webinars that will reach a wide variety of people and organizations, including health care settings, fertility clinics, WIC programs, rape crisis centers, schools, housing and work programs, and criminal justice settings. An intensive 2-3 day trauma skills training institute will also be offered.

Additional Resources:
http://www.womenshealth.gov/owh/
To register for webinars: owh.reg.V.webinars@hhs.gov

U.S. Department of Justice (DOJ)
National Institute of Corrections (NIC)

Trauma is a prominent feature of the experience of justice involved women and can be a contributing factor to entering the system. Women are often introduced to drugs and crime by a partner and frequently use substances to mask the pain of abuse. While woman are incarcerated, trauma may affect their institutional conduct and as a result, may negatively impact their eligibility for treatment and educational programs, increase the likelihood of disciplinary action, and extend release dates. Trauma also affects women's re-entry into the community and can contribute to their risk of re-offending.

- Women now make up 17 percent of all offenders.[lxvii]
- Female inmates in federal and state prisons and in jails have much higher rates of mental health problems than male inmates. The percentage of women with the most severe mental illnesses in jails is twice that of men.[lxviii]
- Women under correctional supervision are more likely to experience physical and sexual abuse than either male offenders or women in the general population.[lxix]
- Behavioral disruptions in prisons are most likely to involve disturbed inmates with histories of trauma, mental illness and substance abuse.[lxx]

It is critical that correctional staff in prisons and jails and probation and parole officers in the community be trauma-informed. Correctional procedures such as cell searches, escorts, and cell removal can easily retrigger earlier trauma, leading the woman to protest or fight back and often ending up with a disciplinary report. Correctional staff not trained in trauma-informed practices can unwittingly re-traumatize the women through typical system responses and further entrench her in the correctional system. Often a woman's response to a trigger could be more effectively addressed by staff who have been trained in application of trauma-informed practices. Emerging evidence-based research in correctional practices has identified areas of risk and need that contribute to recidivisim and can improve treatment targets for both men and women. Gender-responsive research on women offenders further targets areas of concern, including mental health history, depression, relationship dysfunction, and child abuse. Add to the list for women under probation and/or parole supervision, housing safety, anger, victimization as an adult, and stress in the parenting role. These areas should be taken into consideration when managing women in institutional or community corrections settings, and can contribute to improved individual and system outcomes with justice involved women. The National Institute of Corrections (NIC) has integrated training on trauma-informed practices into training programs specific to women offenders as well as other emerging products, women's risk and need assessment, a women offender case management model, and a gender-informed practices assessment – all for use with prisons, jails, and community corrections settings

Additional Resources:
Tonier Cain, *Healing Neem* (DVD) http://www.healingneen.com/about.html
Bloom, B., Owen, B., and Covington, S. (2005) Gender-responsive strategies for women offenders. http://nicic.gov/pubs/2005/020418.pdf
National directory of programs for female offenders www.nicic.gov/wodp
For information on Women's Risk Needs Assessment Project www.uc.edu/womenoffenders
www.nicic.gov/womenoffenders

DOJ - Office of Juvenile Justice and Delinquency Prevention (OJJDP)[5]

Girls are the fastest growing population in the juvenile justice system, and a very high percentage of them have experienced violence and trauma. Since traditional practices may backfire with girls who have trauma histories, it is critical for the juvenile justice system to become trauma-informed and to involve families whenever possible.

- More than 93,000 children are currently locked up in juvenile correction facilities around the country.[lxxi]
- Among a sample of incarcerated youth, girls were 50 percent more likely to be suffering from PTSD than boys.[lxxii]

[5] Drawn in part from Gonsoulin,S. (2010) *Federal Roundtable on Women and Trauma: Juvenile Justice.* Presentation at the Federal Partners Roundtable on Women and Trauma, April 29, Washington, DC.

- Girls are more like to be victims of sexual abuse, are more likely to be victimized by family members, and more likely to run away from home to escape violence.[lxxiii]
- Risk factors for delinquency in girls include sexual abuse, maltreatment, early onset of puberty, and intense mother-daughter conflict.[lxxiv]
- Girls who have been sexually assaulted are five times more likely to commit a delinquent act; almost 30 percent of physically assaulted girls commit a delinquent act compared to 3.2 percent of others. [lxxv]

The detention environment can exacerbate negative feelings and loss of control among girls with trauma histories, resulting in suicide attempts or self-inflicted violence. Traditional methods of preserving order and asserting authority (especially "tough" physically confrontational methods and the use of isolation or restraints) may result in re-traumatization. In addition, symptoms of post-traumatic stress may be misdiagnosed – for example, as oppositional defiance disorder. In contrast, ensuring that girls have access to gender-specific health and personal care items (such as female clothing) or getting treatment closer to home has a positive impact. The National Juvenile Justice Network identified 13 recommendations for improving the juvenile justice response to girls, including mandating trauma screening and assessment, training all staff in trauma-informed care, and instituting gender-specific policies and programs. OJJDP has also created four issue teams to address specific problems with at-risk youth, tribal youth, community re-entry and transition to adulthood, and racial/ethnic disparities.

Additional Resources:
Adams, E.J. (2010) *Healing invisible wounds: Why investing in trauma-informed care for children makes sense.* Washington, DC: Justice Policy Institute

DOJ – Office for Victims of Crime (OVC)

To be a victim of crime is to be invaded at the deepest level. As a victim, one's sense of personal safety and autonomy is shattered. A crime inflicted on one person affects dozens, even hundreds more. From emergency responders to victim service providers, from court personnel to the victim's friends and family, from the media to the public, even a single incident ripples throughout the community and changes the environment.

As part of the U.S. Department of Justice's Office of Justice Programs, the Office for Victims of Crime (OVC) supports a network of victim service providers who supply a full range of services to victims of every type of crime. OVC is charged by Congress with administering the Crime Victims Fund (the Fund), a major source for funding victim services throughout the Nation. Established by the Victims of Crime Act of 1984 (VOCA), the Fund supports thousands of programs annually that represent millions of dollars invested in victim compensation and assistance in every U.S. state and territory, as well as training and demonstration projects designed to enhance the skills of victim service providers. VOCA victim assistance funding – awarded through sub-grants to state agencies and local service providers – is the most far-reaching and visible demonstration of OVC's commitment to providing crisis intervention,

shelter, counseling, social service support, and criminal justice advocacy to those in urgent need of assistance. VOCA compensation grants supplement a state's efforts to provide financial assistance and reimbursement to victims, most frequently for medical and dental care in the aftermath of a violent assault. Discretionary grants administered by OVC play an important role of funding a broad array of programs to meet emerging needs, fill gaps in existing services, demonstrate promising practices and help strengthen the skills and abilities of service providers. For example, through projects supported through discretionary funding, we have made progress toward understanding the service needs of victims of human trafficking, identify theft, and domestic violence victims living abroad. Throughout all of our programs and initiatives, while services are most often offered to both males and females, the issue of violence against women, and the need for comprehensive, gender-specific, and trauma-informed services to women across their lifespan is central to the support and resources that are provided through OVC.

- In 2009, 20 million crimes were committed in the Unites States. Of these, 4.3 million were violent and 15.6 million were property crimes. Only about half (49 percent) of violent crimes and 40 percent of property crimes were reported to the police. [lxxvi]
- Of female rape or sexual assault victims in 2009, 21 percent were assaulted by a stranger, 39 percent of offenders were friends or acquaintances of their victims, and 41 percent were intimate partners.[lxxvii]
- Of female murder victims in 2009, 35 percent were killed by an intimate partner.[lxxviii]
- The National Survey on Children Exposed to Violence measured the past-year and lifetime exposure to violence for children. Using a sample of 4,549 children and adolescents aged 17 and younger, researchers found that during a 1-year period, 60.6 percent of children and youth from birth to 17 years of age experienced at least one direct or indirect (as a witness) victimization. Overall, 9.8 percent of the sample had been sexually victimized in their lifetimes. Adolescents aged 14 to 17 were by far the most likely to be sexually victimized; nearly 1 in 6 (16.3 percent) was sexually victimized in the past year; and more than 1 in 4 (27.3 percent) had been sexually victimized during their lifetimes.[lxxix]
- In 2004, more than 65 percent of elder maltreatment victims who reported to adult protective services were women.[lxxx]
- Rape survivors who had the assistance of an advocate were significantly more likely to have police reports taken and were less likely to be treated negatively by police officers. These victims also reported less distress after their contact with the legal system.[lxxxi]

OVC recognizes that while most victim service providers have a general understanding of the traumatic impact that crime has on victims, some programs still don't always integrate policies and procedures that support the kinds of "trauma-informed" services that victims and survivors want and need. In addition, while the Crime Victims Fund has supported the creation of a strong web of services for many victims, some victims remain inadequately served or un-served. Too often, multiple systems within a community do not work collaboratively to ensure that victims from marginalized communities, who may have experienced multiple forms of victimizations, are being seen in a holistic and coordinated fashion. Training and technical

assistance to victim service providers and allied professionals is paramount to ensure that trauma-informed, victim-centered services are made available to all victims. OVC is committed to working with its federal partners to infuse its training and technical assistance resources, such as the National Victim Assistance Academy, State Victim Assistance Academies, online training opportunities, Web forums, training workshops and grantee meetings with current and relevant information to improve responses to women and girls impacted by violence.

Additional resources:
Office for Victims of Crime: www.ovc.gov.
OVC Training and Technical Assistance Center: www.ovcttac.gov.
2009 Report to the Nation: http://www.ovc.gov/welcovc/reporttonation2009/welcome.html.
National Criminal Justice Reference Service (NCJRS) - for updates on publications, grant funding, training opportunities, etc. www.ncjrs.gov.
Defending Childhood Initiative http://www.justice.gov/ag/defendingchildhood

DOJ – Office on Violence against Women

The Office on Violence against Women (OVW) provides national leadership in developing the nation's capacity to reduce violence against women through the implementation of the Violence against Women Act (VAWA). Created in 1995, OVW administers financial and technical assistance to communities across the country that are developing programs, policies, and practices aimed at ending domestic violence, dating violence, sexual assault, and stalking. Currently, OVW administers two formula grants program and 17 discretionary grant programs, which were established under VAWA and subsequent legislation. Since its inception, OVW has awarded nearly $4 billion in grants and cooperative agreements, and has launched a multifaceted approach to implementing VAWA. By forging state, local, and tribal partnerships among police, prosecutors, victim advocates, health care providers, faith leaders, and others, OVW grant programs help provide victims with the protection and services they need to pursue safe and healthy lives, while simultaneously enabling communities to hold offenders accountable for their violence.

- The 2009 Stalking Victimization Report found that, during a 12 month period, an estimated 3.4 million persons age 18 or older were victims of stalking. Nearly 75 percent of victims knew their offender in some capacity.[lxxxii]
- According to the 2007 National Crime Victimization Survey, approximately 554,000 violent crimes were committed by an intimate partner against female victims and 248,300 rape/sexual assaults occurred in 2007.[lxxxiii]
- In 2009, 10 percent of high school students reported being physically hurt by a boyfriend or girlfriend in the past 12 months. Girls are more likely to report physical injury.[lxxxiv]
- According to a 2004 study by the Bureau of Justice Statistics, American Indians are twice as likely as all other races to experience sexual assault crimes. According to the 2000 National Violence against Women Survey, one in three Indian women reported having been raped during her lifetime.[lxxxv]

Additional resources:

http://www.ovw.usdoj.gov/

U.S. Department of Labor

In the workplace, violence and trauma can significantly affect workers' productivity and job performance, their use of sick leave and health insurance, turnover rates, accident rates, use of supervision, human resources, EEOC and legal resources, and the cost of recruiting and training new employees. The medical care, mental health services, and lost productivity (e.g., time away from work), cost of intimate partner violence (IPV) was an estimated $5.8 billion in 1995. Updated to 2003 dollars, that's more than $8.3 billion. [lxxxvi] According to National Violence against Women Survey estimates, U.S. women lost nearly 8.0 million days of paid work each year because of violence perpetrated against them by current or former husbands, cohabitants, dates, and boyfriends. This is the equivalent of 32,114 full-time jobs each year. [lxxxvii]

Adverse childhood events correlate strongly with several measure of adult work performance, including absenteeism, serious job problems and financial problems.[lxxxviii] The authors of a study on childhood abuse, household dysfunction, and indicators of impaired adult worker performance suggest that adverse childhood experiences merit serious attention from the business community, labor leaders, the everyday practitioners of medicine, and government agencies because child abuse and household dysfunction are common and have long-term effects that are highly disruptive to workers' health and well-being. They suggest that their data indicate the need to adopt the World Health Organization definition of health, necessitating a paradigm shift in which the disease-oriented biomedical approach is replaced by a biopsychosocial approach in which child abuse and household dysfunction are understood in terms of their long-term effects on worker health and well-being.[lxxxix]

According to the 2003 CDC publication *Costs of Intimate Partner Violence against Women in the United States*:

- More qualitative and quantitative data are needed to better determine the full magnitude of IPV and associated human and economic costs. There is also a need for primary prevention – preventing IPV from occurring in the first place – rather than focusing only on treating victims and rehabilitating perpetrators after abuse has occurred. [xc]
- CDC, in its *Injury Research Agenda*, has identified several key areas of research for IPV prevention. These areas include learning how to change social norms that accept intimate partner violence; developing programs for perpetrators and potential perpetrators; increasing our understanding of how violent behaviors toward intimate partners develop; improving collection of data about IPV and its health effects; developing and evaluating training programs for health professionals; and disseminating strategies that work to prevent IPV.[xci]
- Significant resources for research are needed to better understand the causes and risk factors for IPV and to develop and disseminate effective primary prevention strategies.

> Until we reduce the incidence of IPV in the United States, we will not reduce the economic and social burden of this problem.[xcii]

Violence prevention, including sexual violence and intimate partner violence, is one of the injury research priority topics of the CDC Injury Research Agenda. More detail on this topic can be found in the agenda at www.cdc.gov/injury/Research Agenda/CDC Injury Research Agenda-a.pdf.

It is critical that work settings become trauma-informed in order to prevent workplace violence, intervene effectively if it occurs, and identify and respond appropriately to trauma-related incidents. If supervisors are not aware of the impact of violence and trauma, they may not recognize when women with prior trauma histories are being retriggered by something in the work environment, which could result in unnecessary negative consequences for all involved.

Just as awareness of trauma in the workplace must be increased as a *preventive* measure, so too must the value of work be recognized for its potentially critical role in *recovery* from trauma and behavioral health disabilities. Pitney Bowes, Inc., for example, was recognized by the National Business Group on Health for developing a highly innovative personalized program to facilitate the timely, efficient return to work for employees on leave due to mental health issues. The program is based on the following three tenets: (1) Work has inherent therapeutic value; (2) An individual must suffer a significant amount of distress to reach the point where he or she cannot function adequately at work; and (3) Absence from work longer than necessary is not beneficial and may be potentially harmful.

One of the key features of Pitney-Bowes' program is a team approach, which includes the employee, disability clinical care managers, employee assistance program (EAP), Pitney Bowes disability nurse, and a psychiatrist. A detailed, initial assessment allows the team to jointly plan a course of treatment that will result in an efficient, timely return to work. Returning to work is viewed as part of recovery and return-to-work goals are integrated into the treatment process. Constant communication is maintained between the behavioral health disability clinical care manager and the Pitney Bowes disability nurse. Similarly, employee contact with the workplace occurs regularly throughout the recovery process. As a result of the company's efforts, the program has led to a 40 percent reduction in the duration of short-term disability claims. Furthermore, because employees return to work sooner, productivity is restored, morale is boosted, and cost-savings are recognized.

Additional resources:

http://www.workplacementalhealth.org/Pages/EmployerInnovations

DOL - Office of Disability Employment Policy (ODEP)

The emotional, physical and sexual abuse of women with disabilities is a problem of crisis proportions.[xciii] Tolerating abuse from caregivers who inflict pain, threaten to not help with

essential tasks, or withhold medications, wheelchairs, and other orthotic devices until money, sex or other favors are given; abandonment; voyeurism and inappropriate body touching during hygiene tasks; and stealing or extortion "may be the only way for some women to survive."[xciv] Women with disabilities are more likely than their peers to be abused or threatened with violence by their partners, by caregivers, or by others, and as a result may be affected in their ability to carry out their job functions. In addition, trauma can also *cause* both short- and long-term physical, cognitive, and emotional disabilities. Workplace policies and practices need to reflect this reality. In addition, government and private employers need to ensure that violence prevention strategies for people with disabilities, especially women, are widely adopted.

- 37.3 percent of women with disabilities have experienced violent abuse in their lifetime, compared with 20.6 percent of women without disabilities. 28.5 percent have been threatened with violence, compared with 15.4 percent of those without disabilities.[xcv]
- A high percentage of women with disabilities report abuse by personal assistants. This abuse prevents them from being employed (29 percent), taking care of their health (64 percent), and living independently (61 percent).[xcvi]
- Women with disabilities are significantly more likely than men with disabilities to be unemployed, to live in poverty, and to have part-time rather than full-time jobs.[xcvii]

Women with disabilities who have experienced violence and trauma may need specific counseling and support, environmental modifications, or job accommodations. Options for abused women with disabilities may be much more problematic than women without disabilities for the following reasons. Many shelters are physically inaccessible or unable to meet the women's needs for personal assistance for daily living activities; accessible transportation to the shelter may be non-existent or only available during certain times of the day or night; shelter staff may be inexperienced in communicating with a woman who is deaf or hard of hearing or with speech limitations; the woman may depend on the abuser for assistance with personal needs and have no family or friends to stay with; or she may be physically incapable of executing and implementing an escape plan.[xcviii] The Office of Disability Employment Policy (ODEP) is planning a comprehensive study of national and international research, literature, and programs that

EAPs: A Response to Trauma in the Workplace

The same kinds of physical and emotional traumas that happen in the world at large happen in the workplace. Employee Assistance Programs (EAPs) are designed to assist work organizations in addressing productivity issues and "employee clients" in identifying and resolving personal concerns that may affect job performance. All federal agencies and private sector companies with federal contracts are mandated by law to have EAP programs. The Employee Assistance Professionals Association Standards and Guidelines place the EAP in position to interact with relevant departments in the work organization to develop trauma specific policies. Such goals could include:

1) Develop policies that identify and prohibit traumatizing behaviors

2) Train human resource staff, union reps, managers and supervisors to be trauma-informed

3) Educate all employees about trauma

4) Screen employees presenting with health complaints for trauma

5) Ensure that all EAP staff have training in trauma

Nancy Pentz, LICSW, CAC, CEAP

Workplace Bullying

13% of all adult Americans are currently being bullied and 57% of them are women. 24% have been bullied in the past, and 12% have witnessed bullying. That's a total of 71 million people. You would think that something that is evident at this proportion would be discussed all the time, and would be a source of public policy change. Men and women are bullied differently. The majority of the perpetrators are still male. The press loves the "devil wears Prada phenomenon" - they love to tell about a woman targeting a man - but 7 out of 10 cases target women. The big thing I find is that people - just as they discount a victim of violence, saying you should have known better, you should have just gotten out of there and all the rest - they discount stress and workplace bullying.

Gary Namie, PhD

affect women with disabilities with special attention to trauma and trauma-informed care. Key findings will be disseminated widely through briefings and web-based publications, and will provide policy and research recommendations for further consideration by ODEP and key national and international stakeholders.

ODEP and DOL's Women's Bureau (WB) signed a Memorandum of Agreement in August 2010 to collaborate on a Workplace Flexibility (WF) initiative. In January 2011, ODEP and the WB held a Workplace Flexibility Forum: *Advancing Workplace Flexibility Policy and Practices*, attended by the Secretary of Labor, the Assistant Secretary of ODEP, the Director of the WB, the Deputy Director and Deputy Chief of Staff of the Office of Personnel Management, other key federal staff, and several subject matter experts from the general WF field and the disability community. Deliverables from this ODEP-WB WF initiative will be a roadmap of recommendations and a WF electronic toolkit. These deliverables will not only provide general WF recommendations, resources, effective practices, and success stories for employers, employees, policymakers, and researchers, but they will also address the specific WF needs of women and women with disabilities who are in the workforce and/or desiring to enter the workforce. WF (telework, flexi-place, flexi-schedules, job sharing, flexibility around the job tasks, etc.) can be an effective employer workplace policy or practice as a reasonable accommodation to assist women exposed to trauma for any ensuing mental health conditions, such as post-traumatic stress disorder (PTSD) and any other types of mental health issues brought on by PTSD, and to provide WF policies and practices for women who require safe work environments related to domestic violence or intimate partner violence.

DOL - Women's Bureau

Violence against women can have a profound impact on women in the workforce. Women workers may have histories of trauma and abuse, and in addition, they may be subjected to workplace bullying, domestic violence within the work setting or which impacts them as workers, sexual harassment, and harassment based on sex. Women in traditionally male jobs such as the construction trades may experience both sexual harassment and other forms of gender-based harassment.

- A 2007 survey found that 37 percent of workers had been bullied in the workplace. 60 percent of bullies are men; 57 percent of targets are women. 45 percent of targets report stress-related health problems.[xcix]

- A 2003 study found that targeted individuals suffered debilitating anxiety, panic attacks, clinical depression, and post-traumatic stress.[c]
- In FY 2009, EEOC received 12,696 charges of sexual harassment, 84 percent filed by women.[ci]
- While the effects of sexual harassment differ from person to person, it has been linked to anxiety, nausea, headache, high blood pressure, sleeplessness, and ulcers in some persons.[cii]
- 12 percent of women report that their current or past intimate partner harassed them at work.[ciii]
- Of women experiencing domestic violence, almost 24 percent report that it caused them to be late for work or miss work; 15 percent report difficulty in keeping a job, and 20 percent report that it affected their career advancement.[civ]

The Women's Bureau was created by law in 1920 to formulate standards and policies to promote the welfare of wage-earning women, improve their working conditions, increase their efficiency, and advance their opportunities for profitable employments. Its vision is to empower all working women to achieve economic security. The Women's Bureau has four priorities: equal pay, workplace flexibility, higher paying jobs, and homeless women veterans. Women who have experienced violence and the consequent trauma it can cause need employment that provides economic security and workplace flexibility. The need is especially great for homeless women veterans because the majority of women in homeless veterans programs have serious trauma histories.[cv] The Women's Bureau contracted with The National Center on Family Homelessness Institute in California to develop an organizational guide for providing trauma-informed care to women veterans, which will provide examples of trauma-informed practices, encourage service providers to examine their programs with an organizational self -assessment, and offer concrete steps for adopting new practices.

On October 23, 2010, the Women's Bureau sponsored a mini-retreat and stand-down in Kansas City, Missouri, for active duty women and women who served in the military. At the stand-down, the U.S. Department of Veterans Affairs had a specialist on hand to provide information on military sexual trauma and PTSD.

On January 24, 2011, ODEP and the Women's Bureau collaborated on a workplace flexibility initiative for employees with complex needs, including women (and men) who have experienced trauma. Common flexible work options include: flextime; compressed work weeks; part-time work; job sharing; telecommuting; personal days; paid-time-off banks; leaves of absence; emergency flexibility; reporting late; vacation buying, borrowing, sharing; day-at-a-time vacation; floating holidays; shift flexibility; and no-meeting days/hours. Creating a flexible workplace can improve the recruitment, retention, productivity, performance, morale, and commitment of employees, decrease turnover and absenteeism, extend employer business hours, ensure coverage during peak hours without overstaffing, assist in retaining older workers' skills and experience, and offer options in lieu of layoffs. It is also a primary strategy for making work environments and employment practices trauma-informed, offering a way for all employees, including people experiencing the consequences of trauma, to receive supports.

Additional Resources:
http://www.dol.gov/wb/
http://www.dol.gov/odep/
http://homeless.samhsa.gov/ResourceFiles/cenfdthy.pdf
Center for Research on Women with Disabilities (CROWD) www.bcm.edu//crowd
Nosek, M.A. (2009) Violence against Women with Disabilities: Fact Sheet #1 – Findings from Studies 1992-2002. http://www.bcm.edu/crowd/?pmid=1409
Nosek, M.A. (2009) Violence against Women with Disabilities: Fact Sheet #2 – Issues and Recommendations. http://www.bcm.edu/crowd/?pmid=1410
Powers, L.E. and Oschwald, M. (2002) *Violence and Abuse against People with Disabilities: Experiences, Barriers, and Prevention Strategies*. Portland OR: Center on Self-Determination, Oregon Health and Sciences University.
http://www.temple.edu/instituteondisabilities/programs/justice/docs/bibliographyScans/Powers_Oschwald.pdf
The Workplaces Respond to Domestic and Sexual Violence: A National Resource Center
www.workplacesrespond.org
Curriculum on Abuse Prevention and Empowerment. http://www.wid.org/programs/health-access-and-long-term-services/curriculum-on-abuse-prevention-and-empowerment-cape

U.S. Department of Veterans Affairs (DVA)[6]

Female Veterans are at risk for a number of trauma-related problems, including military sexual trauma (MST). MST is defined in US Code as "psychological trauma which resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment that occurred while a Veteran was serving on active duty.[cvi] Approximately one out of every five female VA patients screens positive for MST.[cvii]

All VA facilities screen Veterans for a history of MST and provide free treatment for all MST-related mental and physical health conditions. Additionally every VA facility has a designated MST coordinator who serves as a point person for all MST-related issues. In order to treat women Veterans effectively, the VA offers education and training on evidence-based therapies that have been proven to be effective in treating mental health conditions related to MST. Female Veterans returning from Iraq and Afghanistan are seeking healthcare services from the VA at a higher rate than their male Veteran counterparts (49.7 percent of women compared to 47.1 percent of men.) [cviii] Of women seeking health care services from the VA, 46.7 percent have a mental health diagnosis. The most frequently reported mental health disorders are adjustment reactions, which include PTSD and depression.[cix]

[6] Drawn in part from McCutcheon, S. (2010) *Women Veterans and Trauma*. Presentation at the Federal Partners Roundtable on Women and Trauma, April 29, Washington, DC.

The VA provides both physical and mental health care for all eligible Veterans. Trauma-specific, evidence-based treatments available at the VA include cognitive processing therapy and prolonged exposure for PTSD, and acceptance and commitment therapy for anxiety and depression. Specialized residential programs are also available for those Veterans requiring a more intense level of service.

Additional Resources:
http://www.va.gov/
Department of Veterans Affairs National Center for PTSD http://www.ptsd.va.gov/index.asp

Getting Into Action

At the Federal Partners "Roundtable on Women and Trauma" held on April 29, 2010, more than 80 participants came together to discuss the issues and make recommendations for action. Participants represented a broad range of federal and state agencies, advocacy organizations, academic and research institutions, and individuals with direct experience with trauma (see participant list in Appendix C). In the morning, plenary panel sessions provided basic information about the impact of trauma and violence against women across federal agencies. In the afternoon, a facilitated small group process led to a comprehensive list of recommendations for action in four broad areas: 1) a national action plan; 2) federal policy; 3) practice; and 4) incorporating the perspective of women and girls who have directly experienced trauma (recommendations are included in Appendix D).

Vice President Biden authorized the Violence against Women Act to improve the criminal justice response to domestic violence and sexual assault. We have accomplished a great deal through VAWA, and now is the time to look at what more needs to be done. In the early days, advocates expressed concern that a trauma-based approach would take the focus off of systems reform. Today we know that trauma informed care and systems advocacy are complementary approaches. We can and must do both.

Lynn Rosenthal, White House Advisor on Violence against Women

Evaluation data showed that participants were informed, inspired, and moved to action. One hundred percent of respondents agreed (74 – 89 percent agreed *strongly*) that the meeting had satisfied their expectations, improved their awareness and knowledge base, illustrated the importance of multi-systems approaches, and created a platform for partnership. Ninety-four percent were already considering new approaches to their work as a result of the meeting.

Change began immediately. A collective momentum emerged from the meeting, and many agencies and individuals moved forward to implement suggested changes. Within a month, a national behavioral health organization had launched a training program on trauma and trauma-informed care for more than 200,000 clinical service providers, at least one state had plans to replicate the roundtable, and several federal agencies were working to add requirements for trauma-informed practice into all of their RFPs.

On October 22nd, 2010, the Federal Partners Committee convened a follow-up strategic planning retreat to: 1) review actions taken as a result of the roundtable; 2) prioritize specific recommendations for integrating trauma-informed care into prevention, intervention and treatment activities within each partner agency; 3) formulate a strategy for further raising awareness about trauma-informed care; and 4) select specific projects/initiatives that the Committee could jointly support.

Every agency had followed up with concrete actions designed to implement trauma-informed principles and practices. While some actions had begun prior to the Roundtable and reflected a longstanding commitment to the issue, others were a direct result of the Roundtable and subsequent interagency discussions. The majority of initiatives were in the area of training and technical assistance. Examples included the development of informational materials and curricula; webinars; prevention toolkits; workforce training programs; university-based training; and conference presentations and workshops. One webinar series on "The Impact of Trauma on Women and Girls across the Lifespan," sponsored by DHHS/SAMHSA, was immediately oversubscribed. Other actions reflected new policies, changes in grant programs, and new research directions. Examples included participation in international and global forums; re-examination of policies on workplace violence, bullying and health education; agency resource mapping; development of new state coalitions; and the development of technical guidance memos.

New Partners and Next Steps

Since the Roundtable, representatives from several additional federal agencies and offices have joined the effort, including the Department of Housing and Urban Development, the Department of Education's Rehabilitation Services Administration, the White House Office on Drug Control Policy, and the Peace Corps. These agencies have already become key players, bringing new issues and insights to the table.

The Department of Housing and Urban Development (HUD) brings to the Committee a focus on reducing the risk of homelessness and general housing instability. Victims of domestic violence are often isolated from support networks and financial resources by their abusers. As a result, they may lack steady income, employment, credit history, or landlord references, making affordable housing options difficult to find. They have both short- and long-term housing needs that must be met so that victims do not need to choose between life with their abusers and life on the streets. Homeless shelters, especially domestic violence shelters, play a key role in providing a safe place to stay when leaving their abuser. The McKinney-Vento Act defines any individual or family fleeing or attempting to flee domestic violence, sexual assault, stalking, or other life-threatening conditions that have no other residence and lack the resources to obtain other permanent housing as homeless. In the long term, domestic violence victims need options that let them transition into safe, stable and affordable housing, along with social services that can help them start a new life without their abuser.

Victims of domestic violence are eligible to receive assistance through a variety of HUD programs, including: 1) The Emergency Shelter Grants Program; 2) The Homelessness Prevention and Rapid Re-housing Program; 3) The Supportive Housing Program; 4) Community Development Block Grant Program; 5) HOME Program; and 6) Public and Indian Housing Programs, including Public Housing and the Section 8 Housing Choice Voucher programs.

HUD will continue to work with HHS, VA, DOL and all agencies represented on the Federal Partners Committee to confront the needs of women experiencing violence and trauma, to make preventing and ending homelessness a top priority among the Committee agencies, to highlight the importance of affordable housing, and to work with Public Housing Authorities (PHAs) to ensure that the Violence Against Women Act (VAWA) of 2005 is being implemented effectively. In 2010, HUD issued the Final Rule implementing VAWA, which ensures that victims of domestic violence, dating violence, or stalking are not evicted, terminated from assistance, or denied assistance in HUD's Public Housing and Section 8 programs as a result of the abuse committed against them, in addition to other protections. HUD will issue further guidance to PHAs to assist them in implementing the VAWA Final Rule. Not only will this guidance instruct PHAs on how to effectively implement VAWA, it will provide recommendations on efforts to better inform and protect victims beyond the requirements of VAWA. Further, HUD is actively developing a VAWA Fact Sheet to inform victims of their rights under VAWA. HUD will also recommend new changes to VAWA that will help us to better serve and protect women experiencing violence.

HUD recently issued guidance making it clear that residents who are denied or evicted from housing as a result of domestic violence may have basis to file a discrimination complaint with HUD under the federal Fair Housing Act. HUD's guidance states that while the *Violence Against Women Act* (VAWA) provides some protections to victims of abuse who experience housing discrimination, the Fair Housing Act provides authority for HUD to investigate whether the denial or eviction violates the Act based on gender or another federally-protected basis. This guidance is available through: http://www.hud.gov/offices/fheo/library/11-domestic-violence-memo-with-attachment.pdf In addition, HUD's domestic violence forms, HUD form 91066, "Certification of Domestic Violence, Dating Violence or Stalking" and HUD form 91067, "Lease Addendum - Violence Against Women and Justice Department Reauthorization Act of 2005," are available in 14 different languages on HUD's Limited English Proficiency Web site. http://portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp/promotingfh

The Office of National Drug Control Policy (ONDCP) has also become actively involved in the Federal Partners Committee. For many women, substance abuse is connected with traumatic experiences. Victims of trauma often self-medicate with alcohol or other drugs, rather than seeking proper medical attention.[cx] Furthermore, women who experience trauma are more likely to experience mental health problems, which are also predictors of substance abuse.

To ensure that women who have experienced trauma have access to adequate services, ONDCP is focused on expanding access to gender-responsive treatment and recovery services. ONCDP

recognizes that many women who have been victims of trauma, particularly sexual violence, can feel inhibited from sharing their experiences in group therapy sessions with men, or may be re-traumatized in such intimate settings. By supporting an increase in the availability of services for women, ONCDP intends to support recovery from substance abuse disorders.

Given the significant correlation between lifetime history of drug and alcohol-facilitated rape, posttraumatic stress disorder, and nonmedical use of prescription drugs[cxi], medical professionals working with these populations should be aware of the importance of screening for drug abuse to avoid further health and safety issues. Treatment providers should also be aware of this connection and seek to address the underlying traumatic experiences that have led their patients to abuse substances. ONCDP currently conducts outreach efforts to providers on a number of substance abuse issues and will use this avenue to encourage the use of trauma-informed practices that promote healing.

The Peace Corps is currently developing a "Sexual Assault Prevention and Response" program to address the problem of rape and sexual assault on volunteers. This program, which is being developed by the Office of Safety and Security in partnership with DOJ, DOD and others, will include both training and risk reduction and response strategies, and will incorporate principles of trauma-informed care. With 7500 volunteers in 77 countries, the Peace Corps works in cultural settings where gender roles and expectations vary widely, and collaborates with local law enforcement and legal structures to prosecute crimes. Their international focus will bring an important perspective to the workgroup.

Over the course of the next year, the Federal Partners Committee will continue to meet monthly as a multi-agency workgroup, exchanging information about relevant activities, sharing resources, and planning interagency initiatives. Three overall priorities have been identified for 2011:

1) Broad dissemination of information about the impact of trauma across federal and state agencies and stakeholder groups, and involvement of new partners in the effort. While the Federal Partners Committee has been an exceptional multi-agency effort, some areas of vital importance have not yet been fully explored. Bringing additional partners to the table will expand the scope and impact of the effort.
2) Development and dissemination of topical informational materials on high priority issues, particularly materials that will be useful across agencies, address the concerns of community-based, frontline organizations, and help to integrate knowledge about trauma into the bureaucracy
3) Health care reform. The consequences of violence and trauma for the health of both individuals and populations are clear. An exploration of opportunities to apply this knowledge to health care delivery and preventive services is now needed.

Sub-committees have also been formed to examine specific issues in depth and to continue the process of cross-agency sharing and education. Sub-committees include: 1) trauma-informed care for front-line community providers; 2) screening and assessment; 3) integration of the first person experience; 4) cross-cultural and diversity issues; 5) the workplace and trauma-informed

care; and 6) military women and trauma-informed care. A second roundtable being planned for December 2011 will highlight the work of the sub-committees and will focus on effective strategies for prevention and intervention, moving from identifying the problem to discussing effective approaches to implementing trauma-informed approaches across the service spectrum.

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U.S. Department of Defense	
Defense Centers of Excellence	www.dcoe.health.mil
Office of the Secretary of Defense Health Affairs	www.defense.gov/osd/
Sexual Assault Prevention and Response office	www.sapr.mil
U.S. Department of Education	www.ed.gov
Office for Civil Rights	www2.ed.gov/about/offices/list/ocr/index.html
Office of Safe and Drug-Free Schools	www2.ed.gov/about/offices/list/osdfs/index.html
Rehabilitation Services Administration	www2.ed.gov/about/offices/list/osers/rsa/index.html
U.S. Department of Health & Human Services	
Administration on Aging	www.aoa.gov
Administration for Children & Families	www.acf.hhs.gov/
Agency for Healthcare Research & Quality	www.ahrq.gov/
Centers for Disease Control & Prevention	www.cdc.gov/
Federal Occupational Health Services	www.foh.dhhs.gov/
Health Resources & Services Administration	www.hrsa.gov/
Office of Public Health & Science	www.hhs.gov/agencies/ophs.html
Office of the Surgeon General	www.surgeongeneral.gov/
Office on Women's Health	www.womenshealth.gov/owh/
Substance Abuse & Mental Health Services Administration	www.samhsa.gov/
U.S. Department of Housing & Urban Development	
Community Planning and Development	http://portal.hud.gov/portal/page/portal/HUD/program_offices/comm_planning
U.S. Department of Justice	
Bureau of Prisons, National Institute for Corrections	http://nicic.gov/
Office of Juvenile Justice Prevention & Delinquency	http://www.ojjdp.gov/
Office for Victims of Crime	www.ovc.gov
Office of Violence Against Women	www.ovw.usdoj.gov/
U.S. Department of Labor	
Office of Disability Employment Policy	www.dol.gov/odep
Women's Bureau	www.dol.gov/wb
Worklife, Leave and Benefits Policy & Programs	http://labornet.dol.gov/me/worklife/index.htm
Peace Corps	www.peacecorps.gov/
U.S. Department of State	
Bureau of International Narcotics & Law Enforcement	www.state.gov/p/inl/
Veterans Affairs	
Office of Mental Health Services	www.mentalhealth.va.gov/
White House Office of National Drug Control Policy	http://www.whitehousedrugpolicy.gov/

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ACF	Administration for Children and Families (HHS)
AHRQ	Agency for Healthcare Research and Quality (HHS)
AOA	Administration on Aging (HHS)
ARMY	Army (DOD)
CDC	Centers for Disease Control (HHS)
DOD	Department of Defense
DOJ	Department of Justice
DOL	Department of Labor
ED	Department of Education
HHS	Department of Health and Human Services
HRC	Human Resources Center (DOL)
HRSA	Health Resources and Services Administration (HHS)
HU	Health Unit (DOL)
HUD	Department of Housing and Urban Development
NIC	National Institute of Corrections (DOJ)
OASPE	Office of the Assistant Secretary for Planning and Evaluation (HHS)

OCPD	Office of Community Planning and Development (HUD)
OCR	Office of Civil Rights (ED)
ODEP	Office of Disability Employment Policy (DOL)
OJJDP	Office of Juvenile Justice and Delinquency Prevention (DOJ)
OJP	Office of Justice Programs (DOJ)
OMHS	Office of Mental Health Services (VA)
ONDCP	Office of National Drug Control Policy (WH)
OSD	Office of the Assistant Secretary of Defense (DOD)
OSDFS	Office of Safe and Drug Free Schools (ED)
OSS	Office of Safety and Security (PC)
OVC	Office of Victims of Crime (DOJ)
OVW	Office on Violence against Women (DOJ)
OWH	Office of Women's Health (HHS)
PC	Peace Corps
PSC	Program Support Center (HHS)
RSA	Rehabilitation Services Administration (ED)
SAMHSA	Substance Abuse and Mental Health Services Administration (HHS)
USDA	United States Department of Agriculture
VS	Volunteer Support (PC)
WB	Women's Bureau (DOL)
WH	White House
VA	Department of Veterans Affairs

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Appendix D: Recommendations from the Federal Roundtable

During the Roundtable, participants took part in multiple breakout sessions during which they were asked to discuss the following questions:

1) From your perspective, what are the policy and practice implications of the information shared during the panel presentation?
2) How can we increase awareness and public education, increase outreach and engagement with trauma-affected women and girls, and enhance implementation of trauma-informed care and related supports and services?
3) How can Federal partners and community stakeholders ensure that the voices of women and girls are incorporated into all aspects of the action agenda?

The responses to these questions, as captured in the transcript of the proceedings, are outlined below. The responses reflect recommendation from the stakeholders participating in the Roundtable as possibilities for next steps to be explored. Their inclusion in this Report does not reflect any judgment as to their feasibility, nor do they reflect the endorsement of the Federal Partners Committee or the official views of the federal agencies or other entities that participated in the Roundtable.

A National Action Plan

Political leadership

- Presidential level effort – like *President's New Freedom Commission* but on trauma
- Massive public outreach, similar to *An Inconvenient Truth*
- Involve federal, state and local partners, advocates, and all branches of government
- Unified message across all agencies using shared values and language
- Work to make the issue of women and trauma a national priority

Role of Federal Partners Workgroup

- Use recommendations from the Roundtable to develop priorities and a plan for action
- Reconvene group, form sub-committees, and host roundtables at national and local levels
- Identify and create strategies to counter resistances and sources of misinformation
- Encourage and reward activity at local level *(e.g.,* local legislators, educators)
- Develop website and annual report of progress
- Cross-walk the Adverse Childhood Experiences study with all agencies

Strategies and approaches

- Use the Adverse Childhood Experiences study and its implications for both prevention and trauma-informed care to inform a national action plan. Include short-, medium-, and long-term goals and strategies
- Include a major public education effort, which frames violence as a public health crisis:

    - Widespread dissemination of ACE study findings;
    - Continuum of violence;
    - Focus on safety and wellness of children; and
    - Celebration of resilient adults who have broken the cycle of violence.
- Use the media, the arts, celebrities, messaging in TV soaps, and novellas to promote awareness about the issue of women and trauma
- Branding of the message, through public relations aids like t-shirts, events, and contests
- Examine which effective programs are currently being funded and which are not
- Develop a public health campaign similar to campaigns for seat belt use and to stop smoking – including social media, technology, financial incentives and disincentives, and legal reform
- Connect with other networks, including disability rights, the National Child Traumatic Stress Network, and Employee Assistance Programs

Local community involvement

- Use grassroots simultaneously with national approaches
- Have target audiences (such as cultural groups, and youth) participate in designing and disseminating the message in a meaningful way
- Provide training for local faith communities to engage them as part of the effort to increase awareness about the issue of women and trauma; include a range of faith traditions (*e.g*., Native American spirituality)
- Use Mothers Against Drunk Driving model of involving the entire community in promoting awareness about the issue of women and trauma
- Sponsor dialogues in promoting awareness about the issue of women and trauma in communities across the country involving peers and local leaders

Federal Policy

Legislation and policy

- Identify barriers to trauma-informed care related to federal housing, re-entry and family reunification (*e.g*, women barred from federal housing due to felony conviction)
- Review the Department of Health and Human Services' *Action Agenda to Improve the Health of Women and Girls* developed by the Office on Women's Health
- Review the Department of Health and Human Services' *Healthy People: 2020*
- Review policies and legislation regarding access to services for undocumented immigrants and refugee communities
- Review policies on reasonable accommodations for disabled veterans returning to school
- Develop trauma-informed accountability measures for federal agencies
- Encourage federal grant-making and contracting bodies to identify priority areas critical to trauma-informed care, require community collaboration and consumer participation,

and incorporate language and principles of trauma-informed care in federal grant-making and contracting
- Review federal policies and guidance to ensure the rights of victims of domestic violence and child abuse when the perpetrator is a family member
- Support VAWA's amendment to include trauma-informed services
- Create a "czar" position on the rights of women and children
- Issue an annual report on violence against women and girls in the United States
- Change Medicaid rules to better support trauma-informed care
- Review policies that protect people in the workplace
- Review educational policies such as "zero tolerance" for consistency with trauma-informed care; identify support for school districts and communities that helps children handle violence better

Program interventions and approaches

- Invest in prevention programs; focus on communities not just high-risk individuals
- Fund services for couples/marital therapy for returning vets
- Fund gender-specific services
- Fund multi-site, multi-issue collaborative approaches
- Fund peer and family support and peer specialist services
- Fund pilot projects on a state level for prevention of violence against women coupled with trauma-informed care
- Ensure focus on the LGBT community, with a focus on women and girls
- Prioritize screening and diversion of juvenile offenders and cross-agency support
- Encourage support for programs that educate and heal perpetrators of trauma

Training and human resource development

- Encourage trauma-informed care across all professional training programs and in accreditation, licensure and credentialing standards (*e.g.,* education, mental health, DOC, healthcare, etc)
- Examine ways to help federal agency leaders and staff to incorporate the Adverse Childhood Experiences study and trauma-informed care in mandated training and performance plans
- Encourage support for gender-specific trauma training for mental health providers
- Develop a trauma-informed disaster response curriculum that includes peer involvement, gender issues, and how to avoid re-traumatization
- Develop a clearinghouse to gather and disseminate research, best practices, practice models, speakers, etc. Develop technical assistance partnerships.
- Develop a curriculum for all medical personnel related to trauma-informed care and cultural sensitivity as a condition for medical licensure
- Identify ways to educate all levels of the court system and judicial personnel about trauma and trauma-informed care

- Identify ways to use mandated federal training on diversity and discrimination as doorways into trauma-informed care
- Use webinars and in-service training

Research

- Invest in services research to test and evaluate promising practices in trauma-informed care, including peer support and peer mentoring, culture-specific approaches, and trauma-informed care in rural and isolated areas
- Enlist the Centers for Disease Control in doing research to establish an evidence base for trauma-informed care
- Develop a transparent research agenda informed by trauma survivors and practitioners
- Agree on common outcome measures
- Identify quasi-experimental and qualitative research respecting complexities of trauma-informed care
- Ensure research agenda reflects the diversity of our communities. Test and evaluate models that begin in the community
- Conduct a cost/benefit analysis of prevention, addressing trauma and holistic healing in comparison to current disease-based treatment models; also conduct a cost/benefit analysis of prevention and early intervention in comparison to long-term incarceration and institutionalization. Include cost to workplace in analysis.
- Encourage research and scholarship on why we are such a violent society, how it relates to our history, and social mechanisms that perpetuate violence
- Encourage research and scholarship on historical and intergenerational trauma

Involvement and collaboration of federal partners

- Identify mechanisms for sharing funding between agencies more flexibly
- Encourage collaboration across agencies regarding re-entry from jails and prisons
- Identify ways to ensure that faith communities and representatives of other community-level groups are part of the discussion
- Use this Federal Partners Committee to begin development of cross-agency curricula, policies, protocols, and service models
- Develop guiding principles for trauma-informed care across all federal agencies
- Identify ways to strengthen the involvement of the Department of Justice in promoting awareness about the issue of women and trauma
- Invite and encourage involvement from the following federal partners:
    - US-Mexico Border Health Commission (Department of Health and Human Services, Office of the Secretary, Office of Global Affairs);
    - Office of Adolescent Health (Department of Health and Human Services , Office of the Secretary, Office of Public Health and Science);
    - Office of Refugee Resettlement;
    - US Immigration and Customs Enforcement (Detention and Remand Operations); and

- US Custom and Border Protection (Department of Homeland Security), US Border Patrol.

Practice

Organizational change strategies

- Identify effective approaches to organizational development in implementing trauma-informed care
- Collect examples of workplaces that have successfully incorporated trauma-informed care
- Make the business case for great investment in trauma-informed care, how it will save money and improve effectiveness, and what it will take to make it work
- Move from focus on changing client behavior to developing healing environments

Practice guidelines and standards

- Develop and implement guidelines for trauma-informed practice in different professions and different settings
- Promote operational principles of "do no harm" and "ask what happened rather than what's wrong" for different settings
- Collect examples of professionals who do their work from a trauma-informed perspective (eg, a police officer who tells someone why they are patting them down, dentists changing their practice, etc)
- Institute universal precautions across all settings
- Replace punitive approaches to risky behaviors with trauma-based approaches
- Focus on trauma assessment – who, how, when, and where?
- Incorporate relational principles into practice guidelines
- Take existing guidelines for trauma-informed care and standardize, or adapt for different settings

New partnerships, programs and collaborations

- Shift focus to prevention and early intervention across all agencies
- Reach out to recreational centers, sport organizations, faith communities, holistic health workers, and other community settings where trauma-informed care is needed
- Encourage agencies to work together at the community level to replicate the roundtable and begin discussion about trauma-informed care
- Focus on social interventions as well as individual treatment
- Work to ensure access for underserved populations

Staff training and human resource development

- Work to ensure that all front line staff are trained in trauma and are engaged in trauma-informed practice
- Encourage reflective practice and supervision on trauma-informed care
- Acknowledge staff trauma and support staff healing

Incorporating the Perspective of Women and Girls

Increasing voice

- Identify trauma survivors in all services and settings who can share their experiences (beyond Center for Mental Health Services and Substance Abuse and Mental Health Services Administration)
- Educate other systems about the resilience of survivors and the importance of including their voice
- Encourage all federal agencies to engage in a listening process bringing survivors and providers to the same table
- Explore the process of how people change from the perspective of people going through trauma; address issues of vicarious trauma and burnout for peers

Creating functional roles for people with lived experience

- Create organizational roles for peers to review policies, curricula, training programs, and to shape awareness messages
- Provide a safe way for providers to acknowledge their own status as survivors of trauma and violence
- Use peers in all stages of product development rather than only having them test or review something already developed

Involving new and different survivors and peer groups

- Recognize that every experience is different and therefore many voices must be heard
- Identify organized groups of women and girls with lived experience of trauma and bring them into the discussion
- Bring in leaders from refugee, immigrant, LGBT communities and communities of color and other groups who may not be well represented in mainstream or organized groups

Beyond stories to structural change

- Ensure that personal stories lead to program and policy changes
- Pay people for telling their stories and for sharing their experiential wisdom
- Set goal of “tipping point” for peer involvement to become norm; avoid tokenism
- Hold agencies and organizations accountable for ensuring peer involvement
- Explore how concepts of trauma-informed care are defined differently by different groups (eg, “safety” looks different to staff and patients in a state hospital)
- Explore how power plays out in organizations, and how truly democratic structures and relationships provide safety
- Eliminate the negative consequences of asking for help
- Maintain emphasis on gendered violence while also expanding focus to men and boys