CHAPTER 17

INCREASING ACCESS TO JUSTICE THROUGH TRAUMA INFORMED LAWYERING

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Meadowlark Immigration, PC

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To view these chapter materials and the additional resources below on or before October 30, 2019, go to www.osbplf.org , select Upcoming CLE, select Learning The Ropes, and click on program materials, under Quick Links. After October 30, 2019, select Past CLE, Learning The Ropes, and click on program materials, under Quick Links.

Additional Resources

Trauma Informed Structured Interview Questionnaires for Immigration Cases, National Immigrant Women's Advocacy Project
Trauma Informed Legal Advocacy Practice Scenarios Series, National Center on Domestic Violence, Trauma and Mental Health
SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, Substance Abuse and Mental Health Services Administration

Access to Justice Through Trauma Informed Lawyering

Ali Schneider, Meadowlark Immigration PC

Defining Trauma

Individual Trauma results from an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

- Trauma experiences are highly individualized
- Influenced by culture

Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Examples of Traumatic Experiences

- Sexual abuse/assault
- Physical abuse/assault
- Neglect
- Traumatic Loss
- Being injured
- Industrial or transportation accident
- Imprisonment/torture
- Medical Trauma
- Emotional abuse
- Secondary trauma
- Racial trauma
- Gender based trauma
- Systemic trauma
- War related- combat or refugee
- Natural disaster
- Other

Trauma Informed Defined: The 4 R's

According to SAMHSA's concept of a trauma-informed approach, A program, organization, or system that is trauma-informed:

- ***Realize*** the widespread impact of trauma and understand potential paths for recovery;
- ***Recognize*** the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- ***Respond*** by creating policies, procedures, and practices for all areas of the organization
- Seek to ***resist Re-traumatization***.

Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

SAMHSA's Six Key Principles of a Trauma-Informed Approach

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice, and choice
- Cultural, historical, and gender Issues

Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Barriers

Economic

- Legal fees
- Transportation
- child care
- Extenuating costs

Cultural

- White Supremacy
- Prejudice
- Systemic oppression

Communication

- Literacy
- Language
- Legal jargon
- Systemic processes

Trauma

- Retelling of events
- Memory
- Document Gathering
- Safety

Creating a Trauma Informed Space

- Parking/Transportation accessibility
- Greeting/Reception
- Family friendly
- Comfortable environment
- Safety
- Health

Consultation/Intake

Introduce the Process-
- what is the goal of the meeting
- what kinds of questions you will ask
- confidentiality
- potentially traumatic questions

Explain why you need to ask questions
- No judgment
- develop trust

Remind the client of their power

Legal Advice
- keep it simple
- explain the steps
- check-in for understanding

Case Process and Gathering Evidence

- Set expectations and boundaries
- Explain confidentiality, especially if representing multiple people
- Set check-ins, if a case is going to be pending for a long time
- Respond to phone calls in a timely fashion
- Creating protocols and templates to streamline your processes

Gathering documentation and information can be especially difficult for survivors of trauma, including:

- Recalling dates, addresses, work history, details of events
- Gathering documents, support letters
- Testifying- preparation

Declarations

- Take breaks. May take multiple sessions
- Interpretation- if you need an interpreter, make sure the client feels safe with them
- Do not have other family members in the room if discussing sensitive information
- Provide a comfortable seat
- Is there a case worker that the client wants to have involved?

Stay in your lane! And Practice Self-Care

Remember what you are an expert at, and what you are not. Connect to resources for yourself, staff, and clients.

Resources

- Oregon Coalition Against Domestic and Sexual Violence- https://www.ocadsv.org/
- Substance Abuse and Mental Health Services Administration- https://www.samhsa.gov/
- National Center on Domestic Violence, Trauma, & Mental Health- Trauma Informed Legal Advocacy Project- http://www.nationalcenterdvtraumamh.org/trainingta/trauma-informed-legal-advocacy-tila-project/
- Multnomah County Family Violence Coordinating Council- email Shannon Rose for information on local news and trainings shannon.rose@multco.us
- YWCA- https://www.ywcapdx.org/events/social-justice-trainings/

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Additional Resources

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SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, Substance Abuse and Mental Health Services Administration

Trauma Informed
Structured Interview Questionnaires for Immigration Cases (SIQI)[1]

By: Mary Ann Dutton, Krisztina Szabo, Rocio Molina, Maria Jose Fletcher, Mercedes V. Lorduy, Edna Yang, and Leslye Orloff
The National Immigrant Women's Advocacy Project[2]
September 21, 2015 (Updated April 18, 2018)

The following questionnaires are provided to facilitate the Trauma Informed Structured Interview.[3] During the story developing session, clients are encouraged to share their story uninterrupted while advocates and attorneys listen, take notes, and watch for triggers. This tool is designed to be used during follow up interviews with clients. This Structured Interview Questionnaire for Immigration (SIQI) will aid advocates and attorneys in eliciting additional in-depth information to strengthen their client's immigration case and will also provide a complete picture of trauma and distress endured by survivors. The questions are designed to facilitate the client's healing and to strengthen the client's immigration application by uncovering important details of the story by screening for additional incidents, experiences, and emotional harms that contribute to extreme cruelty and/or substantial mental or physical abuse. Attorneys and advocates should explain the goals of this session to the client before initiating the trauma informed structured interview.

While conducting the Trauma Informed Structured Interview Questionnaire for Immigration (SIQI), it is important to be mindful of the following:

- The story developing session in which clients are encouraged to share and to the extent possible write their stories uninterrupted comes first.
- This SIQI can be used by the attorney or advocate during that first interview as a note taking guide to annotate or identify issues that you want to be sure to follow up on in the second interview. However, trauma informed best practices make it important to assure that the first interview is the victim's uninterrupted account and if you use the SIQI it should be for note taking only.
- These questions should be administered by the advocate or attorney and are not intended to be used as a questionnaire(s) that clients fill out on their own.
- Clients should be told ahead of time that some of these questions are sensitive in nature and that they are not required to answer questions that make them uncomfortable. The advocate or attorney may want to tailor the questions to the client's ability to understand the question. (i.e. education, cognitive understanding, bilingual advocates adapting the questions to be most understandable in the client's native language)
- Use this tool in conjunction with crisis intervention techniques and be mindful of your own self-care needs during this and all other sessions.
- Allow time for breaks and "check-ins" with your client.

This tool was created to help both attorneys and advocates navigate the different immigration protections available to immigrant survivors. The tool will provide you with step by step information on how to

[1] This training is supported by Grant No. 2011-TA-AX-K002 awarded by the Violence Against Women Office, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, conclusions and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

[3] Part of the introduction to this Trauma Informed Tool, pages 1-3, was jointly developed by CALCASA and NIWAP.

make an immigration relief assessment, complete immigration relief intake, draft declarations, collect supporting documents, and complete VAWA and U visa files.

It is paramount that in your interaction and interview with the survivor that you take a trauma-informed approach. A trauma-informed approach recognizes the widespread impact of trauma and understands potential paths for recovery. Trauma is defined as an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives.[4]

A trauma-informed approach recognizes the signs and symptoms of trauma in clients and responds by fully integrating knowledge about trauma into policy and practice while actively seeking to avoid re-traumatization of the victim. Importantly, a trauma-informed approach can be utilized in any setting. The key principles to a trauma-informed approach are: Making the survivor feel safe during the interview process; having a relationship of trust between the interviewer and the survivor; feeling supported; feeling empowered during the course of the interview, having their voice heard and feeling they have choices; the interview proceeding mindful of cultural, historical and gender issues.

Initial Survivor Interview

The story of the survivor is one of the central pieces to Violence Against Women Act (VAWA) and U visa applications and processes, which sets them apart from other immigration proceedings. The story or affidavit is the place for the survivor to impress upon the Department of Homeland Security (DHS) Adjudicator the impact of the trauma on their life and their reasons for needing the support of a VAWA or U visa. When reading the survivor's story, the reader – ultimately, the DHS adjudicator – should be able to know and feel what the survivor felt after being subjected to abuse or crime victimization.

The initial interview also provides advocates and attorneys with the opportunity to establish a good rapport with the survivor, build trust, make the survivor feel heard, safe and supported, further discuss the application process, uncover cultural, historical and gender issues, review supporting documents, and assist with the survivor's declaration. It is important to explain the legal process and any necessary requirements in simple language to avoid confusion. Our goal is to empower clients to reclaim their autonomy and independence. Each survivor will determine what is best for them, and regardless of our personal opinion and/or feelings, we have to support survivor's decisions. The survivor should be given the option of writing their own story, having it transcribed by an advocate, or recording it.

In the initial story telling session, it is important to let the survivor share their story as a stream of consciousness. As the recorder and support interviewer, resist the urge to interrupt the story telling process. Save the clarification of details until later. Ask open-ended questions, such as: and then what happen? And use affirming body language—nodding and agreeing with the survivor. Ask the survivor to let you know when they need a break or if they are feeling stressed or anxious during the story telling.

Preparing for Story Collection

It is important that you prepare prior to preparing the survivor's story. Take time in advance to read police reports, request for protection orders, court records and medical records, or whatever else might be available to you that might be beneficial in telling the survivor's story. Tell your client ahead of time what your goals are before the story collection so they can best prepare. Determine how your client wants to document their story. Do they want to write it themselves, do they want you to transcribe it, or do they want to record it? Ensure that both you and your client have set aside adequate time to document the

[4] American Psychological Association, *Trauma*, http://www.apa.org/topics/trauma/.

story taking into account the use of interpreters and translators. Determine in advance whether you will refer to the "story" as such or refer to it as an "affidavit."

Your Client's Story on Paper

The client is their expert. Listen to your client's story with support and empathy. When your client appears upset or triggered, pause and take a break, offering them a glass of water. Listening to their experience with empathy validates their experience and sympathizes with the trauma they have experienced. It minimizes re-traumatization. If your client does not speak English, you can either record the experience and have it translated later, or transcribe it in their native language and have it translated later. For the first draft, spelling and grammar are not important. Fluidity of story telling is what is important and creating an environment whereby your client tells their story and feels heard is what matters most. Whatever manner your client chooses to document their experience, transcribe it themselves, have you transcribe it, or record it, respect their decision.

Supplemental Interview

After the client has documented their story, you as the advocate/attorney will proceed to the next step in the story development process, reviewing with your client a series of additional questions. These questions are trauma-informed while getting to the details that are important for the visa application. These questions are designed to solicit more complete information about the survivor, their case, experiences, and the impact of these events on the victim and their children. This interview will also be a time when it will be important to ask follow-up questions obtaining more detail about events raised in your client's story. Again, it is important that one follow a trauma-informed approach when asking these questions. One needs to recognize that the questions could be upsetting or trigger a client. When your client appears upset or triggered, pause and take a break, offering them a glass of water or simple breathing or grounding exercises.[5] Do not proceed until your client appears ready to proceed, and you have been given verbal assurance that they are ready to proceed.

Integrating the Story

After you have obtained the story your client wrote/told you, and held your follow up questioning session, you as the advocate/attorney will shape the story into a cohesive whole. In doing so you will: 1) organize the story chronologically; 2) correct all grammar and spelling, and; 3) ensure that the story remains in your client's own words. Once the story has been edited, it will be reviewed with your client one last time, again with a trauma-informed approach. Upon completion, you will secure your client's signature and submit the story as evidence in the immigration case.

Importance of Self-Care

Self-care is particularly important for attorneys and advocates that work closely with clients who have experienced trauma and have difficult stories to tell. Self-care is not a sign of weakness. It is a way of making our bodies and minds stronger, thus enabling us to continue living our lives. Documenting their traumatic experiences can impact those helping them. Often one may experience stress, fatigue or sadness after helping an immigrant survivor document their history of abuse. Remember, we cannot take care of others unless we first take care of ourselves.[6]

STRUCTURED INTERVIEW QUESTIONS FOR VAWA SELF-PETITION

[5] *See* Tula Biederman & Rocio Molina, *Supplemental Grounding Exercises for Trauma-Informed Approach*, NIWAP (2014), http://niwaplibrary.wcl.american.edu/pubs/groundingtool/.

[6] *See* Benish Anver & Rocio Molina, *Self-Care Tools, Strategies and Assessment*, NIWAP (2014), http://library.niwap.org/wp-content/uploads/Self-Care-Tool.pdf.

This section outlines the basic requirements for a VAWA Self Petition and will allow the attorney/advocate to remember follow up questions and details that may be important to document the abuse, battering and extreme cruelty and the impact of these on the client's well-being, physical and mental health and safety for the VAWA self-petition. It begins by documenting the details of the relationship between the abuser and the client, the extreme cruelty suffered and its extent, and any good moral character issues that may affect the client's application. Note that not all sections will apply to your client.

I. Relationship with Abuser and Cohabitation

If the abuser is your spouse or ex-spouse, you will need to show that you got married because you loved each other, and that you lived together at some point.

- When and where did you and your spouse meet?
  - Who introduced you?
  - Who else was there when you first met?
- When did you start dating? What did you do while you were dating?
  - While you were getting to know each other, were you in the U.S. or in another country?
  - Did you go out to eat, go to parties, go to the movies, etc.?
    - What kinds of activities did you do together?
    - Were there people that you went out with?
  - What made you fall in love with your spouse?
- When did you move in together?
- How long did you date or live together before you decided to get married?
- When did you decide to get married?
  - Did your spouse propose to you?
  - Where were you?
  - What were you doing?
  - What did you respond?
  - Was anyone else present?
- When and where did you get married?
  - How was your wedding?
  - Who was present?
  - Was there a party before or after the wedding?
- Did you go on a honeymoon? If yes, when and where?
- Where did you first live as a married couple? Do you remember the address?
- Write down a list of the addresses of all the homes you shared with your spouse and the dates you lived there.
- When you were living together, did anyone else live with you (children, parents, siblings, or friends)?
- Were you allowed to have friends visit you at your home?
- Did you have parties or receptions?
- Do you and your spouse have children together? How many children do you have in common? What are their names and when were they born?
- If you had children from a previous marriage or relationship, did your spouse spend time with them?
- What was the marriage like at the beginning?

  - Were there good times before the abuse started?
  - What did you do together as a family?
  - Do you remember any special occasion from the good times?
  - A family celebration?
  - A birthday party?
  - A family vacation?
- What were your future plans together?

If the abuser is your stepparent, you will need to show that you had a stepparent-child relationship.

- How did your parent and stepparent meet?
  - When did they start dating?
  - When did they move in together?
- How long did your parent and stepparent live together before they decided to get married?
- When and where did your parent and stepparent get married?
  - How was their wedding?
- In addition to you, do your parent and stepparent have any children?
  - How many children do they have in common?
  - What are their names and when were they born?
- Were you ever adopted by your stepparent?
- Did you ever live together with your parent and stepparent?
  - If so, do you remember the address (es)? Try to include all the address (es) of the homes you shared with your parent and stepparent and the dates you lived there.
- Do you remember any special occasions from the good times you spent with your parent and stepparent?
  - A family celebration?
  - A birthday party?
  - A family vacation?

If the abuser is your parent, you will need to show that you had a parent-child relationship.

- How did your parents meet?
  - Did they ever get married?
  - If so, when and where?
- When and where were you born?
- Is the abusive parent listed on your birth certificate or on your baptism record?
- Do you have any siblings or half-brothers or half-sisters from this parent?
- If your parents divorced or separated, did the abusive parent have custody of you?
- Did the abusive parent have to pay child support?
- Did he or she have visitation rights to see you? If so, how often?
- Did you ever live together with your abusive parent?

  - If so, do you remember the address (es)?
  - Try to include all the address (es) of the homes you shared with him or her and the dates you lived there.
- Do you remember any special occasions from the good times you spent with your abusive parent?
  - A family celebration?
  - A birthday party?
  - A family vacation?

If your abuser is your over 21 year old U.S. citizen son or daughter, you will need to show that you had a parent-child relationship.

- When was your son or daughter born?
  - Are you listed on his or her birth certificate or baptism record?
- Did you live with your son or daughter as he or she was growing up?
  - If not, did you visit him or her?
  - If yes, how often did you see your son or daughter?
  - Did you pay child support for him or her?
- When did your son or daughter come to the U.S.?
  - How did he or she become a U.S. citizen?
- Did you ever live together with your son or daughter in the U.S.?
  - If so, do you remember the address (es)?
  - Try to include all the address (es) of the homes you shared with him or her and the dates you lived there.
- Do you remember any special occasions from the good times you spent with your son or daughter?
  - A family celebration?
  - A birthday party?
  - A family vacation?

II. Battery and/or Extreme Cruelty

- When did the abuse begin and where were you at the time?
  - Did it start with an argument or was it unprovoked?
  - Did it escalate into physical violence?
- After the initial mistreatment, how frequent were your abuser's abusive episodes?
  - Did your abuser get more and more violent?
- Please give a detailed description of what the abuse was like.
  - Can you recall a specific violent or abusive outburst?
  - What did your abuser do specifically?
  - Did your abuser do any of the following things:
    - Yell or curse at you? Did your abuser call you names? If so, what words did he or she use?
    - Hit, kick, or slap you? If so, what did your abuser use and how did he or she hurt you?

        - Throw things at you? If so what did your abuser throw at you?
        - Pull your hair?
        - Grab you by the throat?
        - Force you to have sex against your will (when you didn't want to)?
- Did your abuser also hurt your children? How?
- Did your abuser forbid you to communicate with family or friends?
- Did your abuser ever threaten to kill or hurt you, your children, or family members?
- Did your abuser threaten you with a gun or other weapon?
- Did your abuser threaten to commit suicide?
- Did your abuser threaten to destroy your property?
- Did your abuser threaten to have you deported or take your papers away?
    - Did your abuser threaten to take your children away?
- Did anyone, including family and friends, witness the abuse?
- Did you seek medical assistance because of the abuse? When? Where?
- Did you call the police because of the abuse?
    - When?
    - How many times?
    - What did the police do? Was a police report taken at these times?
- Did you ever get a restraining order?
- Has there been a criminal case charged against your abuser? When? Where did it happen?
- After your abuser's violent periods, did you make up?
    - Did your abuser apologize?
    - How was your abuser's behavior afterwards?
    - Did your abuser treat you better momentarily?
- When and why did you decide to leave your husband?
    - How were you able to do it?

III. Good Moral Character

- Think of examples that show that you are a good parent.
    - Do you work long hours or overtime to support your family?
        - Do you work several jobs to make ends meet?
    - Describe your role in taking care of your children.
        - Do you drive them to and from school?
        - Do you dress them in the morning?
        - Do you prepare their meals?
        - Do you take them to the doctor or dentist?
    - Do you help your children with their homework or school projects?
        - Are you involved with their school activities?
    - Describe your favorite activities with your children.
        - Do you read them stories at night?
        - Do you pray together?
        - Do you take them to the playground?
        - Do you play with them?

- Give examples that show that you are a good member of your community.
- Do you regularly attend religious services?
- Are you an active member in your faith community?
- Do you volunteer your time or donate?
- Do you help out your neighbors, friends, or other family members?

STRUCTURED INTERVIEW QUESTIONS FOR VAWA CANCELLATION OF REMOVAL

VAWA Cancellation is a remedy available only to those clients who are in removal (deportation) proceedings who have cases before an immigration judge. For VAWA Cancellation you will need to write and ask about 2 added elements of the case to qualify, in addition to the questions listed above for VAWA self-petition. Therefore, you should ask these additional questions to be able to show: 1) Continuous Presence in U.S. for 3 years and 2) the hardship your client and her family would face if she were returned to her home country.

IV. Continuous Presence in the U.S.

2. When did you come to the U.S.?
3. How long have you lived in the U.S.?
4. Did you ever leave the country?
   - If yes, for how long were you gone?
   - Did your abuser take out outside of the country?
   - Did you leave the county because of the abuse?
   - Did you go on a vacation outside the U.S.?
   - Did you visit relatives in your home country?
5. If you left several times, it's important to make note of those times with specific dates.

V. Hardship if Returned to Home Country

6. What would happen to you or your family if you were to return to your country of origin? Are you afraid of returning to your country of origin? Why?
   - What are the living conditions in your country?
   - Do you think you would be safe?
     - Why or why not?
   - Can you trust the police?
     - Is there a lot of crime?
   - Are there laws or customs in your country that mistreat victims of domestic violence, are divorced, or have children but no husband?
   - Does the government of your country protect victims of crime?
   - Are you afraid that your abuser would take action against you in your country?
     - Or do you think your perpetrator would try to harm you for having called the police?
     - If so, would you be able to receive adequate protection?
   - Are you afraid that the friends and family of your abuser will try to hurt you or your children (physically or psychologically)?

7. Why do you want to stay in the United States?

- If you had to leave the U.S., would you be separated from your loved ones?
- Would you still be able to support yourself and your family?
- Are there services that you have in the U.S. that you wouldn't have if you were deported (ex: social workers, medical help, counseling, government benefits like WIC, etc.)?
- If you or your children are receiving medical treatments or counseling, would you be able to continue them in your home country?
- Do your children speak the native language of your country?
- Would it be difficult for them to adjust going to school in your country?
- Do you need to stay in the U.S.to have access to the courts and/or help the police in investigating your abuser?

8. What hopes do you have for the future, for you and for your children?

9. Is there anything else you would like to mention or tell the Immigration officer about you or your family?

STRUCTURED INTERVIEW QUESTIONS FOR U VISA CASES

This section outlines the basic requirements for a U Visa and will allow the attorney/advocate to remember follow up questions and details that may be important to document the U visa application. There are a number of questions asking about the harm stemming from the crime which may be difficult for your client to answer, but which is useful in meeting the requirement that an applicant demonstrate the substantial physical, psychological, or emotional harm suffered from the crime.

VI. Relationship with Perpetrator (there need not be a relationship perpetrator)

- Is the perpetrator a relative or family member?
  - Did you live together? How long was your relationship with him or her?
- Is the perpetrator your spouse, former spouse, or significant other? How did you meet and what has your relationship been like?
  - How long were you in a relationship?
    - If you were married, when and where did the ceremony take place?
    - Did you have children from a previous relationship?
    - Did you have children with your partner?
    - How did your partner treat the children?
  - Is the perpetrator someone you went on a date with? If so how and where did you meet?
  - Is the perpetrator someone who stalked you or tried to go on dates with you?
  - Is the perpetrator your boss, manager, co-worker, customer, or client?
  - Is the perpetrator your teacher or classmate?
  - Is the perpetrator your neighbor or family friend?
  - Is the perpetrator your clergy member or someone from your faith community?

VII. Qualifying criminal activity

1. <u>If you client was a victim abuse by his/her spouse, partner, or parent:</u>

- When and how did your abuser start mistreating you? For example did your abuser insult you? Did he or she hit you? Push you? Kick you? Did your abuser say bad words to you?

Did he or she call you names?

- How often did your abuser do this?
- Did your abuser do it in front of others? Who?
- How did it make you feel?
- Did you ever call the police? Were you too scared to call for help?
- When was the first time you decided to call the police? What happened?

2. If your client was the victim of a criminal activity or criminal activities by a stranger:
    - Where were you and what were you doing right before the crime? Do you remember the time?
    - How did the incident begin? Did the perpetrator instigate an argument or did he/she attack right away?
    - How and where did the perpetrator hurt you?
    - Did you try to escape? Were you able to cry for help?
    - Did anyone see what happened?

VIII. Physical, physiological, and emotional harm

- Have you suffered any physical injury?
- What was the intensity and the duration of the pain?
- Were you permanently disabled or scarred as a result of the criminal activity?
- Were you taken to the hospital or did your receive any medical care?
- Were you prescribed any medication?
- Have you suffered any psychological injury because of the criminal activity?
- Do you experience humiliation, depression, sleeping problems, anxiety?
- Have you received any counseling?
- Have you been prescribed medication to cope with your psychological problems?
- How has the victimization from the crime changed your physical or emotional energy?
    - Have you been suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
    - Have you been feeling very upset when something reminded you of a stressful experience from the past?
    - Have you been experiencing physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
    - Have you been avoiding thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
    - Have you been avoiding activities or situations because they remind you of a stressful experience from the past? If so, what kind of activities have you been avoiding?
    - Did you lose interest in things that you used to enjoy? If so, what sort of things or activities?
    - Have you experienced trouble falling or staying asleep?
    - Have you been feeling irritable or have you had angry outbursts?
    - Have you experienced difficulty concentrating?
    - Have you been feeling “super alert” or watchful on guard? Have you been feeling jumpy or

easily startled?
    - How has victimization changed your reaction to remembering or thinking about certain things? Do you have repeated, disturbing memories, thoughts, or images of a stressful experience from the past? Do you have repeated disturbing dreams of a stressful experience from the past? Do you have trouble remembering important parts of a stressful experience from the past?
    - How has being a victim of this crime changed how you feel about the future? Have you been feeling as if your future will somehow be cut short?
- How has it change your relationships with people?
- How has being a victim of this crime impacted your ability to work or be productive?
- How has it changed your relationship with your family and children?
- Are you more fearful and mistrusting of people? Are you fearful for your life?
- Have you been feeling distant or cut off from other people?
- Have you been feeling emotionally numb or being unable to have loving feelings for those close to you?
- Were your children affected in any way?
- Are they experiencing sleeping or behavioral problems after the incident? Are they acting out in school?
- Did you receive assistance from any community agency? Financial, therapy, social services? Please describe.
- Have you received any kind of counseling or psychological therapy as a result of the incidents that occurred with your perpetrator?

IX. Helpfulness to Law Enforcement

- Did you call the police? If you didn't, who did?
    - If you called the police on previous occasions, then describe the events that occurred when you called the police the last time.
- What happened while you were waiting for the police to arrive? What happened when the police arrived?
    - Did they arrest the perpetrator?
    - Did the perpetrator get away?
- How were you and the police officers able to communicate?
    - Did someone translate for you? If so, who? Did the police bring an interpreter for you?
- What did the officers ask you? What did you tell them?
    - Did you tell the police you wanted the perpetrator arrested?
- Did the police officers take any photos of your injuries or of the place where the criminal activity occurred?
- Did the police report accurately describe what happened? If not, what were the discrepancies?
- Did the police ever call you to follow-up or ask you more questions?
    - Who called you and how many times did the officers call you to ask questions about the incident?
- Did anyone else call you to ask you about the incident?
    - Who were they and what did they ask you?
    - Did they request you appear in court?
        - In their office?

  - How did you feel about everything that was happening?
- Were social services involved as a result of the criminal activity?
  - If so, how did you help them?
- Was the perpetrator charged with a crime?
  - Do you remember what it was?
- Did you get a restraining order?
  - Did the perpetrator ever violate it?
  - If so, did you call the police?
- Did you receive any correspondence from the Court?
  - The State Attorney's Office? The Police Department?
- Did you receive any telephone calls from the Court?
  - The State Attorney's Office? The Police Department?
  - Who called you and what did they need?
- Did you ever receive a notice to appear in Court?
  - Did you ever receive a Subpoena?
  - If so, did you go to court?
  - If you did, describe what happened in court.
  - How did you feel?
  - Were you confused?
  - Were you afraid? Why?

STRUCTURED INTERVIEW QUESTIONS FOR WAIVER OF INADMISSIBILITY

Note that this section may not apply to those who are not subject to any grounds of inadmissibility. An individual who seeks admission into the United States through a VAWA self-petition, a U visa, a T visa or an application for lawful permanent residency must meet certain *admissibility* requirements to be eligible to receive an approved immigration case, receive a visa and eventually be legally admitted into the United States. Immigration law contains lists of inadmissibility grounds that it is important for advocates and attorneys to identify so that the victim's immigration case application can include waivers of inadmissibility requests as part of the client's application. Identifying whether any of the following issues are present in the victim's immigration case is crucial to ensuring that all needed inadmissibility waivers are identified and addressed as the victim's immigration case is being prepared. The ability to attain approvals in VAWA, T or U visa immigration cases is enhanced when inadmissibility issues are identified and addressed as early as possible in the application process.

X. Inadmissibility

1. What was the unlawful activity that you committed? What or who made you do it?
   - Did you enter the U.S. as a minor?
   - Did you enter unlawfully to reunite with your family?
   - Were you trying to escape abuse, physical or sexual violence, or extreme poverty?
   - Did you drive without a license because you had to get to work, take care of your children, or go to the doctor?
2. What were the consequences of the unlawful activity?
   - Did you resolve the matter by paying a fine?
   - Did you have to go to court?

- If so, what happened at court?
- Did you plead guilty?
- Who advised you to plead guilty or why did you decide to plead guilty?

3. Do you feel sorry for what you did?
4. Ask your client to tell you about positive characteristics regarding the kind of person they are? Often survivors may overlook this part of their character. You may want to ask if they consider themselves:
    - A good person, ask for an detailed examples:
        - Are you a responsible parent?
        - Are you a hardworking employee?
        - Are you a law-abiding person?
    - Do you work long hours or overtime to support your family?
    - Do you work several jobs to make ends meet?
    - Describe your role in taking care of your children.
        - Do you drive them to and from school?
        - Do you dress them in the morning?
        - Do you prepare their meals?
        - Do you take them to the doctor or dentist?
        - Do you help your children with their homework or school projects?
        - Are you involved with their school activities?
    - Describe your favorite activities with your children.
        - Do you read them stories at night?
        - Do you pray together?
        - Do you take them to the playground?
        - Do you play with them?
5. To show that your client is a good member of his/her community, ask:
    - Do you regularly attend religious services?
    - Are you an active member in your faith community?
    - Do you volunteer your time or donate?
    - Do you help out your neighbors, friends, or other family members?
6. Ask your client to conclude by explaining how their life would change if they had to leave the U.S. If your client has children, also discuss how it would change the children's lives if they had to return to the client's native country.
7. What would happen to you or your family if you were to return to your country of origin? Are you afraid of returning to your country of origin? Why?
    - What are the living conditions in your country?
    - Do you think you would be safe? Why or why not?
    - Can you trust the police? Is there a lot of crime?
    - Are there laws or customs in your country that mistreat victims of domestic violence, victims who are divorced, or have children but no husband?
    - Does the government of your country protect victims of crime?
    - Are you afraid that your abuser would take action against you in your country?
        - Or do you think your perpetrator would try to harm you for having called the police?

- If so, would you be able to receive adequate protection?
  - Are you afraid that the friends and family of your abuser will try to hurt you or your children (physically or psychologically)?

8. Why do you want to stay in the United States?
   - If you had to leave the U.S., would you be separated from your loved ones?
   - Would you still be able to support yourself and your family?
   - Are there services that you have in the U.S. that you wouldn't have if you were deported (ex: social workers, medical help, counseling, government benefits like WIC, etc.)?
   - If you or your children are receiving medical treatments or counseling, would you be able to continue them in your home country?
   - Do your children speak the native language of your country?
   - Would it be difficult for them to adjust going to school in your country?
   - Do you need to stay in the U.S.to have access to the courts and/or help the police in investigating your abuser?
9. What hopes do you have for the future, for you and for your children?
10. Is there anything else you would like to mention or tell the Immigration officer about you or your family?

TRAUMA INFORMED EVIDENCE BASED STRUCTURED INTERVIEW QUESTIONS

The following trauma informed interview questions are designed to help you and your client identify additional information that will strengthen your client's VAWA or U visa cases in a variety of ways. This section of the structured interview will use research based trauma informed questions. Going through these questions with your client will help you build a stronger case on issues including extreme cruelty, substantial harm, good moral character and your client's qualification for inadmissibility waivers. They will also help you identify additional incidents of abuse and criminal activity that may not have surfaced through story writing or the follow up questions listed above.

XI. Danger Assessment[7]

Note to Advocates and Attorneys: Research among immigrant survivors has found that advocacy involving danger assessment and safety planning strongly correlates with immigrant survivors' willingness to seek protection orders, immigration relief and other forms of legal protections. For victims scoring high on this danger assessment scale provides you a strong indicator of the importance of working to help your client file for VAWA and U visa relief as soon as possible. This is because filing a VAWA, U, or visa immigration case will cut off the ability of the perpetrator to trigger immigration enforcement actions against your client and will strengthen her safety planning. Assessing danger will also help you identify key areas of evidence to develop in support of proving battering and extreme cruelty in your VAWA case and identifying criminal activities and proving substantial harm in your U visa case. High numbers of yes answers on the danger assessment questions may also provide you evidence that you can use to explain why the client was afraid to call the police for help, cooperate with prosecutors,

[7] Jacquelyn C. Campbell, Ph.D., R.N., Danger Assessment,(2003), http://www.dangerassessment.org/DATools.aspx.

seek medical assistance or file for a protection order.

Script: Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Mark Yes or No for each of the following.
("He/She" refers to your spouse, partner, ex-spouse, ex-partner, or whoever is currently physically hurting you.)

1. Has the physical violence increased in severity or frequency over the past year?
2. Does s/he own a gun?
3. Have you left her/him after living together during the past year?
    a. (If have never lived with her/him, check here___)
4. Is s/he unemployed?
5. Has s/he ever used a weapon against you or threatened you with a lethal weapon?
    a. (If yes, was the weapon a gun?_____)
6. Does s/he threaten to kill you?
7. Has s/he avoided being arrested for domestic violence?
8. Do you have a child that is not his?
9. Has s/he ever forced you to have sex when you did not wish to do so?
10. Does s/he ever try to choke you?
11. Does s/he use illegal drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
12. Is s/he an alcoholic or problem drinker?
13. Does s/he control most or all of your daily activities? (For instance: does s/he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car)?
    a. (If s/he tries, but you do not let her/him, check here:_____)
14. Is s/he violently and constantly jealous of you?
    a. (For instance, does s/he say, "If I can't have you, no one can."?)
15. Have you ever been beaten by her/him while you were pregnant?
    a. (If you have never been pregnant by him, check here:_____)
16. Has s/he ever threatened or tried to commit suicide?
17. Does s/he threaten to harm your children?
18. Do you believe s/he is capable of killing you?
19. Does s/he follow or spy on you, leave threatening notes or messages on answering machine, destroy your property, or call you when you don't want her/him to?
20. Have you ever threatened or tried to commit suicide?

Total "Yes" Answers _____

XII. Conflict Tactics Scale (CTS-2)[8]

Note to Advocates and Attorneys: Domestic violence serves as the basis for all VAWA and many U visa cases. The following questions will help you gain important information about the full range of abuse occurring in the domestic violence, child abuse or elder abuse relationship. In some U visa cases based on sexual assault, trafficking or other crimes these questions could also assist you in obtaining more complete information about the abuse that was occurring that should be included in the victim's application.

Script: No matter how well a couple gets along, there are times when they disagree, get annoyed with each other, want different things from each other, or just have arguments or fights. I'm going to list some things that might happen when you have differences with your partner. For each thing, tell me how many times your partner did these things in the last year:

In the last year…	**1-2 times**	**3-10 times**	**10+ times**	**Happened, but not in last year**	**Never happened**
S/he grabbed me					
S/he pushed me					
S/he threw something at me that could hurt					
S/he slapped me.					
S/he twisted my arm					
S/he pulled my hair					
S/he kicked me					
S/he beat me up					
S/he punched or hit me with something that could hurt					
S/he slammed me against the wall					
S/he choked me					
S/he burned me on purpose					
S/he used or told that s/he would use a knife or gun					
S/he used physical force against me when I was pregnant					
S/he forced me to have sex					
S/he refused to wear a condom during sex					
I had sex with him/her because I was afraid of what s/he would do if I didn't					

[8] Straus, M.A.; Hamby, S.L.; Boney-McCoy, S.; and Sugarman, D.B. The Revised Conflict Tactics Scale (CTS2): Development and preliminary psychometric data. *Journal of Family Issues* 17(3):283-316, 1996.

I felt physical pain that still hurt the next day because of his/her					
I had a bruise or cut because of his/her abuse					
I passed out from being hit so hard by him/her					
I had a broken bone from his/her abuse					
I went to the doctor because of his/her abuse					
I have permanent scars because of his/her past abuse					
I have physical health problems now because of his/her abuse					
I have emotional problems now because of his/her abuse					

XIII. Psychological Maltreatment of Women Inventory (PMWI)[9]

Note to Advocates and Attorneys: For VAWA cases this list of questions will assist you in building the extreme cruelty part of your client's application. For U visa cases these questions will help you collect evidence to help prove substantial harm, domestic violence, stalking and other criminal activities. In addition it is important to remember that under the U visa regulations the perpetrator's actions can in and of themselves be sufficient to prove substantial harm. These questions can help you build that part of your client's U visa case.

Script: Now, I'm going to read you statements about things your partner may have done to you in the last year. For each statement, point to the place on the scale that shows how often the event occurred in the last year.

In the last year…	**Never**	**Sometimes**	**Often**	**Very often**
S/he called you a bad name, swore, yelled or screamed at you				
S/he treated you like less than s/he was				
S/he watched over your activities or insisted you tell him/her where you were at all times				
S/he used your money or made important financial decisions without talking to you about it				
S/he was jealous or suspicious of your friends				

[9] Richard M. Tolman, Ph.D., Psychological Maltreatment of Women (1995), http://sitemaker.umich.edu/pmwi/home.

S/he accused you of having an affair with another man/woman				
S/he interfered with your relationships with family or community members				
S/he tried to keep you from doing things to help yourself (such as learning English, getting a job, exercising, etc.)				
S/he controlled your use of the telephone				
S/he told you that your feelings were crazy				
S/he blamed you for his/her problems				
S/he told you s/he would or actually took your children away				
S/he told you s/he would or actually threw or locked you out of the house				
S/he told you s/he would or actually locked you in the house or in a room in the house				
S/he told you s/he would take away or not give you money				
S/he told you s/he would or actually turned you in to immigration officials				
S/he told you s/he would or actually failed to file or withdrew immigration papers for you or your children				
S/he told you s/he would hurt you or your unborn child when you were pregnant				
S/he destroyed your property				

XIV. Intimate Partner Violence (IPV) Coercion Measure[10]

Note to Advocates and Attorneys: Research has found that identifying and measuring coercive control in intimate partner relationships provides more refined and accurate picture of the details of how power and control plays out in abusive relationships. Since domestic violence under immigration law is defined as "battering or extreme cruelty" and is more inclusive of a broader range of abusive behaviors than most state protection order and criminal domestic violence statutes, identifying coercive control in abusive relationships can be very useful in proving extreme cruelty for VAWA immigration cases. Similarly for U visa cases, proof of coercive control, provides evidence and details of substantial harm, how it is perpetrated and its effect on the victim.

[10] Dutton et al., Intimate Partner Violence (IPV) Coercion Measure, (2006)

This Intimate Partner Violence Coercion Measure aims to detect and measure the cycle of coercive control. In these situations--

1. One party sets the stage for apprehension of impending violence against the other by
   - creating vulnerabilities,
   - exploiting existing vulnerabilities,
   - wearing down resistance, and
   - facilitating attachment.
2. Subsequently, the cycle of coercive control ensues, which consists of:
   - Coercive demand or expectation
   - Credible threat – meaningful and negative consequence for noncompliance and the likelihood that the consequence will be delivered (willing, able, ready)
   - Surveillance
   - Delivery of the threatened consequences

Appraisal or (Understanding) of IPV Coercion

Appraisal of IPV Coercion means understanding of the likelihood that one's partner would or would try to deliver contingent and meaningful negative consequences for one's noncompliance with demand or expectation. The language *"would or would try"* is important since the agent may try, but not succeed because of the target's resistance – but its still coercion.

IPV Coercion is communicating the threat of a meaningful and credible negative consequence for noncompliance with a demand or expectation. IPV Coercion incorporates: 1) communication of demand or expectation, 2) communication of a contingent threat for noncompliance with the demand or expectation, and 3) credibly reasonable ability to carry out the threat.

Ask your client whether and the extent to which the following things are happening in the relationship.

> If yes, ask the extent to which if your client did not do these things their partner would get back at them by doing something hurtful.

Personal Activities:

1. Not leave the house.
2. Not eat certain foods.
3. Sleep where he (or she) says.
4. Sleep when he (or she) says.
5. Wear (or not wear) what he (or she) says.
6. Bath or use the bathroom only when he (or she) says.
7. Not go places or do things on your own without him (or her) or someone else being there.
8. Not read, watch TV, listen to the radio, or use the internet.
9. Watch or read sexually explicit video or print material.

Support / Social life / Family

10. Not talk to friends or family members on the phone.

11. Not spend time with friends or family members.
12. Not talk to others in a social situation.Not participate in church, school, or other community activities.
13. Not seek help from a counselor, clergy, case worker, advocate or other support person or helping professional.

Household

14. Take care of the house in the way he (or she) says.
15. Buy or prepare foods in the way he (or she) says.
16. Live where he (or she) says.

Work / Economic / Resources

17. Not work.
18. Have the kind of job he (or she) says.
19. Work how much he (or she) says.
20. Spend money or use credit cards only on things he (or she) says.
21. Not learn another language (English or other language).
22. Not go to school.
23. Not use the car or truck.
24. Not use or see the checkbook or other financial records.

Children / Parenting

25. Take care of children in the way he (or she) says.
26. Discipline children in the way he (or she) says.
27. Not make decisions concerning the children on your own.

Health

28. Not take certain medication or go to the doctor.
29. Not use birth control.
30. Have (or not have) an abortion.
31. Use drugs or alcohol.

Intimate Relationship

32. Have sex with him (or her) when he (or she) says.
33. Do sexual behaviors in the way he (or she) says.
34. Talk with him (or her) only when he (or she) says.
35. Spend time with him (or her) when he (or she) says.
36. Have sex with someone else when he (or she) says.
37. Not separate, leave the relationship, or get a divorce.

Legal

38. Do things that are against the law.
39. Be with him (or her) when he (or she) is doing things that are against the way (law?).
40. Carry a gun.

Follow-up Questions to Appraisal of IPV Coercion

<u>Types of Expected Consequences for Noncompliance:</u>

Which of the following specific types of consequences do you believe your partner would actually do (or try to do) in the future if you didn't do what he (or she) wanted?

1 = yes
2 = no

1. Emotionally hurt you.
2. Embarrass or shame you.
3. Emotionally hurt your children.
4. Emotionally hurt your friends or family members.
5. Not let you see or talk to others.
6. Reveal personal information about you to others (medical condition, sexual preference, past behavior).
7. Physically restrain you or lock you in the house or in a room.
8. Physically hurt you.
9. Kill you.
10. Physically hurt your children.
11. Kill your child.
12. Physically hurt a friend or family member.
13. Kill a friend or family member.
14. Not let you take medication.
15. Put you in a mental hospital.
16. Not let you see your children.
17. Take your children away from you.
18. Destroyed or took your property.
19. Cause you to lose your job.
20. Cause you to lose your housing.
21. Destroy you financially.
22. Destroy legal papers.
23. Threaten you with legal trouble.
24. Have you arrested.
25. Threat to have you deported.

Involvement of Third Parties:

Do you believe your partner would try to get any of the following people to help him (or her) do any of these hurtful things in the future?

1 = yes
2 = no

1. Police, prosecutor, judge, probation officer or someone else in the justice system
2. Minister, priest, rabbi, or other spiritual leader
3. Your partner's friend or family member
4. Your friend or family member
5. Doctor,, nurse, counselor or someone else in health care
6. DHS-Immigration
7. IRS
8. Mafia
9. Other

Past IPV Coercion

Surveillance:

In The past, has your partner checked to see if you have done what he (or she) demanded or expected?

1 = yes
2 = no

(If yes)
Which of the following things did your partner do (or try to do) to check to see if you actually did what he (or she) wanted?

1. Called you
2. Check the car (odometer, where parked)
3. Asked children
4. Ask someone else (other than children)
5. Told you to report behavior to him (or her)
6. Used recorder
7. Checked clothing
8. Checked house
9. Didn't need to check, he said or acted like he (or she) just knew
10. Other

Prior Response to Coercion:

In the past, how often did you respond in the following ways to your partner's threat to do something hurtful if you didn't do what he (or she) demanded or expected?

1-Not at all or never

2-Infrequently or not very often
3-Sometimes
4-Often
5-All the time

1. Did what my partner wanted, even though I didn't want to
2. Told myself that I wanted to do what my partner wanted, even though I originally didn't want to
3. Did nothing
4. Told my partner I wasn't going to do it
5. Tried to talk my partner out of wanting me to do it
6. Resisted doing what my partner wanted by trying to buy time
7. Sought help from someone else to resist doing what my partner wanted me to do
8. Resisted doing what my partner wanted in some other way
9. Distracted my partner so he (or she) forgot about what he (or she) wanted me to do
10. Other

Specific Consequences for Prior Noncompliance with Coercion:

In the past, which of the following specific types of consequences did your partner actually do (or try to do) when you didn't do what he (or she) demanded or expected?

1 = yes
2 = no

1. Emotionally hurt you
2. Embarrass or shame you
3. Emotionally hurt your children
4. Emotionally hurt your friends or family members
5. Not let you see or talk to others
6. Revealed personal information about you to others (medical condition, sexual preference, past behavior)
7. Physically restrained you or locked you in the house or in a room
8. Physically hurt you
9. Tried to kill you
10. Physically hurt your children
11. Tried to kill your child
12. Physically hurt a friend or family member
13. Tried to kill a friend or family member
14. Not let you take medication
15. Put you in a mental hospital
16. Not let you see your children
17. Took your children away from you

18. Destroyed or took your property
19. Caused you to lose your job
20. Caused you to lose your housing
21. Destroyed you financially
22. Destroyed legal papers
23. Threatened you with legal trouble
24. Had you arrested
25. Threatened to have you deported

XV. Intimate Partner Violence (IPV) Threat Appraisal & Fear Scale[11]

Note to Advocates and Attorneys: The following questions will be useful in VAWA self-petitioning cases providing important evidence about "extreme cruelty". The victim's appraisal of what is likely to happen to her in the future is founded upon the basis of coercion, threats, intimidation, isolation and the abuse she has experienced in the past. In VAWA cancellation and suspension cases this scale can contribute important information to prove "extreme hardship". In U visa cases this scale provides information central to building your case for substantial harm, and obtaining inadmissibility waivers. All VAWA and U visa cases are forms of humanitarian relief, the following factors can be used to convince DHS that the risk of harm to your client is real. This can help obtain fee waivers and can help strengthen all aspects of the victim's case in which the victim must convince DHS to exercise its discretion in the victim's favor.

Script: I'm going to ask you how likely you think it is that your partner will do certain things in the next year. For each statement, point to the place on the scale between "Not At All" and "Definitely" that shows how likely you think it is that the event will happen. There is no right or wrong answer; just the way you feel. Do you have any questions before we begin?

In the next year, how likely do you think it is that your partner will…

	Not at all	Some Likelihood	High Likelihood	Definitely
Threaten to harm you physically				
Actually physically harm you				
Force you to have sex against your will				
Try to kill you				
Control or dominate you				
Embarrass you				
Take away your money				
Tell you s/he will physically harm someone you know, such as friends, co-workers, parents, etc.				

[11] Dutton et al., Intimate Partner Violence (IPV) Threat Appraisal and Fear Scale, (2001).

Actually physically harm someone you know, such as friends, co-workers, parents, etc.				
Call immigration authorities to get you in trouble				
Call police to get you in trouble				
Throw or lock you out of the house or room				
Destroy your property or important documents				
Violate a protective order				
Track you down or find you				
Try to take away, get custody, or kidnap your child or children				
Not sponsor, petition for green card or visa for you or your children				

XVI. Identification of Trauma Related Distress[12]

Note to Advocates and Attorneys: VAWA cases are strengthened when the victim describes in her story not only the events that happened to her, but can also describe the effects that the battering or extreme cruelty had on her. The following questions help prove extreme cruelty, extreme hardship and substantiate evidence of battery, and the range of forms of physical and sexual violence occurring in the abusive relationship. In U visa cases, the following questions provide strong evidence of substantial harm as a result of victimization by the criminal activit(ies). These are items included in the list below are will help advocates and attorneys identify and describe trauma related distress more fully in the victim's application for immigration relief.

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem in the last month.

No.	Response:	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)

[12] This list is being included to assist advocates and attorneys working with immigrant survivors in identifying trauma related distress factors that victims may have experience. This is taken from the PCL-5 (DCM –V). PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx,& Schnurr -- National Center for PTSD. While the facts that this measure collects can be extremely helpful to VAWA, T and U visa immigration cases in a variety of ways, advocates and attorneys should not use this measure to make conclusions whether not a client has any particular mental health diagnosis. Only experienced mental health professionals are qualified to make mental health diagnoses. VAWA, T and U visa immigration cases are decided on the facts of the crime victimization and the effects on the victim; mental health diagnosis is not required. When persons other than mental health professionals attempt to draw conclusions as to mental health diagnosis based on this or any other measure incorrect diagnosis by untrained professionals can undermine credibility of the victim's immigration case.

1.	Repeated, disturbing, and unwanted memories of the stressful experience?					
2.	Repeated, disturbing dreams of the stressful experience?					
3.	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?					
4.	Feeling very upset when something reminded you of the stressful experience??					
5.	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?					
6.	Avoiding memories, thoughts, or feelings related to the stressful experience?					
7.	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?					
8.	Trouble remembering important parts of the stressful experience?					
9.	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, and the world is completely dangerous)?					
10.	Blaming yourself or someone else for the stressful experience or what happened after it?					

11.	Having strong negative feelings such as fear, horror, anger, guilt, or shame?					
12.	Loss of interest in activities that you used to enjoy?					
13.	Feeling distant or cut off from other people?					
14.	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?					
15.	Irritable behavior, angry outbursts, or acting aggressively?					
16.	Taking too many risks or doing things that could cause you harm?					
17.	Being "super alert" or watchful or on guard?					
18.	Feeling jumpy or easily startled?					
19.	Having difficulty concentrating?					
20.	Trouble falling or staying asleep?					

XVII. Patient Health Questionnaire (PHQ-9)[13]

Note to Advocates and Attorneys: The following questions provide an additional opportunity to learn how the battering or extreme cruelty and the criminal activities committed against your client affect her ability to function in her daily life. This can provide strong evidence of extreme cruelty in VAWA self-petitioning cases as well as evidence for fee and inadmissibility waivers, including the domestic violence victim waiver for good moral character purposes. In U visa cases these questions provide additional and powerful evidence of substantial harm that goes beyond physical injuries. This evidence is important for obtaining inadmissibility and fee waivers for U visa cases. In all cases this evidence and the evidence provided by the Trauma related Distress Checklist can provide evidence to secure fee waivers in applications for work authorization.

[13] PHQ9 Copyright © Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD ® is a trademark of Pfizer Inc. This list is being included to assist advocates and attorneys working with immigrant survivors in identifying symptoms of distress or depression that may have experienced. While the facts that this measure collects can be extremely helpful to VAWA, T and U visa immigration cases in a variety of ways, advocates and attorneys should not use this measure to make conclusions whether not a client has any particular mental health diagnosis. Only experienced mental health professionals are qualified to make mental health diagnoses.

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "X" to indicate the answer)

	Not at all	Several days	More than half of the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself	0	1	2	3
	Add columns:			
	Total:			
10. If you checked off any problems, how difficult have these problems made it for you to do work, take care of things at home, or get along with other people?	Not difficult at all ____ Somewhat difficult ____ Very difficult ____ Extremely difficult____			

XVIII. Stressful Life Events Screening Questionnaire (SLESQ)[14]

The SLESQ is helpful to uncover multiple types of trauma exposure. Let the client know that the following questions refer to events that may have taken place at any point in his/her entire life, including early childhood. If an event or ongoing situation occurred more than once, please record all pertinent information about additional events. **FIRST, go through the events and simply ask the Yes/No question as to whether the events have occurred. SECOND, make a reasoned decision as to whether for questions answered "yes" greater detail is necessary and important for the application. If so, follow the prompts to record detail.**

Note to Lawyers and Advocates: The following questions can provide information that in

[14] Goodman, L., Corcoran, C., Turner, K., Yuan, N., & Green, B. (1998). Assessing traumatic event exposure: General issues and preliminary findings for the Stressful Life Events Screening Questionnaire. Journal of Traumatic Stress, 11(3), 521-542.

VAWA cases may provide additional evidence of battering or extreme cruelty. In U visa cases the information gathered below could provide helpful information for substantial harm and inadmissibility waivers. These questions may also in both VAWA and U visa cases uncover additional incidents of abuse or criminal activities that will strengthen your VAWA or U visa case.

yes	no	Trauma Question	Prompts for More Detailed
		1. Have you ever had a life-threatening illness?	• If yes, at what age? • Duration of Illness • Describe specific illness
		2. Were you ever in a life-threatening accident?	• If yes, at what age? • Describe accident • Did anyone die? Who? (Relationship to you) • What physical injuries did you receive? • Were you hospitalized overnight?
		3. Was physical force or a weapon ever used against you in a robbery or mugging?	• If yes, at what age? • How many perpetrators? • Describe physical force (e.g., restrained, shoved) or weapon used against you • Did anyone die? Who?_ • What injuries did you receive? • Was your life in danger?
		4. Has an immediate family member, romantic partner, or <u>very close</u> friend died because of accident, homicide, or suicide?	• If yes, how old were you? • How did this person die? • Relationship to person lost • In the year before this person died, how often did you see/have contact with him/her? • Have you had a miscarriage? If yes, at what age?

		5. At any time, has anyone (parent, other family member, romantic partner, stranger or someone else) ever physically forced you to have intercourse, or to have oral or anal sex against your wishes, or when you were helpless, such as being asleep or intoxicated?	• If yes, at what age? • If yes, how many times? • If repeated, over what period? • Who did this? (Specify stranger, parent
		6. Other than experiences mentioned in earlier questions, has anyone ever touched private parts of your body, made you touch their body, or tried to make you to have sex against your wishes?	• If yes, at what age? • If yes, how many times? • If repeated, over what period? • Who did this? (Specify sibling, date, etc.) • What age was this person? • Has anyone **else** ever done this to you?
		7. When you were a child, did a parent, caregiver or other person ever slap you repeatedly, beat you, or otherwise attack or harm you?	• If yes, at what age • If yes, how many times? • If repeated, over what period? • Describe force used against you (e.g., fist, belt) • Were you ever injured? If yes, describe • Who did this? (Relationship to you) • Has anyone **else** ever done this to you?
		8. As an adult, have you ever been kicked, beaten, slapped around or otherwise physically harmed by a romantic partner, date, family member, stranger, or someone else?	• If yes, at what age? • If yes, how many times? • If repeated, over what period? • Describe force used against you (e.g., fist, belt) • Were you ever injured? If yes, describe • Who did this? (Relationship to you) • If sibling, what age was he/she • Has anyone **else** ever done this to you?

		9. Has a parent, romantic partner, or family member repeatedly ridiculed you, put you down, ignored you, or told you were no good?	• If yes, how many times? • If repeated, over what period? • Who did this? (Relationship to you) • If sibling, what age was he/she • Has anyone **else** ever done this to you?
		10. Other than the experiences already covered, has anyone ever <u>threatened</u> you with a weapon like a knife or gun?	• If yes, how many times? • If repeated, over what period? • Describe nature of threat • Who did this? (Relationship to you) • Has anyone **else** ever done this to you?
		11. Have you ever been present when another person was killed? Seriously injured? Sexually or physically assaulted?	• If yes, at what age? • Please describe what you witnessed • Was your own life in danger?
		12. Have you ever been in any other situation where you were seriously injured or your life was in danger (e.g., involved in military combat or living in a war zone)?	• If yes, at what age?
		13. Have you ever been in any other situation that was extremely frightening or horrifying, or one in which you felt extremely helpless, that you haven't reported? *The interviewer should determine if the respondent is reporting the same incident in multiple questions, and should record it in the most appropriate category.*	• If yes, at what age? • Please describe

NATIONAL Center on Domestic Violence, Trauma & Mental Health

Trauma-Informed Legal Advocacy: Practice Scenarios Series

The Trauma-Informed Legal Advocacy (TILA) Project is designed to offer guidance to legal advocates and lawyers on applying trauma-informed principles to doing legal advocacy with survivors of domestic violence.

This document is part of a series: *Trauma-Informed Legal Advocacy (TILA): Practice Scenarios Series*.[1] Within each scenario in this series, we practice a two-step analysis of (1) what is happening from the perspective of the person we are working with, and (2) what strategies we can try to best support or represent them.

Scenario: Legal Interviewing & Traumatic Triggers

You are having a hard time connecting with someone who you are working with. Maybe they seem distracted, anxious and agitated, or just shut down.

Step 1. What happened from their perspective?

A person may be feeling distracted, anxious and agitated, or shut down for many reasons. From a trauma-informed perspective, traumatic triggers are one factor that may explain why you are having trouble connecting. A *trigger* is something that evokes a memory of past traumatizing events, including the feelings and sensations associated with those experiences. Encountering triggers may cause someone to feel uneasy or afraid, although they may not always realize why they feel that way. A trigger can make someone feel as if they are reliving a traumatic experience and can elicit a fight, flight or freeze response. Many things can be a possible trigger for someone. A person might be triggered by a particular color of clothing, by the smell of a certain food, or the time of year. Internal sensations, such as rapid heartbeat, nausea, or tightened muscles, can be triggers as well.[2]

A person who is being triggered by something may become anxious and agitated. They might feel nauseous or have other physical reactions. They may not know why

[1] The *TILA: Practice Scenarios Series* was created by Rachel White-Domain, JD, NCDVTMH. Find more TILA resources on our the NCDVTMH website: http://www.nationalcenterdvtraumamh.org/trainingta/trauma-informed-legal-advocacy-tila-project/

[2] This paragraph is taken from NCDVTMH's Special Collection: Trauma-Informed Domestic Violence Services: Understanding the Framework and Approach (Part 1 of 3), available at www.VAWnet.org.

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they are feeling or reacting that way. They may also appear bored or uninterested, talk about things in a flat or unemotional way, have a blank stare and spacey look, or appear to be shut down or checked out. Their answers to questions may be slow and incomplete. This may reflect a dissociative response. See Scenario 1 for more information about dissociation.

Step 2. What might help?

There are many things that you can do to limit the number of things in your environment that are common triggers for survivors of trauma, and to make your interactions with someone more trauma informed as well.

1. *Offer options in the physical space.* As best as possible, provide options to the person you are working with in order to avoid situations that might be triggering. For example, you might be able to provide options on where you will meet; which chair they can use; and whether a door is closed, open, or slightly ajar. If you have an office, consider whether you can make slight adjustments to accommodate multiple seating options.

   "Which chair would be most comfortable for you?"

   "Would you prefer the door closed or slightly open?"

   At the same time, be aware that sometimes options can be overwhelming to someone who is not used to being given many choices.

2. *Facilitate self-soothing.* Experiencing trauma can disrupt a person's ability to manage emotions and self-soothe when they are starting to feel upset. All of us do many things to self-soothe (even if we don't call it that), such as listening to music, going for a walk, or snuggling with a dog or cat. In the context of a legal meeting, your options are more limited, but there are still many things that you can do. Doodling or coloring with crayons, fidgeting with toys or other objects, wrapping up in a blanket, looking at calming pictures, and drinking water are all things that can help someone to negotiate their distance from hard material, manage their emotions, and stay present. Consider whether you can provide physical things in your meeting space that will facilitate someone's ability to self-soothe. This may include having pens, crayons, paper, and small toys on the table in the space where you are meeting, offering water, and hanging pictures in places where someone can easily focus if they need to briefly take a little more distance from what's going on.

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3. *Explain things in advance.* For people who have experienced trauma, it can often be helpful to know in advance what is going to happen. This includes telling someone how much time you have to meet, which can also help with building trust. It can also mean telling someone what kinds of things you will need to ask them about during your meeting.

   "We have about 45 minutes to talk today. I'd like to hear you talk about your relationship with your partner and then I'd like to ask you some questions. You can ask me questions at anytime. At the end of the meeting, I'd like to make some copies of the materials you brought."

4. *Offer breaks.* Taking breaks can provide someone with the space they need to stay present during a meeting or interview. Offer breaks not only at the beginning of the meeting but also periodically throughout.

   "How are you doing so far? Would you like to take a break or would you like to keep going?"

5. *Be thoughtful about note taking.* For people who have been involved in criminal legal systems or in social service agencies that don't practice trauma-informed care, having someone take notes about them may have been one part of a very dehumanizing experience. Being open about our note taking, such as by asking permission to take notes, summarizing the notes that we have taken, or using open body language when taking notes can keep this experience from feeling objectifying. Also, don't allow note taking to take you away from being present with someone. Consider how much time you spend with a pen or pencil in your hand. Whenever possible, try to increase the time you spend with the pen or pencil down, just listening.

There are also things that you can do if someone is being triggered.

1. *Notice and validate their feelings.* Noticing and validating someone's feelings can help them become aware of what's happening with them, if they are not already. It can also let someone know that you care about their emotional safety. This matters in part because it contradicts what happens in many traumatic incidents, where a person's feelings of anxiety and fear are often ignored and dismissed, or where showing these feelings may be met with increased violence. Noticing and validating means sitting with someone as they move at their own pace through their feelings.

   "That sounds really scary/hurtful."

   "It really means a lot that you are sharing this with me, even though it makes you sad to talk about it."

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2. *Ask what would help.* When making suggestions, offer several options whenever possible, rather than just asking "yes-no questions." Asking someone how you can help when they seem triggered also reflects that you are approaching the relationship as a partnership of equal respect.

   "Let me know if I can get you a glass of water, or we can just sit together for a moment."

   "Would it help to have a moment to yourself or visit with your friend in the waiting room, or maybe something else?"

3. *Use open body language.* If someone is very upset and agitated, using open body language can help to let them know that you do not pose a threat. This includes keeping your shoulders relaxed, keeping your body posture and hands open and relaxed, and avoiding blocking them from being able to exit or walk away.

4. *Help them to get grounded in the present.* If someone seems to be having a dissociative response, you can say things to help them feel safe and ground themselves in the present. Easy ways to ground someone in the present include helping them notice their breath, their physical presence in the environment, or physical things in the environment. For different people, different senses (sight, sound, smell) may be more grounding than others. (If you know grounding might come up for someone, you can ask in advance.) Remember, dissociative responses come up when cues in the environment tell someone that it is not safe. Therefore, it's also important to be attentive to emotional safety while supporting someone in grounding themselves.

   "I noticed that you are wearing really nice shoes. Are they comfortable?"

   "You know we can sit here on this bench for as long as we need to. We are okay right now, you and me. We can just take our time, no one is going to bother us here."

   "Is it hard for you to focus on these questions? When that happens, some people say it helps them to just take a minute to notice yourself breathing in and out."

***

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SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Prepared by

SAMHSA's Trauma and Justice Strategic Initiative

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Contents

Introduction

Trauma is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. It is an almost universal experience of people with mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. ***In order to maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.***

The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders.[1,2,3,4,5] Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences.[6,7,8,9] However, most people go without these services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders and chronic physical diseases.[1,10,11]

With appropriate supports and intervention, people can overcome traumatic experiences.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma.[12,13] Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems.[5,14] Young people bring their experiences of trauma into the school systems, often interfering with their school success. And many patients in primary care similarly have significant trauma histories which has an impact on their health and their responsiveness to health interventions.[15,16,17]

In addition, the public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing. The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems.

Thus, the pervasive and harmful impact of traumatic events on individuals, families and communities and the unintended but similarly widespread re-traumatizing of individuals within our public institutions and service systems, makes it necessary to rethink doing "business as usual." In public institutions and service systems, there is increasing recognition that many of the individuals have extensive histories of trauma that, left unaddressed, can get in the way of achieving good health and well-being. For example, a child who suffers from maltreatment or neglect in the home may not be able to concentrate on school work and be successful in school; a women victimized by domestic violence may have trouble performing in the work setting; a jail inmate repeatedly exposed to violence on the street may have difficulty refraining from retaliatory violence and re-offending; a sexually abused homeless youth may engage in self-injury and high risk behaviors to cope with the effects of sexual abuse; and, a veteran may use substances to mask the traumatic memories of combat. The experiences of these individuals are compelling and, unfortunately, all too common. Yet, until recently, gaining a better understanding of how to address the trauma experienced by these individuals and how to mitigate the re-traumatizing effect of many of our public institutions and service settings was not an integral part of the work of these systems. Now, however, there is an increasing focus on the impact of trauma and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their "business" under the framework of a trauma-informed approach.

There is an increasing focus on the impact of trauma and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their business under the framework of a trauma-informed approach.

Purpose and Approach: Developing a Framework for Trauma and a Trauma-Informed Approach

PURPOSE

The purpose of this paper is to develop a working concept of trauma and a trauma-informed approach and to develop a shared understanding of these concepts that would be acceptable and appropriate across an array of service systems and stakeholder groups. SAMHSA puts forth a framework for the behavioral health specialty sectors, that can be adapted to other sectors such as child welfare, education, criminal and juvenile justice, primary health care, the military and other settings that have the potential to ease or exacerbate an individual's capacity to cope with traumatic experiences. In fact, many people with behavioral health problems receive treatment and services in these non-specialty behavioral health systems. SAMHSA intends this framework be relevant to its federal partners and their state and local system counterparts and to practitioners, researchers, and trauma survivors, families and communities. The desired goal is to build a framework that helps systems "talk" to each other, to understand better the connections between trauma and behavioral health issues, and to guide systems to become trauma-informed.

APPROACH

SAMHSA approached this task by integrating three significant threads of work: trauma focused research work; practice-generated knowledge about trauma interventions; and the lessons articulated by survivors

of traumatic experiences who have had involvement in multiple service sectors. It was expected that this blending of the research, practice and survivor knowledge would generate a framework for improving the capacity of our service systems and public institutions to better address the trauma-related issues of their constituents.

To begin this work, SAMHSA conducted an environmental scan of trauma definitions and models of trauma informed care. SAMHSA convened a group of national experts who had done extensive work in this area. This included trauma survivors who had been recipients of care in multiple service system; practitioners from an array of fields, who had experience in trauma treatment; researchers whose work focused on trauma and the development of trauma-specific interventions; and policymakers in the field of behavioral health.

From this meeting, SAMHSA developed a working document summarizing the discussions among these experts. The document was then vetted among federal agencies that conduct work in the field of trauma. Simultaneously, it was placed on a SAMHSA website for public comment. Federal agency experts provided rich comments and suggestions; the public comment site drew just over 2,000 respondents and 20,000 comments or endorsements of others' comments. SAMHSA reviewed all of these comments, made revisions to the document and developed the framework and guidance presented in this paper.

The key questions addressed in this paper are:

- **What do we mean by trauma?**
- **What do we mean by a trauma-informed approach?**
- **What are the key principles of a trauma-informed approach?**
- **What is the suggested guidance for implementing a trauma-informed approach?**
- **How do we understand trauma in the context of community?**

SAMHSA's approach to this task has been an attempt to integrate knowledge developed through research and clinical practice with the voices of trauma survivors. This also included experts funded through SAMHSA's trauma-focused grants and initiatives, such as SAMHSA's National Child Traumatic Stress Initiative, SAMHSA's National Center for Trauma Informed Care, and data and lessons learned from other grant programs that did not have a primary focus on trauma but included significant attention to trauma, such as SAMHSA's: Jail Diversion Trauma Recovery grant program; Children's Mental Health Initiative; Women, Children and Family Substance Abuse Treatment Program; and Offender Reentry and Adult Treatment Drug Court Programs.

Background: Trauma — Where We Are and How We Got Here

The concept of traumatic stress emerged in the field of mental health at least four decades ago. Over the last 20 years, SAMHSA has been a leader in recognizing the need to address trauma as a fundamental obligation for public mental health and substance abuse service delivery and has supported the development and promulgation of trauma-informed systems of care. In 1994, SAMHSA convened the Dare to Vision Conference, an event designed to bring trauma to the foreground and the first national conference in which women trauma survivors talked about their experiences and ways in which standard practices in hospitals re-traumatized and often, triggered memories of previous abuse. In 1998, SAMHSA funded the Women, Co-Occurring Disorders and Violence Study to generate knowledge on the development and evaluation of integrated services approaches for women with co-occurring mental and substance use disorders who also had histories of physical and or sexual abuse. In 2001, SAMHSA funded the National Child Traumatic Stress Initiative to increase understanding of child trauma and develop effective interventions for children exposed to different types of traumatic events.

The American Psychiatric Association (APA) played an important role in defining trauma. Diagnostic criteria for traumatic stress disorders have been debated through several iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a new category of Trauma- and Stressor-Related Disorders, across the life-span, included in the recently released DSM-V (APA, 2013). Measures and inventories of trauma exposure, with both clinical and research applications, have proliferated since the 1970's.[18,19,20,21] National trauma research and practice centers have conducted significant work in the past few decades, further refining the concept of trauma, and developing effective trauma assessments and treatments.[22,23,24,25] With the advances in neuroscience, a biopsychosocial approach to traumatic experiences has begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental and substance use disorders across the life-span.[3,25]

Simultaneously, an emerging trauma survivors movement has provided another perspective on the understanding of traumatic experiences. Trauma survivors, that is, people with lived experience of trauma, have powerfully and systematically documented their paths to recovery.[26] Traumatic experiences complicate a child's or an adult's capacity to make sense of their lives and to create meaningful consistent relationships in their families and communities.

Trauma survivors have powerfully and systematically documented their paths to recovery.

The convergence of the trauma survivor's perspective with research and clinical work has underscored the central role of traumatic experiences in the lives of people with mental and substance use conditions. The connection between trauma and these conditions offers a potential explanatory model for what has happened to individuals, both children and adults, who come to the attention of the behavioral health and other service systems.[25,27]

People with traumatic experiences, however, do not show up only in behavioral health systems. Responses to these experiences often manifest in behaviors or conditions that result in involvement with the child welfare and the criminal and juvenile justice system or in difficulties in the education, employment or primary care system. Recently, there has also been a focus on individuals in the military and increasing rates of posttraumatic stress disorders.[28,29,30,31]

With the growing understanding of the pervasiveness of traumatic experience and responses, a growing number of clinical interventions for trauma responses have been developed. Federal research agencies, academic institutions and practice-research partnerships have generated empirically-supported interventions. In SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) alone there are over 15 interventions focusing on the treatment or screening for trauma.

These interventions have been integrated into the behavioral health treatment care delivery system; however, from the voice of trauma survivors, it has become clear that these clinical interventions are not enough. Building on lessons learned from SAMHSA's Women, Co-Occurring Disorders and Violence Study; SAMHSA's National Child Traumatic Stress Network; and SAMHSA's National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraints, among other developments in the field, it became clear that the organizational climate and conditions in which services are provided played a significant role in maximizing the outcomes of interventions and contributing to the healing and recovery of the people being served. SAMHSA's National Center for Trauma-Informed Care has continued to advance this effort, starting first in the behavioral health sector, but increasingly responding to technical assistance requests for organizational change in the criminal justice, education, and primary care sectors.

FEDERAL, STATE AND LOCAL LEVEL TRAUMA-FOCUSED ACTIVITIES

The increased understanding of the pervasiveness of trauma and its connections to physical and behavioral health and well-being, have propelled a growing number of organizations and service systems to explore ways to make their services more responsive to people who have experienced trauma. This has been happening in state and local systems and federal agencies.

States are elevating a focus on trauma. For example, Oregon Health Authority is looking at different types of trauma across the age span and different population groups. Maine's "Thrive Initiative" incorporates a trauma-informed care focus in their children's systems of care. New York is introducing a trauma-informed initiative in the juvenile justice system. Missouri is exploring a trauma-informed approach for their adult mental health system. In Massachusetts, the Child Trauma Project is focused on taking trauma-informed care statewide in child welfare practice. In Connecticut the Child Health and Development Institute with the state Department of Children and Families is building a trauma-informed system of care throughout the state through policy and workforce development. SAMHSA has supported the further development of trauma-informed approaches through its Mental Health Transformation Grant program directed to State and local governments.

Increasing examples of local level efforts are being documented. For example, the City of Tarpon Springs in Florida has taken significant steps in becoming a trauma-informed community. The city made it its mission to promote a widespread awareness of the costly effects of personal adversity upon the wellbeing of the community. The Family Policy Council in Washington State convened groups to focus on the impact of adverse childhood experiences on the health and well-being of its local communities and tribal communities. Philadelphia held a summit to further its understanding of the impact of trauma and violence on the psychological and physical health of its communities.

SAMHSA continues its support of grant programs that specifically address trauma.

At the federal level, SAMHSA continues its support of grant programs that specifically address trauma and technical assistance centers that focus on prevention, treatment and recovery from trauma.

Other federal agencies have increased their focus on trauma. The Administration on Children Youth and Families (ACYF) has focused on the complex trauma of children in the child welfare system and how screening and assessing for severity of trauma and linkage with trauma treatments can contribute to improved well-being for these youth. In a joint effort among ACYF, SAMHSA and the Centers for Medicare and Medicaid Services (CMS), the three agencies developed and issued through the CMS State Directors' mechanism, a letter to all State Child Welfare Administrators, Mental Health Commissioners, Single State Agency Directors for Substance Abuse and State Medicaid Directors discussing trauma, its impact on children, screening, assessment and treatment interventions and strategies for paying for such care. The Office of Juvenile Justice and Delinquency Prevention has specific recommendations to address trauma in their Children Exposed to Violence Initiative. The Office of Women's Health has developed a curriculum to train providers in primary care on how to address trauma issues in health care for women. The Department of Labor is examining trauma and the workplace through a federal interagency workgroup. The Department of Defense is honing in on prevention of sexual violence and trauma in the military.

As multiple federal agencies representing varied sectors have recognized the impact of traumatic experiences on the children, adults, and families they serve, they have requested collaboration with SAMHSA in addressing these issues. The widespread recognition of the impact of trauma and the burgeoning interest in developing capacity to respond through trauma-informed approaches compelled SAMHSA to revisit its conceptual framework and approach to trauma, as well as its applicability not only to behavioral health but also to other related fields.

SAMHSA's Concept of Trauma

Decades of work in the field of trauma have generated multiple definitions of trauma. Combing through this work, SAMHSA developed an inventory of trauma definitions and recognized that there were subtle nuances and differences in these definitions.

Desiring a concept that could be shared among its constituencies — practitioners, researchers, and trauma survivors, SAMHSA turned to its expert panel to help craft a concept that would be relevant to public health agencies and service systems. SAMHSA aims to provide a viable framework that can be used to support people receiving services, communities, and stakeholders in the work they do. A review of the existing definitions and discussions of the expert panel generated the following concept:

> ***Individual trauma results from an* event*, series of events, or set of circumstances that is* experienced *by an individual as physically or emotionally harmful or life threatening and that has lasting adverse* effects *on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.***

THE THREE "E'S" OF TRAUMA: EVENT(S), EXPERIENCE OF EVENT(S), AND EFFECT

Events and circumstances may include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. This element of SAMHSA's concept of trauma is represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as "trauma and stressor-related disorders" to include exposure to a traumatic or stressful event as a diagnostic criterion.

The individual's **experience** of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another (e.g., a child removed from an abusive home experiences this differently than their sibling; one refugee may experience fleeing one's country differently from another refugee; one military veteran may experience deployment to a war zone as traumatic while another veteran is not similarly affected). How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event, or a force of nature) has power over another. They elicit a profound question of "why me?" The individual's experience of these events or circumstances is shaped in the context of this powerlessness and questioning. Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. When a person experiences physical or sexual abuse, it is often accompanied by a sense of humiliation, which can lead the person to feel as though they are bad or dirty, leading to a sense of self blame, shame and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal, shattering a person's trust and leaving them feeling alone. Often, abuse of children and domestic violence are accompanied by threats that lead to silencing and fear of reaching out for help.

How the event is experienced may be linked to a range of factors including the individual's cultural beliefs (e.g., the subjugation of women and the experience of domestic violence), availability of social supports (e.g., whether isolated or embedded in a supportive family or community structure), or to the developmental stage of the individual (i.e., an individual may understand and experience events differently at age five, fifteen, or fifty).[1]

The long-lasting adverse **effects** of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognize the connection between the traumatic events and the effects. Examples of adverse effects include an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions. In addition to these more visible effects, there may be an altering of one's neurobiological make-up and ongoing health and well-being. Advances in neuroscience and an increased understanding of the interaction of neurobiological and environmental factors have documented the effects of such threatening events.[1,3] Traumatic effects, which may range from hyper-vigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally, and emotionally. Survivors of trauma have also highlighted the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences.

SAMHSA's Trauma-Informed Approach: Key Assumptions and Principles

Trauma researchers, practitioners and survivors have recognized that the understanding of trauma and trauma-specific interventions is not sufficient to optimize outcomes for trauma survivors nor to influence how service systems conduct their business.

The context in which trauma is addressed or treatments deployed contributes to the outcomes for the trauma survivors, the people receiving services, and the individuals staffing the systems. Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care.[22,32,33] SAMHSA's concept of a trauma-informed approach is grounded in a set of four assumptions and six key principles.

A program, organization, or system that is trauma-informed* realizes *the widespread impact of trauma and understands potential paths for recovery;* recognizes *the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and* responds *by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively* resist re-traumatization*.

A trauma informed approach is distinct from trauma-specific services or trauma systems. A trauma informed approach is inclusive of trauma-specific interventions, whether assessment, treatment or recovery supports, yet it also incorporates key trauma principles into the organizational culture.

Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care.

THE FOUR "R'S: KEY ASSUMPTIONS IN A TRAUMA-INFORMED APPROACH

In a trauma-informed approach, all people at all levels of the organization or system have a basic **realization** about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals. People's experience and behavior are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past (i.e., a client dealing with prior child abuse), whether they are currently manifesting (i.e., a staff member living with domestic violence in the home), or whether they are related to the emotional distress that results in hearing about the firsthand experiences of another (i.e., secondary traumatic stress experienced by a direct care professional).There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in prevention, treatment, and recovery settings. Similarly, there is a realization that trauma is not confined to the behavioral health specialty service sector, but is integral to other systems (e.g., child welfare, criminal justice, primary health care, peer–run and community organizations) and is often a barrier to effective outcomes in those systems as well.

People in the organization or system are also able to **recognize** the signs of trauma. These signs may be gender, age, or setting-specific and may be manifest by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance, and supervision practices.

The program, organization, or system **responds** by applying the principles of a trauma-informed approach to all areas of functioning. The program, organization, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly. Staff in every part of the organization, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviors and policies to take into consideration the experiences of trauma among children and adult users of the services and among staff providing the services. This is accomplished through staff training, a budget that supports this ongoing training, and leadership that realizes the role of trauma in the lives of their staff and the people they serve. The organization has practitioners trained in evidence-based trauma practices. Policies of the organization, such as mission statements, staff handbooks and manuals promote a culture based on beliefs about resilience, recovery, and healing from trauma. For instance, the agency's mission may include an intentional statement on the organization's commitment to promote trauma recovery; agency policies demonstrate a commitment to incorporating perspectives of people served through the establishment of client advisory boards or inclusion of people who have received services on the agency's board of directors; or agency training includes resources for mentoring supervisors on helping staff address secondary traumatic stress. The organization is committed to providing a physically and psychologically safe environment. Leadership ensures that staff work in an environment that promotes trust, fairness and transparency. The program's, organization's, or system's response involves a universal precautions approach in which one expects the presence of trauma in lives of individuals being served, ensuring not to replicate it.

A trauma-informed approach seeks to **resist re-traumatization** of clients as well as staff. Organizations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the well-being of staff and the fulfillment of the organizational mission.[27] Staff who work within a trauma-informed environment are taught to recognize how organizational practices may trigger painful memories and re-traumatize clients with trauma histories. For example, they recognize that using restraints on a person who has been sexually abused or placing a child who has been neglected and abandoned in a seclusion room may be re-traumatizing and interfere with healing and recovery.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

1. **Safety**
2. **Trustworthiness and Transparency**
3. **Peer Support**
4. **Collaboration and Mutuality**
5. **Empowerment, Voice and Choice**
6. **Cultural, Historical, and Gender Issues**

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

The six key principles fundamental to a trauma-informed approach include:[24,36]

1. **Safety:** Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.

2. **Trustworthiness and Transparency:** Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.

3. **Peer Support:** Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term "Peers" refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as "trauma survivors."

4. **Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. As one expert stated: "one does not have to be a therapist to be therapeutic."[12]

5. **Empowerment, Voice and Choice:** Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery.[34] Staff are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff need to feel safe, as much as people receiving services.

6. **Cultural, Historical, and Gender Issues:** The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); offers, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

Guidance for Implementing a Trauma-Informed Approach

Developing a trauma-informed approach requires change at multiples levels of an organization and systematic alignment with the six key principles described above. The guidance provided here builds upon the work of Harris and Fallot and in conjunction with the key principles, provides a starting point for developing an organizational trauma-informed approach.[20] While it is recognized that not all public institutions and service sectors attend to trauma as an aspect of how they conduct business, understanding the role of trauma and a trauma-informed approach may help them meet their goals and objectives. Organizations, across service-sectors and systems, are encouraged to examine how a trauma-informed approach will benefit all stakeholders; to conduct a trauma-informed organizational assessment and change process; and to involve clients and staff at all levels in the organizational development process.

The guidance for implementing a trauma-informed approach is presented in the ten domains described below. This is not provided as a "checklist" or a prescriptive step-by-step process. These are the domains of organizational change that have appeared both in the organizational change management literature and among models for establishing trauma-informed care.[35,36,37,38] What makes it unique to establishing a trauma-informed organizational approach is the cross-walk with the key principles and trauma-specific content.

TEN IMPLEMENTATION DOMAINS

1. **Governance and Leadership**
2. **Policy**
3. **Physical Environment**
4. **Engagement and Involvement**
5. **Cross Sector Collaboration**
6. **Screening, Assessment, Treatment Services**
7. **Training and Workforce Development**
8. **Progress Monitoring and Quality Assurance**
9. **Financing**
10. **Evaluation**

GOVERNANCE AND LEADERSHIP: The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach; there is an identified point of responsibility within the organization to lead and oversee this work; and there is inclusion of the peer voice. A champion of this approach is often needed to initiate a system change process.

POLICY: There are written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission. Organizational procedures and cross agency protocols, including working with community-based agencies, reflect trauma-informed principles. This approach must be "hard-wired" into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.

PHYSICAL ENVIRONMENT OF THE ORGANIZATION: The organization ensures that the physical environment promotes a sense of safety and collaboration. Staff working in the organization and individuals being served must experience the setting as safe, inviting, and not a risk to their physical or psychological safety. The physical setting also supports the collaborative aspect of a trauma informed approach through openness, transparency, and shared spaces.

ENGAGEMENT AND INVOLVEMENT OF PEOPLE IN RECOVERY, TRAUMA SURVIVORS, PEOPLE RECEIVING SERVICES, AND FAMILY MEMBERS RECEIVING SERVICES: These groups have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation.) This is a key value and aspect of a trauma-informed approach that differentiates it from the usual approaches to services and care.

CROSS SECTOR COLLABORATION: Collaboration across sectors is built on a shared understanding of trauma and principles of a trauma-informed approach. While a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization's mission is a critical aspect of building collaborations. People with significant trauma histories often present with a complexity of needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could then undermine the progress of the individual.

SCREENING, ASSESSMENT, AND TREATMENT SERVICES: Practitioners use and are trained in interventions based on the best available empirical evidence and science, are culturally appropriate, and reflect principles of a trauma-informed approach. Trauma screening and assessment are an essential part of the work. Trauma-specific interventions are acceptable, effective, and available for individuals and families seeking services. When trauma-specific services are not available within the organization, there is a trusted, effective referral system in place that facilitates connecting individuals with appropriate trauma treatment.

TRAINING AND WORKFORCE DEVELOPMENT: On-going training on trauma and peer-support are essential. The organization's human resource system incorporates trauma-informed principles in hiring, supervision, staff evaluation; procedures are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress or vicarious trauma, resulting from exposure to and working with individuals with complex trauma.

PROGRESS MONITORING AND QUALITY ASSURANCE: There is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based trauma specific screening, assessments and treatment.

FINANCING: Financing structures are designed to support a trauma-informed approach which includes resources for: staff training on trauma, key principles of a trauma-informed approach; development of appropriate and safe facilities; establishment of peer-support; provision of evidence-supported trauma screening, assessment, treatment, and recovery supports; and development of trauma-informed cross-agency collaborations.

EVALUATION: Measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma and appropriate trauma-oriented research instruments.

To further guide implementation, the chart on the next page provides sample questions in each of the ten domains to stimulate change-focused discussion. The questions address examples of the work to be done in any particular domain yet also reflect the six key principles of a trauma-informed approach. Many of these questions and concepts were adapted from the work of Fallot and Harris, Henry, Black-Pond, Richardson, & Vandervort, Hummer and Dollard, and Penney and Cave.[39, 40, 41,42]

While the language in the chart may seem more familiar to behavioral health settings, organizations across systems are encouraged to adapt the sample questions to best fit the needs of the agency, staff, and individuals being served. For example, a juvenile justice agency may want to ask how it would incorporate the principle of safety when examining its physical environment. A primary care setting may explore how it can use empowerment, voice, and choice when developing policies and procedures to provide trauma-informed services (e.g. explaining step by step a potentially invasive procedure to a patient at an OBGYN office).

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH

KEY PRINCIPLES					
Safety	**Trustworthiness and Transparency**	**Peer Support**	**Collaboration and Mutuality**	**Empowerment, Voice, and Choice**	**Cultural, Historical, and Gender Issues**
10 IMPLEMENTATION DOMAINS					
Governance and Leadership	• How does agency leadership communicate its support and guidance for implementing a trauma-informed approach? • How do the agency's mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports? • How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories?				
Policy	• How do the agency's written policies and procedures include a focus on trauma and issues of safety and confidentiality? • How do the agency's written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery? • How do the agency's staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training? • How do human resources policies attend to the impact of working with people who have experienced trauma? • What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?				

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Physical Environment	• How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff? • In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this? • How has the agency provided space that both staff and people receiving services can use to practice self-care? • How has the agency developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities).
Engagement and Involvement	• How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services? • How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information? • How is transparency and trust among staff and clients promoted? • What strategies are used to reduce the sense of power differentials among staff and clients? • How do staff members help people to identify strategies that contribute to feeling comforted and empowered?
Cross Sector Collaboration	• Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions? • Are collaborative partners trauma-informed? • How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services? • What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?
Screening, Assessment, Treatment Services	• Is an individual's own definition of emotional safety included in treatment plans? • Is timely trauma-informed screening and assessment available and accessible to individuals receiving services? • Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services? • How are peer supports integrated into the service delivery approach? • How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, are gender-specific trauma services and supports available for both men and women? • Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding? • How are these trauma-specific practices incorporated into the organization's ongoing operations?

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Training and Workforce Development	• How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences? • How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions? • How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions? • How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person's experience of trauma, access to supports and resources, and opportunities for safety? • How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors. • What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work? • What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization's workforce?
Progress Monitoring and Quality Assurance	• Is there a system in place that monitors the agency's progress in being trauma-informed? • Does the agency solicit feedback from both staff and individuals receiving services? • What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency? • How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes? • What mechanisms are in place for information collected to be incorporated into the agency's quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?
Financing	• How does the agency's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development? • What funding exists for cross-sector training on trauma and trauma-informed approaches? • What funding exists for peer specialists? • How does the budget support provision of a safe physical environment?
Evaluation	• How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach? • How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey? • What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality? • What measures or indicators are used to assess the organizational progress in becoming trauma-informed?

Next Steps: Trauma in the Context of Community

Delving into the work on community trauma is beyond the scope of this document and will be done in the next phase of this work. However, recognizing that many individuals cope with their trauma in the safe or not-so safe space of their communities, it is important to know how communities can support or impede the healing process.

Trauma does not occur in a vacuum. Individual trauma occurs in a context of community, whether the community is defined geographically as in neighborhoods; virtually as in a shared identity, ethnicity, or experience; or organizationally, as in a place of work, learning, or worship. How a community responds to individual trauma sets the foundation for the impact of the traumatic event, experience, and effect. Communities that provide a context of understanding and self-determination may facilitate the healing and recovery process for the individual. Alternatively, communities that avoid, overlook, or misunderstand the impact of trauma may often be re-traumatizing and interfere with the healing process. Individuals can be re-traumatized by the very people whose intent is to be helpful. This is one way to understand trauma in the context of a community.

A second and equally important perspective on trauma and communities is the understanding that communities as a whole can also experience trauma. Just as with the trauma of an individual or family, a community may be subjected to a community-threatening event, have a shared experience of the event, and have an adverse, prolonged effect. Whether the result of a natural disaster (e.g., a flood, a hurricane or an earthquake) or an event or circumstances inflicted by one group on another (e.g., usurping homelands, forced relocation, servitude, or mass incarceration, ongoing exposure to violence in the community), the resulting trauma is often transmitted from one generation to the next in a pattern often referred to as historical, community, or intergenerational trauma.

Communities can collectively react to trauma in ways that are very similar to the ways in which individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation. Communities are often profoundly shaped by their trauma histories. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma.

Many people who experience trauma readily overcome it and continue on with their lives; some become stronger and more resilient; for others, the trauma is overwhelming and their lives get derailed. Some may get help in formal support systems; however, the vast majority will not. The manner in which individuals and families can mobilize the resources and support of their communities and the degree to which the community has the capacity, knowledge, and skills to understand and respond to the adverse effects of trauma has significant implications for the well-being of the people in their community.

Conclusion

As the concept of a trauma-informed approach has become a central focus in multiple service sectors, SAMHSA desires to promote a shared understanding of this concept. The working definitions, key principles, and guidance presented in this document represent a beginning step toward clarifying the meaning of this concept. This document builds upon the extensive work of researchers, practitioners, policymakers, and people with lived experience in the field. A standard, unified working concept will serve to advance the understanding of trauma and a trauma-informed approach for public institutions and service sectors.

Endnotes

[1] Felitti, G., Anda, R., Nordenberg, D., et al., (1998). Relationship of child abuse and household dysfunction to many of the leading cause of death in adults: The Adverse Childhood Experiences Study. American Journal of Preventive Medicine, 14, 245-258.a

[2] Anda, R.F., Brown, D.W., Dube, S.R., Bremner, J.D., Felitti, V.J., and Giles, W.G. (2008). Adverse childhood experiences and chronic obstructive pulmonary disease in adults. *American Journal of Preventive Medicine*, 34(5), 396-403.

[3] Perry, B., (2004). Understanding traumatized and maltreated children: The core concepts – Living and working with traumatized children. The Child Trauma Academy, www.ChildTrauma.org.

[4] Shonkoff, J.P., Garner, A.S., Siegel, B.S., Dobbins, M.I., Earls, M.F., McGuinn, L., …, Wood, D.L. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, 129(1), 232-246.

[5] McLaughlin, K.A., Green, J.G., Kessler, R.C., et al. (2009). Childhood adversity and adult psychiatric disorder in the US National Comorbidity Survey. Psychol Med. 40(4), 847-59.

[6] National Child Traumatic Stress Network Systems Integration Working Group (2005). Helping children in the child welfare system heal from trauma: A systems integration approach.

[7] Dozier, M., Cue, K.L., and Barnett, L. (1994). Clinicians as caregivers: Role of attachment organization in treatment. *Journal of Consulting and Clinical Psychology*, 62(4), 793-800.

[8] Najavits, L.M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press.

[9] Covington, S. (2008) "Women and Addiction: A Trauma-Informed Approach." *Journal of Psychoactive Drugs*, SARC Supplement 5, November 2008, 377-385.

[10] Anda, R.F., Brown, D.W., Dube, S.R., Bremner, J.D., Felitti, V.J, and Giles, W.H. (2008). Adverse childhood experiences and chronic obstructive pulmonary disease in adults. *American Journal of Preventive Medicine*, 34(5), 396-403.

[11] Dube, S.R., Felitti, V.J., Dong, M., Chapman, D.P., Giles, W.H., and Anda, R.F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The Adverse Childhood Experiences Study. *Pediatrics*, 111(3), 564-572.

[12] Ford, J. and Wilson, C. (2012). SAMHSA's Trauma and Trauma-Informed Care Experts Meeting.

[13] Ford, J.D. (2013). Treatment of complex trauma: A sequenced, relationship-based approach. New York, NY, US: Guilford Press.

[14] Wilson, C. and Conradi, L. (2010). Managing traumatized children: A trauma systems perspective. *Psychiatry*. doi: 10.1097/MOP.0b013e32833e0766

[15] Dutton, M.A., Bonnie, L.G., Kaltman, S.I., Roesch, D.M., and Zeffiro, T.A., et al. (2006). Intimate partner violence, PTSD, and adverse health outcomes. *Journal of Interpersonal Violence*, 21(7), 955-968.

[16] Campbell, R., Greeson, M.R., Bybee, D., and Raja, S. (2008). The co-occurrence of childhood sexual abuse, adult sexual assault, intimate partner violence, and sexual harassment: A mediational model of posttraumatic stress disorder and physical health outcomes. *Journal of Consulting and Clinical Psychology*, 76(2), 194-207.

[17] Bonomi, A.E., Anderson, M.L., Rivara, F.P., Thompson, R.S. (2007). Health outcomes in women with physical and sexual intimate partner violence exposure. *Journal of Women's Health*, 16(7), 987-997.

[18] Norris, F.H. (1990). Screening for traumatic stress: A scale for use in the general population. *Journal of Applied Social Psychology*, 20, 1704-1718.

[19] Norris, F.H. and Hamblen, J.L. (2004). Standardized self-report measures of civilian trauma and PTSD. In J.P. Wilson, T.M. Keane and T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63-102). New York: Guilford Press.

[20] Orisllo, S.M. (2001). Measures for acute stress disorder and posttraumatic stress disorder. In M.M. Antony and S.M. Orsillo (Eds.), *Practitioner's Guide to Empirically Based Measures of Anxiety* (pp. 255-307). New York: Kluwer Academic/Plenum

[21] Weathers, F.W. and Keane, T.M. (2007). The criterion A problem revisited: Controversies and challenges in defining and measuring psychological trauma. *Journal of Traumatic Stress*, 20(2), 107-121.

[22] Van der Kolk, B. (2003): The neurobiology of childhood trauma and abuse. Laor, N. and Wolmer, L. (guest editors): *Child and Adolescent Psychiatric Clinics of North America: Posttraumatic Stress Disorder,* 12 (2). Philadelphia: W.B. Saunders, 293-317.

[23] Herman, J. (1992). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror*. New York: Basic Books.

[24] Harris, M. and Fallot, R. (2001). Using trauma theory to design service systems. *New Directions for Mental Health Services*, 89. Jossey Bass.

[25] Bloom, S. (2012). "The Workplace and trauma-informed systems of care." Presentation at the National Network to Eliminate Disparities in Behavioral Health. Cohen, J., Mannarino, A., Deblinger, E., (2004). Trauma-focused Cognitive Behavioral Therapy (TF-CBT). Available from: http://tfcbt.musc.edu/

SAMHSA's National Center for Trauma-Informed Care (2012), *Report of Project Activities Over the Past 18 Months, History, and Selected Products*. Available from: http://www.nasmhpd.org/docs/NCTIC/NCTIC_Final_Report_3-26-12.pdf

[26] Bloom, S. L., and Farragher, B. (2011). *Destroying sanctuary: the crisis in human services delivery systems*. New York: Oxford University Press.Guarino, K., Soares, P., Konnath, K., Clervil, R., and Bassuk, E. (2009). *Trauma-Informed Organizational Toolkit*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network and the W.K. Kellogg Foundation.

[27] Dekel, S., Ein-Dor, T., and Zahava, S. (2012). Posttraumatic growth and posttraumatic distress: A longitudinal study. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(1), 94-101.

[28] Jakupcak, M., Tull, M.T., McDermott, M.J., Kaysen, D., Hunt, S., and Simpson, T. (2010). PTSD symptom clusters in relationship to alcohol misuse among Iraq and Afghanistan war veterans seeking post-deployment VA health care. *Addictive Behaviors* 35(9), 840-843.

[29] Goodwin, L. and Rona, R.J. (2013) PTSD in the armed forces: What have we learned from the recent cohort studies of Iraq/Afghanistan?, *Journal of Mental Health* 22(5), 397-401.

[30] Wolf, E.J., Mitchell, K.S., Koenen, C.K., and Miller, M.W. (2013) Combat exposure severity as a moderator of genetic and environmental liability to post-traumatic stress disorder. *Psychological Medicine*.

[31] National Analytic Center-Statistical Support Services (2012). Trauma-Informed Care *White Paper*, prepared for the Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality.

[32] Ford, J.D., Fallot, R., and Harris, M. (2009). Group Therapy. In C.A. Courtois and J.D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp.415-440). New York, NY, US: Guilford Press.

[33] Brave Heart, M.Y.H., Chase, J., Elkings, J., and Altschul, D.B. (2011). Historical trauma among indigenous peoples of the Americas: Concepts, research, and clinical considerations. *Journal of Psychoactive Drugs*, 43 (4), 282-290.

[34] Brown, S.M., Baker, C.N., and Wilcox, P. (2012). Risking connection trauma training: A pathway toward trauma-informed care in child congregate care settings. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4 (5), 507-515.

[35] Farragher, B. and Yanosy, S. (2005). Creating a trauma-sensitive culture in residential treatment. *Therapeutic Communities*, 26(1), 93-109.

[36] Elliot, D.E., Bjelajac, P., Fallot, R.D., Markoff, L.S., and Reed, B.G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, 33(4), 461-477.

[37] Huang, L.N., Pau, T., Flatow, R., DeVoursney, D., Afayee, S., and Nugent, A. (2012). Trauma-informed Care Models Compendium.

[38] Fallot, R. and Harris, M. (2006). *Trauma-Informed Services: A Self-Assessment and Planning Protocol*. Community Connections.

[39] Henry, Black-Pond, Richardson and Vandervort. (2010). Western Michigan University, Southwest Michigan Children's Trauma Assessment Center (CTAC).

[40] Hummer, V. and Dollard, N. (2010). *Creating Trauma-Informed Care Environments: An Organizational Self-Assessment. (part of Creating Trauma-Informed Care Environments curriculum)* Tampa FL: University of South Florida. The Department of Child and Family Studies within the College of Behavioral and Community Sciences.

[41] Penney, D. and Cave, C. (2012). *Becoming a Trauma-Informed Peer-Run Organization: A Self-Reflection Tool* (2013). Adapted for Mental Health Empowerment Project, Inc. from *Creating Accessible, Culturally Relevant, Domestic Violence- and Trauma-Informed Agencies*, ASRI and National Center on Domestic Violence, Trauma and Mental Health.

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