TRAUMA MATTERS

Highlights of Trauma-Informed Practices in Women's Substance Use Services

Did you know that:

- **The vast majority of women who are in substance use treatment report a history of trauma.** [1]
- **Women have a longer duration of post-traumatic symptoms than men, and are more sensitive to trauma stimuli.** [2]

Women who have both substance use and trauma issues seek help from:

- **substance use treatment or mental health services,**
- **hospitals, public health units, primary health care practices, community health centres, community care access centres,**
- **child protection agencies, parent-child services,**
- **violence against women services,**
- **criminal justice and correctional services,**
- **social services agencies, housing services, or shelters, and**
- **other services for substance-involved women.**

Trauma *matters* because…

Psychological trauma is a major public health issue affecting the health of people, families and communities across Canada. Trauma places an enormous burden on every health care and human service system.... Given the enormous influence that trauma has on health outcomes, it is important that every health care and human services provider has a basic understanding of trauma, can recognize the symptoms of trauma, and appreciates the role they play in supporting recovery.

Klinic Community Health Centre (2013) The Trauma-Informed Toolkit (2nd Edition), Manitoba

This document will introduce you to the elements of trauma-informed practices. Comprehensive guidelines can be found in:

Trauma Matters – Guidelines for Trauma-Informed Practices in Women's Substance Use Services

Available on-line, at many websites, including:

www.jeantweed.com, www.addictionsandmentalhealthontario.ca/, or eenet.ca

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Why Use Trauma-Informed Practices?

Trauma is epidemic among populations in public mental health and addiction service systems. [3]

The majority of women in substance abuse treatment have been impacted by trauma. [4] Canadian research studies report that up to 90% of substance-involved women who are receiving services have experienced trauma. Large-scale studies in the United States have reported equally high rates.

They need to realize that there is nothing wrong with us, there is something that happened to us for us to behave the way we do.

Focus group participant, Ontario 2012

Experience and evidence show that trauma-informed approaches can generate numerous benefits:

- Reduced trauma symptoms, drug use severity and mental health symptoms. [5]
- Increased effectiveness of services - in engagement, retention, and outcomes. [6]
- Cost effective - do not cost more than standard programming. [7]
- Decreases in use of acute care and crisis services. [8]
- Positive organizational outcomes: enhanced staff skills and morale; more collaboration within and outside their agencies; reduced vicarious trauma; [9] fewer negative events. [10]

Trauma-informed practices can reduce frustration, improve communication, enhance the quality of the relationship, and increase work satisfaction. Investing in integrating a trauma-informed perspective does not create more work but can instead make the work easier, and more satisfying. [11]

What is Trauma?

Trauma can be precipitated by many types of events and circumstances – for example:

- Physical/sexual/emotional abuse in childhood and in adulthood
- Neglect, significant personal losses
- Violence, accidents/physical injuries
- Criminal justice involvement
- War, colonization
- Natural disasters, displacement

Traumatic events are more than merely stressful – they are overwhelming. They can be shocking, terrifying, and devastating, resulting in feelings of terror, shame, helplessness, and powerlessness. [12]

Experiences of trauma are unique and individual. Whether a woman experiences trauma cannot be determined by the nature of an event alone. An event may be experienced as trauma for one person and not for another. How a woman experiences an event, and the effects of that experience, are often linked to an array of individual, interpersonal, and environmental factors.

Trauma is the sum of the event, the experience, and the effect. [13]

Trauma responses can relate to a single event, to repeated events, and to ongoing circumstances across the life span.

- Trauma is *cumulative* – the more times an event is experienced, the greater the impact.
- Trauma is also *additive* – additional types of traumatic events can have greater impacts.

Trauma can become an organizing principle that is ever-present in a woman's life. It can shape the way a woman sees herself, others, and the world; it can have a serious effect on how she functions, forms relationships, and establishes safety and security in her life.

What Are the Impacts of Trauma?

Trauma affects the whole person. It has a mind-body impact — physical and emotional responses are interwoven.

Research has highlighted the central role of trauma in substance use and mental health problems, as well as links between trauma and an array of chronic physical diseases. [14]

The effects of trauma can be acute, chronic, and/or delayed. Women can experience those effects in multiple domains, including:

- Physical illness and chronic disease,
- Impacts on relationships and attachment,
- Difficulties regulating emotions,
- Memory, attention, thinking, processing, and learning,
- Problematic substance use,
- Health risk behaviours,
- Self-injury,
- Depression, anxiety, sleep problems, psychosis, eating disorders, suicidality and other mental health issues.

No listing of symptoms does justice to the private reactions and anguish experienced by [women who have experienced trauma] and their loved ones. [15]

Trauma leaves a wake. Its effects extend beyond the woman who has experienced trauma to broadly impact:

- Families, significant others, friends, employers, and others;
- Publicly funded systems *(e.g. health care, social services, other care giving systems, criminal justice and correctional systems).*

Trauma can affect communities across generations. It can be built into the cultural memory, passed from one generation to another, as has been seen among Canada's Aboriginal communities.

Trauma can hinder engagement with substance use and mental health services. Experiences of trauma pose an assault on a woman's sense of self, safety, belonging, and connection. The erosion of trust in others can make it difficult for a woman to engage with the very organizations that can provide needed help – to trust that services will be responsive, helpful, and respectful.

Trauma reactions can also affect the ability to regulate emotions and thinking processes. This can make it difficult for a woman to fulfill program requirements or match the expectations of staff. Such difficulties — if they are not understood as trauma-related — may be interpreted negatively. Misunderstanding trauma-related behaviour (*for example, as 'attention-seeking', 'lack of motivation', 'aggression' etc.)* can result in ineffective interventions and services, and can retraumatize a woman.

[Women who have experienced trauma] often cycle in and out of public mental health and substance abuse systems for years, using a tremendous number of services without experiencing any improvement. As treatment systems erode trust, self-efficacy, and a sense of safety, women begin to disengage and may refuse assistance. [16]

The consequence of trauma can impede women's access to primary health care and dental care. Medical and/or dental procedures can trigger trauma responses. For example, trauma memories and reactions can be triggered by the touch of a physician, a physiotherapist, or a dentist. Without tools and support to manage triggers, a woman may see avoidance of health and dental care as the best available option. Forgoing needed care can compound health problems, and result in more severe, acute, and chronic illness and increased need for long-term and acute medical services.

What Are the Interconnections with Substance Use?

We have compelling evidence that women's substance use is linked to their experiences of trauma and violence. Yet service providers and policy makers have not always acted on these known connections. [17]

Women often use substances to help them manage emotional distress. Experiences of trauma have been shown to be closely connected with women's substance use. [18]

My recovery [from substance use] really started to be solid when I realized the connections with trauma – before that, the trauma kept pulling me down.

Focus group participant, Ontario, 2012

When women who have experienced trauma stop or reduce substance use, many experience increases in trauma reactions. Women who have 'lived experience' tell us that using substances helped them to manage the impacts of trauma. To support a woman's substance use goals (*whether those goals involve abstinence, moderated use, or safer use practices*) she needs tools and skills to cope with the ongoing impacts of trauma.

When you take away the substance, and there's nothing else to replace it, it's too much.

Focus group participant, Ontario 2012

What Are Trauma-Informed Practices?

Trauma-informed practices are *not* types of services or program components. Rather, they are an evidence-based foundation that transforms the way current services are understood, planned, delivered, and evaluated.

Whenever there is a really difficult situation, the impact of trauma … is usually a factor. Keeping this in mind helps us as staff to not be reactive [and] to think outside the box of 'treatment as usual'.

Substance Use Service Provider, Ontario 2012

Trauma-informed practices can and should be integrated into existing service systems. They should be braided with existing programs and services for substance-involved women, so that every woman can receive services that are welcoming, appropriate, and effective in every service setting.

Knowledge of trauma and its consequences is integrated by:

- ***Realizing*** the prevalence and profound impacts of trauma;
- ***Recognizing*** how trauma affects all individuals involved with organizations, staff, and teams; and
- ***Responding*** by putting that knowledge into practice in policies, procedures, practices, physical setting, and services.

Recognizing and acknowledging the prevalence of trauma among substance-involved women, its profound impacts, and the interconnections with substance use helps service providers to shift their understanding. Instead of seeing 'non-compliance', 'resistance', or 'difficult behavioural issues', they are able to see a woman attempting to adapt, respond, or cope with the consequences of trauma.

The central question changes...
from
What is wrong with this woman?
to
What has happened to this woman?

Services that are not trauma-informed can inadvertently retraumatize women in the very settings where they are seeking help. In substance use services, and in other health care settings, if staff do not appreciate the inter-connections between trauma and substance use they may:

- Misinterpret trauma-related behaviours,
- Lack the skills to respond in a helpful way,
- Inadvertently trigger trauma reactions,
- Respond to trauma-related behaviours with punitive or inflexible measures, or
- Miss opportunities to help women understand the connections between trauma and substance use, and to help them build skills and strengths.

> *There were times when I was having flashbacks … I was told to just focus on my addiction.*
>
> Focus group participant, Ontario 2012

Trauma-informed practices *do not* provide trauma-specific treatment. Rather, they enable service providers to:

- Appreciate the context in which a woman who has experienced trauma is living,
- Help her engage with, and benefits from, services,
- Provide a safe environment and reduce risks of retraumatizing women, and
- Help women build on strengths and acquire skills and coping strategies.

Working in a trauma-informed way does **not** require disclosure of trauma or ensuring that women seek trauma-specific care. Until a woman is ready, in her own time and her own way, to discuss her trauma experiences with a trusted and skilled service provider, a rush to disclosure is counter-therapeutic and can cause more harm than good.

Core Concepts

Key principles of trauma-informed practices:

1. Acknowledgement

Experiences of trauma are often shrouded in silence, secrecy, and shame. Service providers can begin to shed light by acknowledging that trauma is prevalent among substance-involved women, and is often interconnected with problematic substance use. Organizations and their staff can acknowledge the prevalence and links on the organization website, in program materials, in client information sessions, and in dialogue with individual women.

2. Trustworthiness

Because interpersonal trauma often involves boundary violations and abuses of power, it is particularly important that the roles and boundaries of the staff team are clear, consistent, and predictable. Information (e.g., about the program, service options, expectations, informed consent, client rights, etc.) should be provided verbally as well as in writing, with time and space for answering a woman's questions and addressing her concerns.

3. Safety

Establishing safety involves moving beyond standard notions of what is 'safe', to incorporate emotional and cultural safety, as well as physical safety in every aspect of service. Safety is established through every interaction and in every aspect of a program, including the physical environment. Risks that a woman will be retraumatized are reduced by minimizing trauma triggers and by helping women to develop coping skills and safety plans. Services are paced to meet each woman's needs and respect her choices.

4. Choice and control

Many women who have experienced trauma feel as though they have not been able to make choices in the past and the present. Trauma-informed services provide as many real choices as possible about service options

and service linkages – and then support women to select the choice that fits best for them. *"A woman must be a full partner in determining her goals and how she participates in services, with the paramount aim of increasing her ability to make these choices."* [19]

5. Relational and collaborative approaches

Strong relationships between service providers and women who have experienced trauma are particularly important because trauma creates disconnection from others. The connections made within the therapeutic relationship can be restorative. When staff recognize that a woman is an expert in her own life and collaborate with her, they are able to share power and strengthen the therapeutic relationship.

6. Strengths-based and empowerment

Women's responses to trauma reveal strengths and resilience; working from a woman's strength is critical. Staff validate resilience, even when a woman's coping behaviours are causing difficulties. Focusing on a woman's capacity for personal growth is the primary building block for change.

At its best, trauma-informed care is resilience-informed care. [20]

Learn from women who have 'lived experience'. Trauma-informed practices recognize the knowledge and wisdom of women who have experienced trauma and engage their expertise. Examples:

- Inclusion of women with lived experience in organizational planning;
- Seeking and acting on their feedback;
- Involving them in delivering staff training.

The most important thing is validation. Validation. Validation. And the acknowledgment of the things we have been through and why we have done the things we have done. Just how it's all linked.

Focus Group Participant, Ontario, 2012

Go beyond a singular focus on problematic substance use, or even a dual focus on trauma and substance use. Those issues must be understood as part of a bigger picture that includes gender, culture, and other factors.

Gender and gender identity can affect both experiences of trauma and substance use patterns. Trauma-informed practices need to be braided with other program components that are responsive to differing issues and needs across genders.

[Being in a] woman-specific program gave me a comfort level to share and not feel judged.

Focus group participant, Ontario, 2012

Cultural competence enables staff to work within each woman's values and perspective. Trauma may have different meanings in different cultures, and trauma reactions may be expressed differently within different cultural frameworks. Every 'strand' of a woman's cultural identity can be a source of both risk and resilience.

Use coordinated, team-based approaches. Consistent responses from staff teams foster safety and trust. Team-based approaches help staff build a shared understanding that is a foundation for more effective services. By learning from and supporting each other, staff are able to broaden their knowledge and skills. Both clinical expertise and self-care practices play a critical role in the effectiveness of the team, and in the health and well-being of staff.

Collaborate across sectors. Given the array of impacts that trauma can have, a woman may also need access to other services such as income security, housing, parenting and children's services, primary health care, mental health services, and culture-specific services. Collaborative team-based approaches across multiple service sectors can facilitate seamless connections, reduce the need for a woman to re-tell her story repeatedly, and build systemic responses to complex issues and needs

Trauma-Informed Practices in Action

In *systems* where substance-involved women are served:

- ✓ Policy and planning recognize trauma as a significant concern.
- ✓ Expectations for meeting standards and guidelines are reflected in funding arrangements.
- ✓ System-wide and cross agency protocols reflect trauma-informed principles.
- ✓ System resources support development of staff and team competencies.
- ✓ Trainings are inclusive of staff and teams from a range of service areas and sectors.
- ✓ Coordinating mechanisms help organizations to work collaboratively across sectors (e.g., substance use, mental health, health care, criminal justice, social services, child welfare, and other community organizations).

In *organizations* that provide services to substance-involved women:

- ✓ Senior leaders recognize the impact of trauma on the people they serve, and make a formal and sustained commitment to trauma-informed practices.
- ✓ Policies and procedures are reviewed and changed, as needed, to ensure that they are trauma-informed.
- ✓ The organization integrates input and feedback from women who have lived experience of trauma into its planning, training, services, and evaluation.
- ✓ The service environment is physically and psychologically safe for clients and staff.
- ✓ Agency policies are clear and promote trust, collaboration, and transparency.
- ✓ Programs and services reflect the principles of trauma-informed practices.
- ✓ Regular monitoring of trauma-informed practices supports continuous improvement.
- ✓ Human resource practices incorporate trauma-informed principles in hiring, supervision, and staff evaluation.
- ✓ Ongoing training (with an appropriate budget), clinical supervision and consultation, and human resources policies support the development of trauma-competencies.
- ✓ The agency promotes a culture of continuous learning and self-care.
- ✓ Clinical infrastructures help to minimize the risks of vicarious traumatization.

> *All staff need to be trauma-informed, not just counsellors; it can be as simple as letting women know when loud noises are about to happen, like a fire drill.*
>
> *Substance Use Service Provider*

Among the staff and teams who work with substance-involved women:

- ✓ All staff have education about the prevalence and impacts of trauma, including the interconnections between trauma and substance use.
- ✓ Staff perceive and understand the behaviour of clients through a 'trauma-informed' lens.
- ✓ People in every part of the organization (from the person who greets clients at the door to senior managers and governance bodies) take into consideration the impacts of trauma in their language and behaviours.
- ✓ Direct service staff apply trauma-informed practices in their roles and content areas, help clients manage triggers and trauma reactions, establish therapeutic relationships, and maintain healthy boundaries.
- ✓ Staff understand the risks of vicarious trauma and utilize self-reflection and self-care strategies.

> *We have to assume that we are going to be affected by the work … We need to expect it and work with it.*
>
> *Substance Use Service Provider*

Supporting Ongoing Learning
Practice in Action Example

Organizations that have adopted trauma-informed practices emphasize that ongoing learning is critical. Organizational leaders must identify the training and clinical supports needed to ensure that staff have the necessary competencies. Some of the questions that leaders should consider include: [21]

- Who will deliver training?
- How will it be resourced?
- How will the success of training be measured and evaluated?
- Who will complete training and when?
- How will ongoing learning be supported?
- Can momentum be maintained through a 'train the trainer' model, or through informal champions within the agency or local system?
- What opportunities can be generated for multi-agency or cross-sector training or knowledge exchange?

What does our organization do to promote a culture of learning?

Is clinical supervision and consultation available?

Do staff have a safe place to process their experiences and concerns?

All employees *(including administrative, support, maintenance, cooks, volunteers, and students)* should receive education about:

- The prevalence and impacts of trauma,
- How language, behaviour, and organizational practices can trigger trauma reactions, and
- The intersections of culture, race, ethnicity, gender, age, sexual orientation, ability, and socio-economic status, and the implications for service delivery.

Direct service and clinical staff require more comprehensive, ongoing training to support trauma-informed practices in their roles and content areas:

- A trauma-informed understanding of behaviours;
- Trauma dynamics and how to avoid triggering or retraumatizing;
- Tools and strategies that can help women to manage trauma responses;
- The intersections of trauma with substance use, mental health, other health issues, and behavioural issues;
- Helping women to connect with other services, including trauma-specific treatment;
- Maintaining professional boundaries to create a climate of trust and safety for clients;
- The risks of vicarious traumatization and the importance of self-care strategies.

Fostering Safety
Practice in Action Example

Safety is paramount. Organizations take action to establish overall safety in the service environment, but 'safety' means different things to different women. Staff can help each woman to assemble a basic skill set for dealing with trauma-based reactions and practicing healthy self-care. This means:

- Discussing what safety means to her ,
- Working together to define goals and strategies that work for her,
- Helping her to identify specific triggers, and what will help her to feel safe in those situations, and
- Discussing unsafe situations and behaviours in her life, and identifying how to increase her safety.

First, do no more harm.
Recognize that harm has been done. [22]

Ways to increase safety and reduce risks of retraumatization:

Pace the work to ensure that a woman feels safe and comfortable, be sensitive to cues from a woman, and be ready to adjust the pace when needed.

Find out about triggers

Triggers can be sensory and/or situational; often, they involve seeing, feeling, hearing, smelling, or tasting something that recalls past trauma and activates the fight or flight response.

Examples:

Lack of privacy, darkness, arguments or loud noise, being isolated, being touched.

ASK: *What makes you feel scared or upset or angry? What could cause you to go into crisis or be in distress?*

Find out about early warning signs

A trauma response is a mind/body reaction, so signals of distress can sometimes be observed.

Examples:

Emotional arousal or mood swings; abrupt changes in behaviour; difficulty maintaining attention; isolation or lack of engagement; dissociation; self injury; suicidal thoughts; substance use/relapse; high-risk behaviours.

ASK: *What might you or others notice when you are triggered? What might you feel or do when you are at risk of losing control?*

Find out about what helps

Triggers occur in spite of efforts to anticipate and avoid them. Women and the staff who work with them can brainstorm to identify things that can help them manage triggers.

ASK: *What could I say that would help when you are triggered?*

Examples:

Do you want to talk about what you are feeling? I'm here to listen. It's your choice to discuss. What do you need right now? You are going to be okay. How can we help? You are safe here. Are you comfortable?

ASK: *What are some things that you could do to get grounded or manage the feelings when you are triggered?*

Examples:

Taking a walk; being able to cry; having someone sit with me for a while; a glass of water; drawing; being able to yell; being in a quiet, safe space; being allowed to have something of my own to comfort me.

Make a safety plan that identifies strategies to help to deal with triggers and avoid being retraumatized. A written plan can gather the ideas that a woman and a staff member have developed together and make them readily available. Make the plan a 'living document' — add additional strategies for grounding, self-soothing, and support, as they become part of a woman's skill set.

Safety Features in a Trauma-Informed Environment:

- You are greeted and welcomed.
- You know what is going to happen—when and where.
- People take time to ask if you have any questions, ask what can they do, and then they listen.
- You feel that you have control over what you say—information is not pulled out of you.
- People ask before closing a door, and lights are not turned out.
- You aren't told 'trust me, I've been doing this for years and know what's best'. You are told that 'trust is earned and develops over time'.

I will not give up …
I will be one of the first in my family to put these things behind me.

Early Childhood Development Project participant

END NOTES

1. 55% to 99% of women in substance use treatment and 85% to 95% of women in the public mental health system report a history of trauma. National Council for Behavioural Health, Need for Trauma-Informed Behavioural Healthcare. Retrieved on-line (2014) from: https://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioural-healthcare
2. American Psychological Association, Facts About Women and Trauma. Retrieved on-line (2014) from: http://www.apa.org/about/gr/issues/women/trauma.aspx
3. Substance Abuse and Mental Health Services Administration (SAMHSA) (2011). *Technical Assistance Package, Implementing Trauma-Informed Approaches in Access to Recovery Programs*. http://humanservices.arkansas.gov/dbhs/Documents/11-0901_TIS%20TA%20Package_508%20Compliant%20(REVISED).pdf
4. Jennings, A. (2008). *Models for Developing Trauma-Informed Behavioural Health Systems and Trauma-Specific Services*. (Update of 2004 report) National Centre for Trauma-Informed Care.
5. Moses, D.J., Reed, B.G., Mazelis, R., and D'Ambrosio, B. (2003). *Creating Trauma Services for Women with Co-Occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study*. Delmar, NY: Policy Research Associates. Available at: http://homeless.samhsa.gov/Resource/View.aspx?id=25663
6. SAMHSA (2011). *Technical Assistance Package, Implementing Trauma-Informed Approaches in Access to Recovery Programs.* http://humanservices.arkansas.gov/dbhs/Documents/11-0901_TIS%20TA%20Package_508%20Compliant%20(REVISED).pdf
7. Domino M.E., Morrissey J.P., Chung S., Huntington N., Larson M.J., Russell L.A. (2005). *Service Use and Costs For Women With Co-Occurring Mental And Substance Use Disorders and a History Of Violence*. Psychiatry Serv 2005; 56: 1223-32.
8. Community Connections (2005). *Trauma and Abuse in the Lives of Homeless Men and Women.* On-line Power Point presentation. Washington, DC. Available from: http:/www.pathprogram.samhsa.gov/ppt/Trauma_and_Homelessness.ppt
9. SAMHSA (2011). *Technical Assistance Package, Implementing Trauma-Informed Approaches in Access to Recovery Programs.* http://humanservices.arkansas.gov/dbhs/Documents/11-0901_TIS%20TA%20Package_508%20Compliant%20(REVISED).pdf
10. Hopper, E. K., Bassuk, E.L., Olivet, J. (2010). *Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings*. The Open Health Services and Policy Journal, 3, 80-100.
11. Moses, D.J., Reed, B.G., Mazelis, R., and D'Ambrosio, B. (2003). *Creating Trauma Services for Women with Co-Occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study*. Delmar, NY: Policy Research Associates. Available at: http://homeless.samhsa.gov/Resource/View.aspx?id=25663
12. Courtois, C. (June 2012). Presentation at *Trauma Talks Conference*. Toronto, Ontario.
13. SAMHSA (2011). *Technical Assistance Package, Implementing Trauma-Informed Approaches in Access to Recovery Programs*. http://humanservices.arkansas.gov/dbhs/Documents/11-0901_TIS%20TA%20Package_508%20Compliant%20(REVISED).pdf
14. Felitti. V., Anda, R., Nordenberg, D. et al., (1998). *Relationship of Child Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences Study.*
15. Courtois, C. (June 2012). Presentation at *Trauma Talks Conference*. Toronto, Ontario.
16. Klinic Community Health Centre (2008). *The Trauma-Informed Toolkit*, Winnipeg, Manitoba.
17. The British Columbia Centre of Excellence for Women's Health (2011). *Coalescing on Women and Substance Use: Trauma-informed Online Tool*. http://www.coalescing-vc.org/virtualLearning/documents/trauma-informed-online-tool.pdf
18. SAMHSA (2011). *Technical Assistance Package, Implementing Trauma-Informed Approaches in Access to Recovery Programs*. http://humanservices.arkansas.gov/dbhs/Documents/11-0901_TIS%20TA%20Package_508%20Compliant%20(REVISED).pdf
19. Moses, D.J., Reed, B.G., Mazelis, R., and D'Ambrosio, B. (2003). *Creating Trauma Services for Women with Co-Occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study*. Delmar, NY: Policy Research Associates. Available at: http://homeless.samhsa.gov/Resource/View.aspx?id=25663
20. SAMHSA (2011). *Technical Assistance Package, Implementing Trauma-Informed Approaches in Access to Recovery Programs.* http://humanservices.arkansas.gov/dbhs/Documents/11-0901_TIS%20TA%20Package_508%20Compliant%20(REVISED).pdf
21. Jennings, A., Ph.D. (2008). *Models for Developing Trauma-Informed Behavioural Health Systems and Trauma-Specific Services.* SAMHSA/National Centre for Trauma Informed Care, pp 110 to 112. http://www.theannainstitute.org/Models%20for%20Developing%20Traums-Report%201-09-09%20_FINAL_.pdf
22. Courtois, C. (June 2012). Presentation at *Trauma Talks Conference*. Toronto, Ontario.