THE TRAUMA AND HOMELESSNESS INITIATIVE

TRAUMA AND HOMELESSNESS SERVICE FRAMEWORK

Acknowledgements

This Service Framework is based on the work of the Trauma and Homelessness Initiative: a collaboration between the Australian Centre for Posttraumatic Mental Health and four agencies providing services to people who are homeless or who are at risk of homelessness: Sacred Heart Mission, Mind Australia, Inner South Community Health and VincentCare Victoria.

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This document draws on the experiences of over 100 people experiencing long-term homelessness. They shared their time and in many cases their most painful and distressing experiences with the researchers in order to contribute to a deeper understanding of how trauma impacts homelessness. The Framework document has also drawn on the practice wisdom and experience of workers from the participating agencies.

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EXECUTIVE SUMMARY

The importance of understanding the impact of trauma is increasingly recognised by service providers working with people experiencing homelessness. The Trauma and Homelessness Initiative (THI) was established to investigate the relationship between trauma and homelessness and to develop a framework for trauma-informed practice for Sacred Heart Mission (SHM), Mind Australia, Inner South Community Health (ISCH), VincentCare Victoria, and the wider service provision community.

The initiative has involved a series of four studies designed to investigate the nature of the relationship between trauma and homelessness, with each study building on the findings of the last. The first three studies involved a literature review (stage I) and qualitative interviews with direct service workers (stage II) and service users (stage III). The fourth stage involved quantitative interviews with 115 service users from the four partner agencies, and investigated the relationship between a history of homelessness, exposure to traumatic experiences, and mental health.

This framework document provides an overview of the key findings from the research undertaken by the initiative. It combines consensus understandings of trauma-informed practice, an understanding of the service provision context of the four participating agencies, the identified needs of service users, and knowledge about what supports recovery from exposure to trauma. The research has allowed the development of an explanatory model that describes the interrelated factors which are thought to impede recovery from trauma exposure, perpetuate experiences of compromised mental health and social disadvantage, and contribute to long-term homelessness.

Background to the initiative

There has been little Australian research that has examined the type and impact of trauma exposure for people experiencing homelessness. Traumatic events involve threat to life and are psychologically overwhelming. They are more than merely stressful, as they can be shocking, terrifying, and devastating to the survivor, resulting in profoundly upsetting feelings of terror, fear, shame, helplessness, and powerlessness[1]. Traumatic events involve the experience of actual or threatened death, serious injury or sexual violation, or exposure to the death, injury or suffering of others. This includes witnessing these events as they occur to others (especially significant others), or learning that these events occurred to significant others.

The scientific literature makes the distinction between traumatic events that occur as single events (such as motor vehicle accidents or natural disasters) and those that are interpersonal, enduring and prolonged (e.g., child abuse). Single occurrences of traumatic events are known as Type I trauma. For a significant minority of people, exposure to Type I trauma is associated with the development of psychiatric disorders such as posttraumatic stress disorder and depression[2].

Events that are interpersonal, prolonged and/or repeated in nature are referred to as Type II trauma. Type II trauma often occurs in childhood and involves people known to the child (i.e., their immediate or extended family) who have primary responsibility for care. Type II trauma often leads to particularly complex social and mental health problems, in addition to very high rates of psychiatric disorders such as posttraumatic stress disorder, substance use disorders and depression.

Main findings of the initiative

The literature review and the qualitative studies with service providers and service users supported the universality of trauma exposure amongst people experiencing homelessness. It was found that existing understandings and practices among the four partner agencies were consistent with principles of trauma-informed care (TIC), that practitioners recognised the complexity of needs and experiences of the people they supported, and that the agencies valued the importance of addressing trauma as a mediator of homelessness outcomes. The importance of Type II trauma was also highlighted as a construct which could help explain the complex mental health and social difficulties of people experiencing homelessness.

The final study examined in detail the relationships between a history of homelessness, experiences of trauma, and mental health issues. This study underscored the universality of trauma exposure amongst people experiencing homelessness, with all participants experiencing at least one traumatic event, and 97% experiencing more than four events. Trauma was identified as a common precursor to experiencing homelessness, and further, trauma exposure tended to escalate following onset of homelessness.

The final study found that the majority of participants (88%) met criteria for at least one current mental health diagnosis. These included current posttraumatic stress disorder (PTSD; 73%), current depression (54%), alcohol abuse disorder (49%), alcohol dependence disorder (43%), substance abuse disorder (51%), substance dependence disorder (44%), and current psychotic disorder (33%). PTSD was found to be highly comorbid with other disorders. Definitions of these disorders can be found in the Glossary at the end this framework.

Both Type I and Type II trauma were experienced by the majority of participants. Consistent with expectations based on previous research, outcomes for the 60% of participants exposed to Type II trauma included high levels of difficulties with: emotional regulation (62%), maintaining social relationships (93%), managing risk taking behaviour (41%), suicidal ideation (19%), dissociative experiences (72%), and holding negative perceptions of the world and self (66%). However, participants who had experienced multiple Type I traumas also reported increased difficulties with relationships, dissociation, negative views, and suicidal ideation, indicating that very high rates of trauma exposure drive similar outcomes irrespective of the type of trauma experienced.

Findings from the THI research suggest that long-term homelessness, trauma exposure, mental health difficulties and social disadvantage represent a cluster of vulnerability. They occur together, and drive each other with significant consequences across a lifetime. Trauma exposure usually begins in childhood, is a precipitant to becoming homeless, and then escalates upon becoming homeless. Trauma may lead to mental health problems which lead to social and relationship difficulties which in turn maintain homelessness. Similarly, mental health difficulties might lead to social relationship difficulties which increase the risk of trauma exposure and homelessness.

In order to provide a practical framework for intervening with this cluster of vulnerabilities, the THI research identified a number of principles and considerations for integrating trauma-informed principles and trauma-specific interventions. The explanatory and recovery models described in this framework articulate these principles and considerations, and identify specific areas to focus on in order to contribute to the development of psychosocial stability, and strengthen pathways to recovery within homelessness support agencies.

INTRODUCTION TO THE SERVICE FRAMEWORK

The Trauma and Homelessness Initiative (THI) was established to investigate the relationship between trauma and homelessness and develop a framework for trauma-informed practice for the homelessness sector. The initiative is a partnership between the Australian Centre for Posttraumatic Mental Health and four homelessness service providers: Sacred Heart Mission (SHM), Mind Australia, Inner South Community Health (ISCH), and VincentCare Victoria. The research component of the work was supported with a contribution from the Helen McPherson Smith Trust.

The initiative involved a series of four studies designed to investigate the nature of the relationship between trauma and homelessness, with each study building on the findings of the last. The first three studies included a literature review and qualitative interviews with direct service workers and service users. For the final study, a quantitative methodology was used to investigate the relationship between a history of homelessness, exposure to traumatic experiences, and mental health. This study involved structured interviews with 115 service users from the four partner agencies.

The research did not investigate the psychological or neurobiological underpinnings of trauma reactions or posttraumatic mental health problems. Rather, the focus was on the impact of trauma on the individual and their relationships with others, which have direct implications for services working with people experiencing homelessness.

This service framework contains an overview of the THI research and is intended to provide a reference point for agencies addressing homelessness within a TIC paradigm. This framework combines learnings from the literature relating to trauma and homelessness, from consensus understandings of TIC, from the literature relating to recovery from posttraumatic mental health conditions, and from the results of the research conducted by the initiative.

The framework offers an explanatory model of the relationship between trauma and long-term homelessness, and provides a rationale for integrated provision of trauma-specific services within the homelessness sector. The framework is accompanied by a practical guidebook resource for informing the work of on-the-ground service providers.

BACKGROUND LITERATURE IN TRAUMA AND HOMELESSNESS RESEARCH

This summary of the THI's literature review presents the current state of knowledge on the nature of the relationship between exposure to traumatic events in people's lives and the experience of homelessness. It highlights areas that were deemed to be particularly relevant to the research conducted by the THI consortium, as well as for the development of a framework for trauma-informed practice. For a comprehensive review of this literature, please refer to the THI literature review.

Defining a traumatic event

A traumatic event is defined as one where an individual is confronted with actual or threatened death, serious injury or sexual violation, or they are exposed to the death, injury or suffering of others. In the case of childhood trauma, this includes witnessing these events as they occur to others (especially primary caregivers) or learning that these events occurred to a parent or primary caregiver.

People who are exposed to a traumatic event(s) may experience a range of traumatic stress symptoms which include (but are not limited to): intrusive memories about the event, behavioural and emotional avoidance, high levels of arousal (such as increased startle and hypervigilance), sadness, anxiety, and guilt. Discrete, single occurrences of trauma are known as Type I trauma. For some people, especially those who experience events that are interpersonal, prolonged and/or of a repeated nature (e.g., imprisonment, torture), the impact of traumatic events can be pervasive and long-lasting. This type of trauma is often referred to as Type II trauma[3]. Type II trauma that occurs in childhood, and that involves direct harm and/or neglect by caregivers, often occurs at developmentally vulnerable times for the child, and can give rise to complex psychological, social and behavioural problems in adulthood. Central to this concept is that exposure to this trauma occurs within an environment where escape is impossible (especially when the trauma is perpetrated by a primary caregiver).

Types of traumatic events experienced by people who experience long-term homelessness

High rates of exposure to traumatic events among people who experience homelessness are well documented[4-6]. Australian studies have found that between 91% and 100% of people experiencing homelessness have experienced at least one major trauma in their lives[7-9]. In comparison, 57% of the general Australian population report one major traumatic event in their life[10].

Few rigorous studies have investigated the prevalence of childhood trauma in people who experience long-term homelessness. The few well-designed published studies suggest that adults who experience homelessness have experienced high rates of childhood trauma including sexual abuse (ranging from 23% to 84%),[7,11-13] and physical abuse (70% to 77%).

Other types of traumatic events that are particularly prevalent within adult homeless populations include physical abuse, witnessing someone being badly injured or killed, and rape and sexual abuse[7,14].

In summary, people who experience homelessness have often experienced traumatic events in their childhood/adolescence. They are also at increased risk for experiencing traumatic events during their periods of homelessness.

Prevalent mental health disorders

The vast majority of people who experience homelessness also experience at least one psychiatric disorder, and the prevalence of psychiatric disorder among adults experiencing homelessness is much higher than in representative community samples[15]. Mood disorders, psychotic disorders (i.e., schizophrenia and bipolar disorder) and trauma-related disorders (e.g., posttraumatic stress disorder [PTSD]) have all been found to be over-represented amongst adults experiencing homelessness[7,16,17].

An Australian survey of men and women experiencing homelessness found that 73% of men and 81% of women met criteria for at least one mental health disorder in the past year (12 month prevalence) and that 40% of men and 50% of women had at least two mental disorders[18].

Psychiatric disorder often precedes homelessness, but there is also evidence that some people become mentally ill as a result of experiencing chronic homelessness.

Surprisingly few studies have assessed PTSD among people experiencing homelessness, and the studies that have been conducted fail to show a consistent

picture. In the only Australian peer-reviewed study to examine PTSD prevalence rates in adults experiencing homelessness, it was found that 79% of the sample met criteria for a lifetime diagnosis of PTSD, while the 12 month prevalence of PTSD was 41% (PTSD present in the last 12 months)[9].

In the general population, males are less likely than females to develop PTSD or depression following traumatic events, but more likely to develop substance use disorder. Therefore, it might be expected that for people experiencing homelessness, women would have a higher prevalence of PTSD than men. However, this has not been addressed in the literature, suggesting a pressing need for epidemiological research examining trauma exposure and PTSD, particularly in men experiencing homelessness.

When PTSD occurs in the context of homelessness it is also associated with high levels of comorbidity with other psychiatric disorders. For example, in an Australian study of adults experiencing homelessness, of those who met criteria for current PTSD, 55% screened positive for psychosis; 69% scored in the severe or extremely severe range for depression; 50% scored in the severe or extremely severe range for anxiety; 63% screened positive for harmful or hazardous drinking or alcohol dependence; and 88% screened positive for substance use, probable abuse or dependence[9].

Risk factors that contribute to recurring homelessness after the experience of trauma

Studies in non-homeless samples report that characteristics about the individual increase their risk for developing PTSD after exposure to a traumatic event. These include, previous psychiatric history, prior trauma history, family history of mental illness, and early childhood adversity. Other factors such as a low level of education, female gender, and personality traits have been identified as increasing risk for PTSD. Importantly, these characteristics can also increase the risk of becoming homeless[19,20].

At the macro level, risk factors for homelessness include poverty, poor education, social exclusion and long-term unemployment. Familial factors include family dysfunction, family violence and sexual abuse, childhood institutionalisation, and poor family and social support. Individual attributes such as mental health problem, physical or mental disability and coping ability also play a key role[21-23].

In one of the only longitudinal studies to examine risk factors of long-term homelessness, the most important predictors were: older age, past or current unemployment, a lack of earned income, poorer coping skills, less adequate family support, a history of substance abuse and an arrest history[24].

Impact of trauma exposure and resulting mental health problems upon homelessness

Prior to the THI, there was limited research into the relationship between trauma exposure and mental health problems within homeless samples. The literature that did exist suggests that trauma, PTSD, substance abuse, and physical and mental illness often occur before, during and after periods of homelessness, but the causal pathways and nature of the relationships among these factors remain in need of systematic empirical study.

Very few studies have investigated the temporal relationship between PTSD and homelessness (i.e., which occurs first), but there is some evidence to suggest that the development of PTSD commonly precedes the onset of homelessness.

Barriers to mental healthcare for people who experience homelessness

Despite high levels of need, many people who experience homelessness do not receive adequate or appropriate physical or mental healthcare. Systematic barriers include deinstitutionalisation and an apparent lack of a responsive community mental healthcare system to respond to the needs of people with severe mental illness; the general inaccessibility of healthcare to people who experience homelessness; and the pressures of extreme poverty – such as the necessity to obtain food over healthcare.

Mental health service-seeking among those experiencing homelessness tends to be related to level of need, education, residential stability and having a usual place to sleep. Barriers can also come from providers who are reluctant to treat clients experiencing homelessness, and from clients who are distrustful about the providers and authorities.

Practical problems can hamper efforts to engage with mental health services, such as lack of transportation and the cost of using public transport. People with mental health problems experiencing homelessness are less likely than other mental health consumers to experience continuity of care. Furthermore, difficult client behaviour, such as behaviours related to active substance use, and difficulties with engagement, can sometimes hinder efforts by workers to promote recovery.

SUMMARY OF THE TRAUMA AND HOMELESSNESS INITIATIVE RESEARCH

Service provider consultation

The agency consultation component of the THI research gathered on-the-ground perspectives on the relationship between trauma exposure and homelessness, and factors that help or hinder the provision of effective services to this population. Focus groups were run using a modified nominal group technique (NGT). This technique was developed by Delbecq and Van de Ven (1971)[43] and can be thought of as a structured variation of small group discussion methods. This technique is useful for synthesising judgments where a diversity of opinions exist on an issue, or where participants have different types and extent of knowledge.

The staff consultations indicated a high degree of agreement in the attitudes, beliefs, competency expectations and practices of workers across the four collaborating agencies, and principles of trauma-informed care identified in the literature. There was strong endorsement of overarching principles such as being person-centred, strengths-focussed, socially inclusive, and social justice driven. Similarly, respondents identified attending to needs holistically, working motivationally, and having excellent systems knowledge as enablers of good practice. These practice and philosophical orientations are highly consistent with TIC principles outlined later in this framework.

The findings of the staff consultations relating to six specific topics such as understanding the needs of service users, providing effective care, and managing barriers to care are summarised below.

Topic 1: On the basis of your experience, what is your hunch about the link between trauma and difficulties in maintaining secure housing?

Responses from staff about the linkage between trauma and homelessness clustered around two main explanatory factors – psychosocial mediators (primarily characteristics related to the individual) and more systemic mediators (relating to the limitations of the existing service system).

- **Psychosocial mediators**

Across all groups, there was a view that trauma may result in the development of coping mechanisms designed to survive or adapt to trauma, such as substance use, self-harm, low trust, poor affect regulation, and poor attachment. These coping mechanisms, in turn, are related to behaviours not compatible with maintaining housing; for example, low engagement with services, reluctance to attend meetings or sign contracts, difficulties managing aggression, mental health problems, and substance abuse or dependence. One comment noted, for example, that:

> *"People with a history of trauma may have problems with confidence, life skills, hypersensitivity, trust issues, [which can] create planning [and] organising issues".*

A psychosocial mediation model of trauma and homelessness may be a way to describe these relationships, whereby trauma is seen to impact behaviour and relationships, which in turn is seen to impact on housing security. A comment that exemplified this was:

> *"It is the link between trauma/mental illness/ substance abuse and difficulties forming and maintaining positive relationships that impacts on the capacity to maintain housing".*

- **Systemic mediators**

A number of staff raised the issue of the experience of homelessness or living in unsecure accommodation as being traumatic in itself. In this context, participants reported that an important systemic issue was being unable to provide secure housing for many of their clients. For example, feedback indicated that one agency was "unable to provide secure housing 90% of the time". Obstacles included the lack of available secure housing and the complications inherent in shared living facilities such as rooming houses; "shared facilities for people without the skills to do so". In addition to the problem of limited resources, focus group participants also felt that the way in which trauma is addressed within the system is often inadequate, meaning that people feel unsupported and past traumas continue to have an adverse effect on their current circumstances. As one support/case worker noted:

> *"Individuals who have experienced trauma have not addressed the trauma which causes them to continue the cycle of homelessness".*

Topic 2: In your experience, what works well in supporting people with trauma?

Responses to this question about enablers of good practice articulated both characteristics of effective staff, and service level predictors of good outcomes.

- **Characteristics and competencies of staff**

In terms of supporting people with trauma, participants identified a range of factors that predict good outcomes, falling under two main themes. The first related to characteristics and competencies of the case workers themselves. The ability of the worker to build a strong therapeutic relationship with the client was a theme identified by all four services. Trust, consistency, and clarity of boundaries were considered crucial in building good relationships with clients. Also falling under the theme of support/case worker factors was the worker's interpersonal (or clinical relational) skills. Confidence and competence in employing a trauma-informed approach was seen to be important, as were more general client and interpersonal skills such as managing complexity, reflective listening, and capacity for self-care. In particular, participants felt that the ability to listen to and validate the client's experience of trauma was essential; as one participant put it, being "comfortable in this unpleasant space".

- **Service level factors**

The second theme identified as relevant to supporting people with a history of trauma related to service-level factors. All services discussed the importance of "being well versed in what the system/service offers", and what the limits of a given service are (such as the amount of time available to support people), having good links with other services, and being able to refer clients on when appropriate while maintaining continuity of care. Flexible service delivery models, such as group work, and outreach and after-hours services, were also mentioned as effective in supporting people with a history of trauma.

Topic 3: What tends to get in the way of effective work (i.e., clinically)?

Three main themes emerged when participants were asked to identify what tended to get in the way of working effectively with service users. These were practitioner, service, and client-level factors.

- **Practitioner characteristics**

All groups identified lack of confidence and relevant skills as an impediment to effective TIC. Representative comments addressed the need for "confidence and experience for workers to be able to ask the questions and engage with clients around trauma", and the problem of "feeling overwhelmed, how do you make a difference?"

- **System characteristics**

Participant endorsements indicated that system-level factors appeared to be the most substantial barriers to effective work for support/case workers across the services. A number of issues were considered and strongly endorsed, including problems with the inflexibility of the system, long waiting lists, limited time for support/case workers to spend with clients, lack of funding, large caseloads, and limited options for referrals. There was a view that the mental health system remains inaccessible for many clients, creating a sense of hopelessness for both clients and staff.

Rigidity around mental health diagnosis and its consequences was seen to be a significant issue. Participants noted, for example, the "challenge to get services, particularly mental health to this client group, for example, if [there is] no diagnosis [it is] hard to engage services". Other issues relating to this topic included being turned away for having the wrong diagnosis, or the problem of a diagnosis resulting in reductionist thinking, with all subsequent issues attributed to, and interventions targeted at, symptoms of that disorder.

- **Client characteristics**

Client characteristics were also seen to pose a barrier to the delivery of effective services, including reluctance to engage, experiencing ongoing chaos or crisis, or presenting with a lack of insight about issues like mental health difficulties. In addition, some demographic characteristics, such as culture and gender, were noted to impact on effective practice.

Topic 4: In a perfect world, how would your agency respond more effectively to people with trauma?

Not surprisingly, when asked how their agency could respond more effectively to people with trauma, participants noted many of the issues they had previously identified as getting in the way of effective work, whilst offering a range of practical methods for addressing these issues.

Participants identified that additional training and clinical supervision, increased flexibility and consistency, decreased caseload, more time with clients, and the capacity to work long-term would improve responses to the difficulties experienced by staff and clients. Smoothing the transition between services was raised a number of times as a mechanism for improving agency response; participants commented on the need for "better

relationships with other services" and improved "referral pathways, communication", both internally and externally. A number of participants suggested that agencies should employ multidisciplinary teams in order to improve their response to people with trauma, including in-house trauma counsellors.

Across all groups, agency-wide implementation of trauma-informed policy and practice was highlighted as a key improvement. One highly ranked comment noted the need for a "work based culture that is trauma-informed, consistent approach", while another suggested the introduction of "interview/assessment templates to identify trauma – training for all staff".

Several comments identified the need for additional funding, or suggested that changes to funding models would allow agencies to respond more effectively to people with trauma. For example, one participant noted that at present, the "funding model and service model don't allow for effective long-term engagement", particularly for clients who cycle in and out of the agencies.

Topic 5: In a perfect world, how would staff respond more effectively to people with trauma?

- **Staff skills and capabilities**

All groups highlighted the need for staff to be well-trained, and have a good understanding of trauma and trauma-informed practice. Relatedly, the importance of good supervision was raised by a number of case workers, although some supervision models were seen to be more useful than others. Specifically, support/case workers articulated a need for external clinical supervision, as opposed to or in conjunction with line management supervision.

Another strongly endorsed component of improving staff response to trauma was the ability to build a strong therapeutic relationship with clients. Apparent from support/case workers' responses was the importance they placed on fostering empathy, non-judgemental listening, acknowledging the client's experience, and sensitive assessment practices; as expressed by one case worker, "not re-traumatising a client through the assessment process".

- **Staff self-care**

A key issue that emerged in relation to improving staff response was the need for staff to be aware of the impact of their work on themselves. Representative comments from support/case workers identified the importance of "staff knowing, understanding [the] limitations of their own practice", and "making sure staff take care of themselves". In the context of recognising their own limitations, case workers noted the value of knowing when to refer clients to more appropriate services. The need for staff to be "aware of their own responses" and "deal with [their] own personal issues [and] issues surrounding countertransference" was also considered crucial in improving staff's ability to respond effectively to people with trauma.

Topic 6: Do you have anything else that you would like to add in relation to either trauma or the experience of repeated homelessness?

A significant theme to emerge when support/case workers were asked to contribute any other comments related to trauma or homelessness was the need for policy and service-delivery frameworks that more closely aligned with client needs. In particular, comments highlighted the need for a diverse range of housing options, and the importance of people with a history of trauma having access to safe accommodation (as opposed to rooming houses which were seen to re-traumatise), given that these individuals are likely to feel constantly unsafe and live in a state of heightened arousal.

Across agencies, social isolation was identified as a key issue for this client group and a suggested goal for staff was to support individuals in developing or maintaining social connections.

Another theme identified in response to the invitation for additional comments focussed on the cyclical and interwoven nature of trauma and homelessness. This theme encompassed the ideas that as much as trauma can lead to homelessness (as discussed in topic 1 *What is the link between trauma and homelessness?*), homelessness also increases the risk of exposure to subsequent trauma, and for many clients, the experience of homelessness is traumatic in itself. One highly endorsed statement related to this theme stated that:

> *"People who are long-term homeless have commonly experienced a lifetime of trauma, i.e., profound early childhood trauma [such as] sexual abuse, that is compounded by a lifetime of disadvantage, poverty, violence, and ongoing trauma".*

Finally, a number of participants raised the issue of disparity between client and case worker expectations. It was noted that "not all outcomes can be measured … some people will not be able to get to a high level of functioning", and that culturally and linguistically

diverse clients may have different expectations or be reluctant to change. Other case workers mentioned that some clients may not have insight, "occupy a different reality", or may not even consider themselves as experiencing homelessness due to their different notions of what homelessness means.

Taken together, these staff consultations indicate that trauma-informed practices and understandings are well embedded in the four agencies participating in the consultations. This level of awareness reflects a high degree of familiarity with trauma-informed care concepts. It also suggests that the practitioners who participated see very real benefits of adopting a trauma-informed paradigm of service delivery. There is a high degree of concordance between these consultation results, the Trauma and Homelessness Literature Review, and the outcomes of the initiative's research with service users, which is presented in the next section.

Service user consultations

This section presents the results from the third THI study, where ideas developed from the two previous studies about the nature of the relationship between trauma and homelessness were tested. Twenty service users from four agencies: SHM, Mind Australia, ISCH, and VincentCare Victoria were interviewed for this study. We used a qualitative methodology to investigate the relationship between a history of homelessness, exposure to traumatic experiences, and mental health. This section provides an overview of the key findings from these qualitative interviews with service users.

Methodology

A qualitative methodology was used, including open-ended questions. Interviews were digitally recorded and transcribed. The data was analysed using the Thematic Analysis methodology which enables key themes to be identified.

Key findings

General background

- Eleven males (55%) and 9 females (45%) were interviewed.
- Average age was 42.35 years (range 22-61).
- Marital status: single (n=13, 65%), separated or divorced (n=6, 30%), widower (n=1, 5%).

Current and past accommodation

- Participants currently live in a range of accommodation: supported accommodation (n=6, 30%); public housing (n=5, 25%); transitional housing (n=3, 15%); community housing (n=3, 15%); rooming house (n=1, 5%); van (n=1, 5%); and in a hotel (n=1, 5%).
- First experience of homelessness ranged from birth to 50 years of age (average first experience at 17.2 years of age).

Participants were asked about what needed to happen for them to be housed in the long term. The following themes emerged:

- Changes external to the participant. Examples included, finding employment, finding suitable housing, or having increased financial support.
- Changes internal to the client, which included personal changes such as improved parenting strategies.

Events that led to the participants' first experiences of homelessness were identified under four themes. They included:

- Childhood trauma
- Disintegration or absence of family unit
- Mental health issues
- Accumulation of stressful life events.

Factors that made it hard to find somewhere permanent to live were identified as:

- Lack of employment
- Lack of affordable housing and availability
- Personal experiences and attitudes of others, such as being used to being homeless, and experiences of social exclusion.

Participants identified a number of events that got in the way of staying in secure housing. These were grouped under the following themes:

- Disintegration or absence of family unit
- Difficult interpersonal relationships
- Drug use
- Mental health issues.

Traumatic experiences

- All 20 participants (100%) reported experiencing at least one traumatic event in their lifetime.
- Type I trauma was experienced by 20 (100%) of the participants.
- Type II trauma was experienced by 15 (75%) of the participants.
- Sixteen participants (80%) had sought professional assistance for dealing with these experiences in the past.

Mental health issues

Participants were asked if they had experienced emotional regulation difficulties (i.e., strong emotions or feelings that were hard to manage). Participants reported a number of emotions that were difficult to manage including:

- Feeling down or hopeless (n=20, 100%)
- Anger (n=16, 80%)
- Anxiety (n=18, 90%)
- Experiencing panic attacks (n=15, 75%)
- Hypervigilance (n=14, 70%)
- Strong cravings or urges (n=15, 75%).

When asked how these emotional regulation difficulties impacted on the participants' lives, the following themes emerged:

- No perceived impact (n=8, 40%)
- Perceptions of being unable to cope (n=5, 25%)
- Interpersonal and relationship difficulties (n=5, 25%)
- Impulsive and risk taking behaviours (n=3, 15%).

Participants were asked whether they had had dissociative experiences.

- Two participants (10%) reported having dissociative experiences.

When asked about social relationship difficulties (i.e., difficulties finding or maintaining good relationships with people), most participants described having relationship difficulties (n=18, 90%). The perceived reasons for these difficulties were:

- Low levels of trust in other people (n=9 out of the 18 people who had relationship difficulties, 50%)
- The belief that they had nothing to offer to a relationship (n=4 out of 18, 22%)
- The belief that having poor relationships did not impact on them (n=3 out of 18, 16%)
- Poor communication skills leading to an inability to maintain the relationship (n=1 out of 18, 6%).

Participants were asked about their risk-taking behaviour, and the extent to which they put themselves in danger. Participants reported the following types of experiences:

- Risky substance use (n=16, 80%)
- Interpersonal risk taking (n=15, 75%)
- Self-harm/suicide attempt (n=13, 65%)
- Risk of physical harm (n=13, 65%)
- Risk of sexual harm (n=9, 45%).

Participants were asked about their views of self. The themes to emerge included:

- Negative views of self (n=11 out of the 14 people who responded to the question, 78%)
- Self as a survivor (n=3 out of 14, 22%).

They were also asked how they perceived the world. The themes to emerge included:

- The world is a dangerous place (n=6 out of the 14 people who responded to the question, 43%)
- There is good in the world (n=8 out of 14, 57%).

The findings from the third study supported the need for a larger quantitative study to investigate trauma exposure and its consequences in the homeless population. These findings helped to refine the focus of the various constructs proposed from the literature review to be explored in the larger quantitative study, the results from which are presented in the following section.

Quantitative research

The aim of the quantitative study was to systematically and scientifically examine the relationship between a history of homelessness, experiences of trauma (including type [Type I or Type II] and frequency of trauma exposure), and mental health issues.

The specific key questions that the fourth study sought to investigate were:

1. What are the types of traumatic events that are experienced by people who experience homelessness?
   - What is the frequency with which traumatic events were experienced?
   - What is the prevalence of Type I and Type II trauma?
   - At what age did each traumatic event occur?
   - When did each traumatic event occur relative to becoming homeless?
2. Does the experience of trauma contribute to homelessness (as measured by the length of time that someone has experienced homelessness to date)?
   - Does experiencing trauma prior to homelessness contribute to length of time spent homeless?
   - Does the experience of Type II trauma contribute to length of time spent homeless?
   - Does the number of traumatic events (lifetime) contribute to the time spent homeless?

- Do people who develop PTSD after experiencing trauma, spend more time homeless than those who do not develop PTSD?

3. What is the prevalence of mental health disorders amongst people who experience homelessness?
   - What are the prevalence rates of PTSD, depression, psychosis and substance use disorders?
   - What are the prevalence rates of other mental health difficulties often associated with complex trauma presentations such as emotional regulation difficulties, risk taking, suicidality, dissociation, and difficulties maintaining social relationships? Are these difficulties more likely to be experienced by those who have a history of Type II trauma relative to those who have not been exposed to this type of trauma?
4. What are the levels of social support, community connectedness and social exclusion that are experienced by those who experience homelessness?
5. What are the barriers encountered by people who experience homelessness, in seeking help for issues related to trauma or mental health?

By addressing these questions, this study aimed to provide valuable information for the final part of the project, the development of a trauma-informed service framework.

Methodology

In this multi-sited study which involved SHM, Mind Australia, ISCH and VincentCare Victoria, 115 people experiencing homelessness were recruited for participation. This represents one of the largest Australian studies examining the trauma experiences of this highly marginalised population. A rigorous quantitative methodology was used, including random selection of participants, the use of validated clinical interviews and self-report measures, and the collection of data across multiple services. All interviews were digitally recorded to ensure that responses were captured in an accurate and comprehensive way. In recognition of the potential distress associated with the interview, after each interview the researcher provided feedback to the team leader. The scope of this feedback was limited to how the participant coped with the interview, and team leaders could alert case managers if a participant required additional support.

Key findings

General background

- Seventy-seven males (67%) and 38 females (33%) were interviewed.
- Their average age was 45 years (range 18-86) with 22% of participants under 35 years.
- The majority of the sample was single (61%).
- Participants currently live in a range of accommodation, that is: rooming house (24%), public housing (24%), the street (19%), supported accommodation (6%), community housing (5%), transitional housing (5%), couch-surfing (5%), traditional housing (4%), vehicle (4%), and other (4%).
- The average age at which participants first experienced homelessness was 23 years of age. This ranged from some participants being born into homelessness to first experience at 56 years of age.

The main events that led to the participants' first experience of homelessness were:

- Childhood trauma (17%)
- Disintegration or absence of family unit (26%)
- Mental health issues (10%)
- Accumulation of stressful life events (15%). For a definition of this, refer to the Glossary.

Traumatic experiences

- There was an extremely high level of reported exposure to trauma events, with all 115 participants reporting at least one traumatic event in their lifetime. Type I (single incident) trauma, was experienced by 98% of the participants. There were very high levels of exposure to interpersonal violence (including sexual and physical assault) as well as natural disasters, and life threatening accident. Type II trauma was directly experienced by 60% of the participants.
- Most participants reported exposure to multiple traumatic events. Over 97% of those interviewed had experienced more than four traumatic events in their lifetime. The comparable rate in the general community is 4%.
- Seventy per cent of participants experienced at least one trauma before experiencing homelessness. The majority of participants were exposed to trauma during their childhood. For many participants this childhood trauma was prolonged and repeated, and constituted Type II trauma (e.g., child abuse). For others, it was exposure to other events such as motor vehicle accidents, natural disasters and violence (Type I trauma).

- Trauma was often identified as a precipitant to becoming homeless.
- Although most of the sample was exposed to trauma prior to becoming homeless, trauma exposure escalated after becoming homeless such that the majority of trauma exposure occurred after becoming homeless.

Mental health issues

- A structured clinical interview enabled assessment of current and lifetime mental health disorders. These assessments showed that 88% of the sample met criteria for current diagnosis of a mental health disorder. These included current PTSD (73%), current depression (54%), alcohol abuse disorder (49%), alcohol dependence disorder (43%), substance abuse disorder (51%), substance dependence disorder (44%), and current psychotic disorder (33%). Definitions of these disorders can be found in the Glossary of Terms.
- PTSD was highly comorbid with other disorders including major depressive episode (67% of PTSD was comorbid with major depressive episode), current alcohol abuse (54%), alcohol dependence (47%), substance abuse (61%), substance dependence (54%), and current psychotic disorder (38%).
- Participants reported high levels of symptoms often associated with exposure to repeated and prolonged traumatic events. These included: emotional regulation difficulties (62%), difficulty maintaining social relationships (93%) risk taking and putting self in danger (41%), suicidal ideation (19%), dissociative experiences (72%), and negative perceptions of the world and self (66%).
- The literature review identified that Type II trauma was associated with high levels of complexity across a number of mental health domains. Our research findings partially supported this finding. In our sample, participants who had experienced Type II trauma had a somewhat more complex presentation than those who had experienced Type I trauma only. Specifically, those who had experienced Type II trauma were significantly more likely to meet criteria for a diagnosis of current PTSD than those who did not, and their PTSD severity scores were significantly higher. They were also significantly more likely than those who had experienced Type I trauma only, to meet criteria for a diagnosis of lifetime PTSD, to experience emotional regulation difficulties, and have high levels of risk taking and self-endangering behaviour.
- However, those who had experienced Type I trauma only also presented a complex presentation across a number of other mental health and social domains. In this sample, those experiencing Type I trauma only, reported high levels of negative social relationships, dissociation, negative views of the world or themselves, and suicidal preoccupation. They also had high levels of major depressive episode, anxiety, alcohol and substance use disorder, and psychotic disorder. They had low levels of social support and social connectedness and high levels of social exclusion. Across these domains those who had experienced Type I trauma only, looked very similar to those with Type II trauma, in terms of complexity.
- This high level of complex mental health presentation seen in those who had experienced Type I trauma only may be driven by the high level of trauma exposure experienced by this group. Those participants who were exposed to Type I trauma only, experienced this trauma in a repeated, frequent and ongoing way, such that their mental health and social difficulties look similar to those who had experienced Type II trauma.

Impact of trauma on homelessness

- In simple analyses, it was identified that people who experienced trauma prior to homelessness were significantly more likely to have longer periods of homelessness than those who experienced trauma after homelessness.
- When a planned stepwise multiple regression was conducted, characteristics of trauma exposure or mental health did not significantly predict length of time spent homeless, after controlling for age. One potential explanation for this finding is that the incredibly high rates of trauma exposure by all people in the sample led to the inability to discriminate differences within the sample in terms of trauma.
- These findings may also indicate that the factors which influence the length of time people experience homelessness are very complex and multi-dimensional. Our analyses tested whether trauma had a direct relationship with length of time someone was homeless (it would appear that it did not). However, it may be that trauma experienced played an indirect role on length of time spent homeless. For example, trauma may have impacted upon a person's mental health, or social relationships, which in turn may have impacted upon the amount of time the person spent experiencing homelessness. Future studies with larger sample sizes may be useful to explore these indirect relationships.

Help-seeking

- Of those who experienced trauma, 67% (n=77) sought assistance for dealing with these experiences at some time in their lifetime. The most frequent help-seeking activity was to visit a psychologist (27%, n=21 out of the 77 people who sought assistance) or a GP (25%, n=19 out of 77). Sixty-five per cent of these people (n=77) described the assistance that they received as beneficial.
- However, 50% of the total sample reported that there had been a time when they did not get professional help for a mental health issue, despite wanting to do so. The most common reasons for this included: not knowing how to get help (35%); not trusting anyone (11%); thinking that no one could understand their situation (11%); cost (7%); and not caring or feeling ready to engage (9%).

Social support and social connectedness

- The sample had low to moderate levels of social support and social connectedness and moderate to high levels of social exclusion. This is consistent with the finding that 95% of the sample reported high levels of difficulties maintaining social relationships.
- Social difficulties as a whole were experienced at a high level regardless of whether the individual had experienced Type II trauma or Type I trauma only.
- Taken together, social difficulties represent a fundamental component of the relationship between trauma and homelessness.

WORKING WITH PEOPLE WHO EXPERIENCE HOMELESSNESS: A TRAUMA-INFORMED CARE APPROACH

Research shows that people who experience homelessness experience high rates of exposure to traumatic events both prior to and after losing secure accommodation. Currently, few programs providing services to individuals experiencing homelessness directly address the specialised needs of trauma survivors[25]. However, in an effort to respond to the needs of those who have experienced trauma, some programs that service clients who experience homelessness are developing trauma-informed services. These services recognise the significance of violence and trauma exposure in understanding client problems. The critical need to deliver services that are trauma-informed has been recently recognised[6, 7], however, the wider adoption across the Australian homelessness service is still in its infancy[26].

Trauma-informed care (TIC)

At a minimum, trauma-informed services aim to provide an increased sense of safety, and strive to avoid any re-traumatisation of their service users[11]. In the past, the nature of TIC was ill-defined. Recently, however, in a seminal peer-reviewed article by Hopper, Bassuk and Oliver[25], a consensus-based definition of TIC within homelessness service settings was developed:

> *Trauma-informed care is a strengths-based Framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment* (p.82)

Within the practice literature, being trauma-informed requires that every aspect of service delivery is mindful of the trauma histories of service users. The themes encompassed by this consensus-based definition can be articulated in greater detail. The key themes include:

- **Trauma awareness:** Trauma-informed service providers incorporate an understanding of trauma into their work. This may mean that it is necessary to alter *staff perspectives* on how to understand various presenting symptoms and behaviours. This is facilitated by *staff training, consultation,* and *supervision*. Organisational changes may also be made, such as routine screening for histories of trauma and assessment of safety. The *self-care* of staff is also an essential element of trauma-informed services [25].
- **Emphasis on safety:** Trauma survivors can feel unsafe and some are at ongoing risk of experiencing trauma (e.g., victims of domestic violence), therefore TIC works towards building *physical and emotional safety* for both *service users and providers.* Because interpersonal trauma often involves boundary violations and abuse of power, systems should be developed that take into account trauma dynamics, and *clear roles, responsibilities and boundaries* should be delineated. *Privacy, confidentiality and mutual respect* should be maintained to develop an emotionally safe atmosphere, and *cultural differences and diversity* (e.g., gender, ethnicity, sexual orientation) should be respected[25].
- **Opportunities to rebuild control:** Control is often taken away in traumatic situations, and homelessness itself is disempowering, therefore TIC emphasises the *importance of choice* for service users. Trauma-informed services create *predictable environments* and allow individuals to rebuild a sense of *efficacy and personal control* over their lives. This includes involving service users in the design and evaluation of services[25.]
- **Strengths-based approach:** Importantly, TIC is *strengths-based*, rather than deficit-orientated. Individuals are assisted by the service in identifying their own strengths and developing or enhancing their own coping skills. TIC service settings are focussed on *the future* and utilise *skills-building* to further develop resiliency[25].

The scientific evidence related to TIC

A small number of studies have examined TIC in relation to psychiatric symptoms and substance use, and provide evidence on the *outcomes* for TIC (e.g.,[27]). A meta-analysis of a nine-site quasi-experimental study of comprehensive trauma-informed and consumer-involved services for women with mental health problems[28], found that sites which provided more integrated counselling produced more favourable results for mental

health symptoms six months post-program. Early indications also suggest that TIC may have a positive effect on housing stability. A multi-site descriptive evaluation of trauma-informed services for homeless families found that almost 90% of participants had either remained in government subsidised housing or moved to permanent housing[29] 18 months after engaging with the program. Although this research suggests that TIC may be effective for those who experience homelessness, there have yet to be any rigorous quantitative studies exploring outcomes within homelessness service settings [25].

From this review of both quantitative and qualitative studies, there is evidence to suggest TIC is generally viewed favourably by service users and providers and there is some evidence linking it to more effective outcomes across several areas including increased rates of housing stability[25]. There are, however, significant gaps in current knowledge for homelessness-specific models and further research is necessary to examine its effectiveness[25].

Corroborative evidence related to TIC

High level (peer-reviewed) evidence for the effectiveness of TIC is still in its infancy, however, a review of the grey literature in this area yields a wealth of information about current practices and policy initiatives. Many of the models of TIC that are currently in use in service settings, for example, A Long Journey Home[30] and Phoenix Rising [31], emphasise staff education, involving consumers, and transforming systems to be responsive to the needs of trauma survivors. A number of self-assessment tools designed to support organisations in adapting TIC to their own organisation's unique needs have been developed. These include the 'Trauma-informed Organisational Self-Assessment for Programs Serving Homeless Families'[32], and the 'Trauma-Informed Facility Assessment'[33]. These models for TIC and self-assessment tools have facilitated the development of a number of TIC programs within the homelessness service system in the US[25]. What is now needed is more rigorous research investigating attitudes, implementation and outcomes of TIC services.

Operationalising TIC

A scoping of the peer-reviewed and grey literature investigated the ways in which TIC has been operationalised and implemented within services that cater to traumatised populations. This scoping involved reviewing available documentation relating to existing services and programs, as well as an investigation of more general manuals and guides for implementation of TIC. The scoping focussed on resources that provided sufficient information to evaluate the consistency of TIC principles, and that either detailed the manner in which TIC had been practically implemented within service settings, or contained detailed recommendations for implementation.

It is important to note that whilst there is a considerable body of available work relating to TIC, there are few resources providing detail about the operationalisation of trauma-informed care within homelessness contexts, and much of the available literature relates to implementation within other service contexts, or settings where homelessness services were secondary.

Examples of well-described and articulated resources included models such as ARC - Attachment Regulation and Competency, which focusses on child and caregiver interventions for trauma and complex trauma[34]; CARE - Child Adult Relationship Enhancement[35]; and A Long Journey Home[36]. Other models and programs include the Sanctuary model[37]; Phoenix Rising[31], which is based on the ARC Framework; and the Lighthouse Foundation model[38] – primarily child-focussed programs. Other well-described resources related to programs that target trauma alongside comorbid psychiatric conditions, such as the STAR program (Seeking Treatment and Recovery) and Trauma-informed or Trauma Denied program that focus on co-occurring homelessness, mental health and substance abuse difficulties[39].

There are potential limitations to the generalisability of these programs to trauma-informed homelessness services. Either they focus on specific service user populations (such as youth, women, and veterans), or deal with specific comorbidities without directly addressing homelessness (for example, the Seeking Safety program for treatment of comorbid PTSD and substance use[40]). Some of the available information related to specific settings – for example, residential alcohol and drug programs, limiting the generalisability to other service contexts (i.e., outpatient, non-appointment based services, and homelessness services more generally).

Another important source of guidance for delivering TIC are the existing guides and manuals for the implementation of TIC. These resources provide definitions of trauma and TIC, organisational principles (and in some cases self-assessment tools), and recommendations about the delivery of specific supports and interventions. These manuals

also vary in their generalisability due to their service context focus (for example, the British Columbia Trauma-informed Practice Guide[41] relates to mental health and substance use programs; A Long Journey Home[36] focusses on women and children). The Trauma-informed Toolkit [67] is a more generalist resource, and is intended to be used by all service providers working with people affected by trauma. The (US) National Centre on Family Homelessness' Trauma-Informed Organisational Toolkit for Homelessness services is particularly relevant as it has a specific focus on provision of homelessness services, and provides explicit guidance on service design and delivery via its organisational self-assessment measure[42].

In the table on the following page, we have summarised the specific aspects of these reference materials as they relate to the development of this framework and the accompanying worker guidebook. The following criteria were thought to be of particular interest:

- Does the resource reflect consistency with the field with respect to how TIC is described?
- Does the resource support or recommend a focus on practical physical and emotional safety?
- Does the resource support or recommend provision of training for staff and psychoeducation for service users about trauma?
- Does the resource specify organisational service delivery principles – like the need for universal trauma training, and consistency in policy and procedures?
- Does the resource articulate issues relating to relational practices such as engagement, management of issues of control and boundary maintenance?
- Does the resource support, recommend or contain psychosocial stability skill interventions?
- Does the resource support, recommend or contain holistic referral, advocacy and case management practices?
- Does the resource support, recommend or contain trauma-specific services alongside TIC?
- Have the programs relating to the resource been empirically tested and supported?

Selected existing TIC models and guides – key aspects of operationalisation.

Program	Consistency in TIC principles	Focus on physical and emotional safety	Need for trauma awareness	Organisational service delivery principles	Relational practices	Psychosocial stability skill interventions	Provision of trauma-specific services	Evaluated or tested
ARC	✓	✓	✓	✓	Not explicit	✓	✓	✓
CARE	✓	✓	✓	✓	Not explicit	✓	✗	✓
Sanctuary Model	✓	✓	✓	✓	Not explicit	Not explicit	✓	✓
Phoenix Rising	✓	✓	✓	✓	✓	✓	Not explicit	? SAHMSA supported
Lighthouse Foundation	✓	✓	Not explicit	✓	Not explicit	Not explicit	✓	✗
Long Journey Home	✓	✓	✓	✓	✓	✓	✓	✗
STAR	Not explicit	Not explicit	✓	Not explicit	Not explicit	Not explicit	✓	✓
Trauma-informed or Trauma Denied	✓	✓	✓	✓	✓	Not explicit	✓	✗
Trauma-informed Organisational Toolkit	✓	✓	✓	✓ with detailed organisational checklist	✓	✓ crisis management	✓	✗
BC Trauma-informed Practice Guide	✓	✓	✓	✓	✓	✓	As referral	✗
Trauma-Informed Toolkit	✓	✓	✓	✓	✓	✗	✗	✗
Australia ASCA Practice Guidelines[68]	✓	✓	✓	✓	✓	✓	✓	✗

The specific definitions of TIC varied across these programs, although there was a high degree of concordance across programs in the core principles. Importantly, these principles were found to be broadly in agreement with Hopper's consensus definitions as outlined previously. This provides strong support for the use of Hopper's definition for the development of the current framework and guidebook resources.

There was also a high degree of agreement about the need for comprehensive trauma education for staff, for a primary focus on safety and stability interventions, and for organisational-level implementation of trauma-informed care principles. Additionally, these resources supported a focus on development of relationships as a mechanism for recovery (attention to safe and appropriate relational practices). They support the provision of skill-based interventions targeting trauma-related difficulties such as emotional regulation and self-efficacy. In many cases these programs and resources recommended that programs refer traumatised service users to trauma-specific services, or alternatively, deliver these trauma-specific services in an integrated fashion.

This broad consensus of philosophy and practice recommendations provides a consistent rationale for adoption of TIC models within homelessness services. Furthermore, this consensus is suggestive of an approach which addresses both 'how' services are delivered: that is, within a trauma-informed paradigm; and 'what' services are delivered, that is, those which lessen the impacts of trauma, via recovery and resilience skills interventions and trauma-specific services. Further guidance on operationalising TIC within services can be found in the final section of this framework.

TRAUMA AND HOMELESSNESS: AN EXPLANATORY AND RECOVERY MODEL

The findings from the THI present a picture of a cyclical interrelationship between trauma exposure, chronic homelessness, mental health difficulties and social disadvantage. The interrelationships between the elements of the cycle see them driving each other. This in turn produces an environment which presents a formidable barrier to recovery. A diagram representing this relationship is presented below.

Figure 1: Explanatory maintenance model of the relationship between trauma exposure, mental health difficulties, social disadvantage and long-term homelessness.

Trauma exposure in this model includes exposure to Type II trauma and/or frequent exposure to Type I trauma, exposure to high levels of interpersonal violence, and high levels of trauma in childhood (which may or may not be Type II trauma). Mental health difficulties may include the psychiatric disorders measured in this study (PTSD, depression, substance use disorders, psychosis) as well as other Axis I disorders (see Glossary for definition – such as panic disorders, agoraphobia, bipolar disorder) and Axis II disorders (personality disorders such as borderline, antisocial personality disorders). Importantly, the scope of mental health difficulties goes beyond specific psychiatric disorders. Other mental health difficulties include emotional regulation difficulties, dissociation, risk taking, negative views about the world and self, and suicidality. Social disadvantage encompasses the spectrum of social difficulties including difficulties in forming and maintaining close interpersonal

relationships, lack of social connectedness, and social exclusion. In the explanation below, we focus on difficulties maintaining close interpersonal relationships as these often form the foundation of social disadvantage.

As the focus of this project is on the role trauma plays in maintaining chronic homelessness, exploration of the model will examine the reciprocal relationship between trauma and homelessness, trauma and social disadvantage, and trauma and mental health.

The link between trauma and homelessness

As was seen in the THI research, traumatic events are often a precursor to becoming homeless. In many cases people left their home to avoid ongoing trauma in the form of assault, child abuse and other forms of interpersonal violence. The findings from the THI research is consistent with the Victorian Government report which states that a substantial proportion of women with children and young single women who seek assistance from specialist homelessness services do so to escape violence[44].

It is also the case that being homeless is a risk for experiencing further trauma. In the THI research, the frequency of trauma exposure escalated when people lost their secure accommodation. Homelessness deprives individuals of a safe place for everyday activities and exposes them to risky, unpredictable environments. That is, homelessness is more than the absence of physical shelter. Homelessness is a stressful, dehumanising, and dangerous circumstance in which individuals are at high risk of being witness to, or victims of, a wide range of traumatic events[45].

The link between trauma exposure and social disadvantage

The early work of Bowlby[46] described the human need for intimate and long-lasting social attachments as a biological imperative. Trauma, especially that caused by the primary caregiver or other forms of interpersonal trauma, impacts on an individual's sense of safety and connection with other people, and therefore impacts on the ability to develop and maintain social relationships[47]. Much of the literature exploring the relationship between trauma exposure and social relationships has examined the impact of trauma exposure in childhood. The literature is very relevant to people experiencing homelessness given the high level of childhood trauma experienced by people in the THI research studies. Children exposed to high levels of trauma often experience difficulty negotiating relationships with caregivers, peers and subsequently, marital partners[48]. Children exposed to high levels of trauma are at risk for impaired social-emotional development which is a foundation for healthy relationships[47]. They may lack the many skills of social understanding which is the ability to understand feelings, beliefs and desires, and their role in social behaviour. Emotional knowledge, the ability to recognise emotional expressions in others and to understand the types of situations that can give rise to particular emotions[47], is often lacking. Difficulties with these skills can impair children's ability to predict and understand others' reactions to their behaviour and therefore impair the ability to form friendships[47]. Entering adulthood with impaired skills in social understanding may give rise to the high levels of relationship difficulties seen in the THI research.

Complicated social adaptions to severe and frequent trauma are not only limited to children. Research with rape survivors, women exposed to domestic violence, and concentration camp survivors, show detrimental effects on self-identify, self-awareness, intimacy, sexuality, and communication, all of which are key elements in the maintenance of healthy interpersonal relationships[49,50].

Difficulties forming healthy social relationships may also drive trauma exposure. Partner violence, which includes physical, emotional, and sexual violence, is the leading contributor to death, disability and ill health in Victorian women aged 15 to 44[51]. Family violence has a profound and devastating impact on women, children, young people and communities, and is a significant contributor to homelessness among families[52]. This was very evident in the THI research where disintegration of the family unit was often a precursor to becoming homeless.

The link between trauma and mental health

Exposure to traumatic events in childhood is significantly associated with mental health problems in adulthood[53]. Childhood trauma increases risk for a complex presentation of psychological, social and behavioural disturbances, including (but not limited to) emotional dysregulation (difficulty regulating emotional responses), social dysregulation (including poor early and later attachment), negative perceptions of self and the world, dissociation, self-destructive behaviours, substance abuse, difficulty trusting people, and hopelessness[48,49,54,55]. Trauma exposure and its consequences are not limited to childhood trauma. While it is well recognised that PTSD is a psychiatric disorder that may develop following trauma exposure, there is growing research that other disorders develop following trauma exposure including depression and

substance abuse[56]. In their research on homeless men, Kim et al.[13] found that a history of adulthood trauma exposure was significantly associated with mental health problems. Furthermore, PTSD itself is associated with an increased risk of developing other mental health problems such as substance use problems[57]. The findings from the THI research also support the relationship between trauma exposure and mental health. Not only were the prevalence rates of psychiatric disorders elevated in this population, but other adverse mental health experiences were also frequently reported. These experiences included difficulties such as emotional dysregulation, dissociation, suicidality, negative views about the self and the world, and risk taking. These adverse experiences were all frequently reported regardless of whether trauma had been experienced in childhood or adulthood.

These adverse experiences are important to note for several reasons. Difficulties such as these form the core of distressing and recovery-interfering aspects of exposure to trauma. In addition, risk taking behaviour, suicidality and dissociation also have important implications for safety. We also focus on these experiences because they suggest windows of opportunity for services to provide targeted assistance to people experiencing homelessness – to help lessen the impacts of trauma exposure, and make contributions towards the development of safety and psychosocial stability.

Emotional regulation difficulties have been identified as an outcome of persistent trauma exposure[58]. Emotional regulation difficulties include having difficulty distinguishing emotional responses in self and others, a low threshold for triggering strong emotional responses, high intensity emotional reactions, and difficulty calming down (and returning to equilibrium)[58]. These difficulties are often associated with a lack of skills for managing emotional reactions which includes compromised emotional recognition, poor distress tolerance[59], and difficulties controlling intensity and duration of emotional experiences[60]. Dissociation may be understood as a consequence of these emotional regulation difficulties. It can be characterised as a response to trauma exposure, which at first enables an individual to cope with the traumatic environment, but over time becomes less helpful. Suicidality also can be seen in terms of diminished capability in regulation of emotion and problem solving skills.

Negative views of self and the world is a consequence of ongoing trauma exposure[61]. These beliefs can provide a lens through which future experience is understood[59]. Beliefs which carry unhelpful expectations of outcome or an individual's worth/capability can significantly impact on recovery after trauma. For example, a belief that bad outcomes are inevitable may underlie a person's feelings of hopelessness and helplessness, and a reluctance to seek or accept assistance.

Risk taking and self-destructive behaviours have long been recognised to be associated with trauma exposure[48,62]. Risk taking is the behavioural consequence of a compromised ability to identify risk in a situation. Risk taking is also an outcome of high levels of impulsivity whereby risk is not considered within a situation. It is also associated with difficulty using problem solving strategies, reduced care for consequences, and ambivalence about living. Often risk taking and emotional dysregulation are linked, so that risks are taken during high states of distress[59].

The maintaining relationship between trauma, homelessness, social disadvantage and mental health

Drawing together the individual pathways between trauma and homelessness, trauma and social disadvantage, and trauma and mental health, leads to an explanatory model of reciprocal and interconnected relationships. Trauma may lead to mental health problems which lead to social and relationship difficulties, which in turn maintain homelessness. For example, interpersonal violence may lead to a posttraumatic stress response that includes hypervigilance (high levels of physiological arousal), irritability, and avoidance, which in turn may lead a person to refuse accommodation that involves being with other people because they view other people as dangerous. Similarly, mental health difficulties might lead to social relationship difficulties which increase the risk of trauma exposure and homelessness. For example, a person with a substance use disorder may experience stress within their relationship which results in interpersonal violence, and homelessness is a consequence of avoiding the violence which in turn perpetuates the use of substances. And of course there are cycles within this cycle. For example, research shows that traumatic experiences and resulting PTSD may lead to social difficulties which in turn maintains PTSD[63].

The THI research identified that complex social and mental health outcomes associated with high trauma exposure were frequently reported. These included emotional dysregulation, difficulties maintaining close

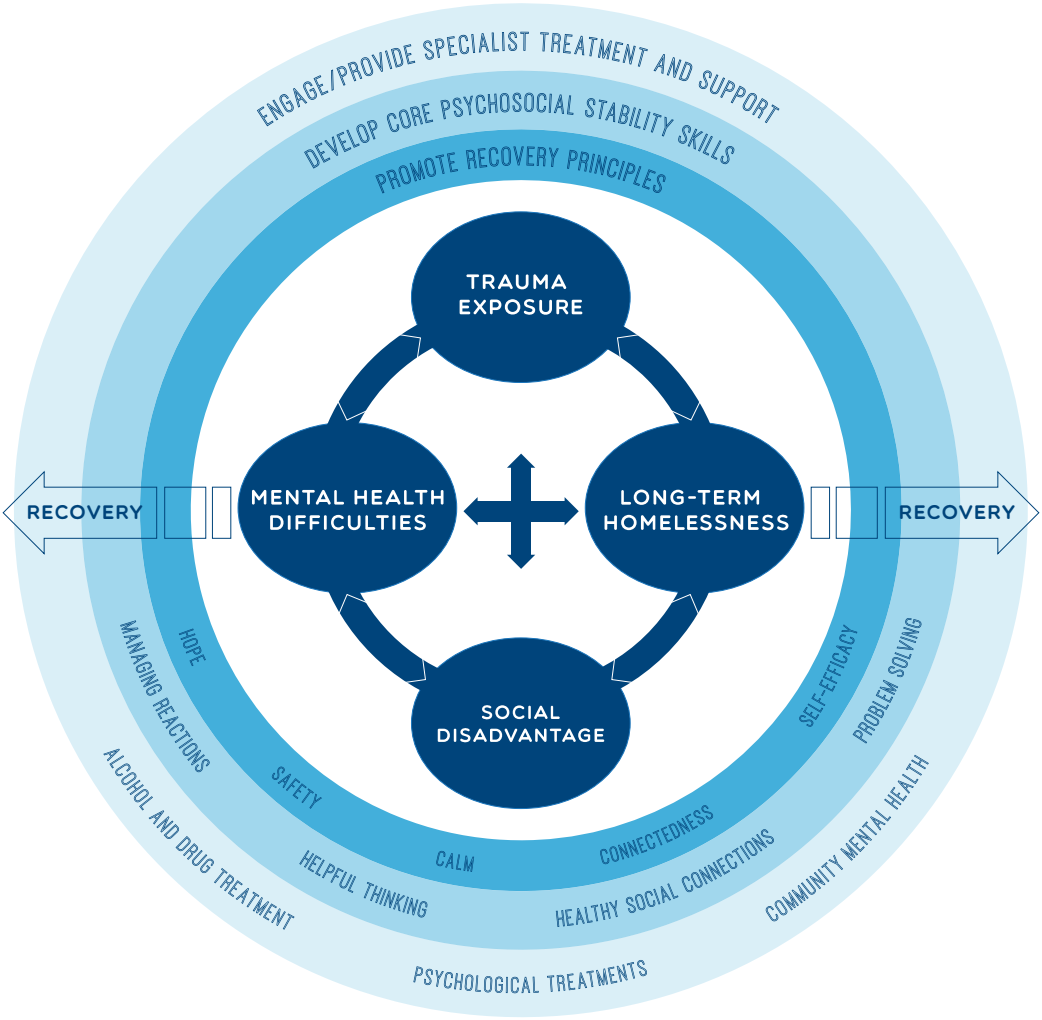
relationships, negative perceptions of self and the world, dissociation, and risk taking. It is easy to see how these outcomes may contribute to maintaining the cycle described above. For example, difficulties regulating emotions may lead to high levels of anger and aggression being expressed which may lead to interpersonal violence which contributes to difficulties maintaining close relationships, and leads to negative perceptions about self and increased substance abuse, which in turn contributes to maintaining homelessness.

While the proposed explanatory model may be useful to understand the interconnectedness between trauma, homelessness, mental health difficulties, and social disadvantage, it is important to acknowledge that there are many more factors that contribute to the development and maintenance of homelessness. Other factors such as compromised access to resources (poverty, poor education, and long-term unemployment) and compromised health (such as chronic illness) may also contribute to the cycle of chronic homelessness[64].

Implications for practice

A model of recovery must take into account this cyclical interrelationship between trauma exposure, chronic homelessness, mental health difficulties, and social disadvantage. The findings from the THI research also articulate a number of principles and considerations for integrating trauma-informed principles and trauma-specific interventions. This model articulates these principles and considerations, and identifies specific areas to focus on in order to develop psychosocial stability, and strengthen pathways to recovery within homeless support agencies. This model of recovery is depicted by Figure 2.

Figure 2: A model of recovery for people experiencing long-term homelessness.



The centre section of this model illustrates the previously described interrelationships between long-term homelessness, trauma exposure, mental health difficulties and social disadvantage. Again, each component of this model serves to potentiate the others: and ultimately this interaction prevents or delays recovery from trauma, improvement in mental health and social connectedness, and sustainable resolution of homelessness.

It is important to note that for the sake of simplicity and universality, the central factors identified in the recovery model serve as umbrella terms for a more complete set of factors which may or may not be present or significant for any given individual. For example, social disadvantage as an umbrella term incorporates systemic social exclusion, individual social isolation and difficulties forming and maintaining relationships. Mental health difficulties incorporates experiences of diagnosable mental health disorders, but also includes issues such as cognitive impairment, substance use difficulties, and symptoms of compromised mental health that do not meet criteria for formal diagnosis.

When viewed as a model of recovery, the role of these central factors is to provide a basis for trauma understanding and awareness. The need for trauma awareness is a key aspect of TIC, but TIC cannot be delivered in isolation from understandings of the impacts of social disadvantage and mental health difficulties. By looking at the interaction of these factors, this model allows for understanding that goes beyond categorising symptoms, disorders, and needs within unconnected domains or silos.

At an agency level, awareness of the interplay of these factors facilitates high-level planning. This includes considerations of what expertise, training and supervision of staff is required, which specific programs should be delivered, and what linkages with other services or sectors are necessary to address the factors contributing to long-term homelessness. At the level of individual work, an understanding of how these factors have manifested for an individual is key to developing deeper understandings and insights, demonstrating empathy, providing psychoeducation, and planning for and resourcing recovery.

This model also describes the factors that support recovery from the nexus of trauma, long-term homelessness, mental health difficulties and social disadvantage. The innermost concentric circle describes principles that support recovery and resilience: promotion of hope, safety, calm, connectedness and self-efficacy[65]. These principles serve as guides for practice at the agency and individual worker level. They are relevant for responding to immediate crises, and recent and past experiences of trauma. These universal recovery principles also incorporate and, to some extent, subsume Hopper's consensus principles of trauma-informed care.

A focus on promoting hope communicates a strengths-based approach to recognising and managing the impacts of trauma. Hope carries an expectation of recovery and resilience in the future – that people affected by trauma can recover from and/or manage the impacts of trauma.

A focus on promoting safety involves reducing exposure to current risks and threats. It recognises and manages risk, works to prevent ongoing trauma, and to minimise the risk of re-traumatisation within service settings. A focus on safety also involves providing a physically and emotionally safe space to engage and work with people.

A focus on promoting calm recognises the distressing and overwhelming nature of living with the impacts of trauma. It emphasises the importance of providing a predictable, stable and comfortable experience for people accessing help and support. It supports practices which respond to challenging and recovery-interfering behaviours with consistent and compassionate understanding and responses. A focus on calming also recognises that there are interventions that can directly support people's intrinsic abilities to self-soothe and gain a sense of control over their lives.

A focus on promoting connectedness recognises the key role that social connectedness and support play in mediating recovery from the impacts of trauma. The principle of connectedness also relates to the critical role of establishing and maintaining safe and strong relationships between service providers and service users, relationships that are characterised by well-defined roles and boundaries, and that are respectful of diversity.

Finally, a focus on promoting self-efficacy recognises the importance of fostering opportunities for people to rebuild self-control, empowerment and a sense of personal agency in dealing with the consequences of trauma exposure. This principle is readily operationalised at the individual level and emphasises locating control in the hands of the service user. It also applies at the organisational level by emphasising the importance of service user inclusion in service design, provision and evaluation.

The second concentric circle describes a set of foundational psychosocial stability skills that are thought to promote resilience and recovery from trauma. These are specific skill-based activities that a range of workers can offer across a variety of situations. The activities are core components of cognitive behavioural therapy interventions and provide, within the trauma context, an evidence-informed package of brief interventions[66]. These interventions have as their core goal the reduction of ongoing distress and promotion of recovery for people affected by trauma. It is important to note that these interventions do not represent a 'therapy' model *per se*, but rather a flexible and adaptable set of brief interventions that target areas of common difficulty for people who have been affected by trauma. The activities focus on the development and enhancement of skills relating to problem solving, managing emotional reactions, using helpful thinking, and maintaining healthy social connections. Importantly for the housing sector, these skills are able to be delivered by workers with non-specialist clinical backgrounds.

These activities are explained in the accompanying Worker Guidebook, along with several supporting activities including a guide to how to approach and manage conversations about trauma experiences, and a method for prioritising which of the skill activities will be of most benefit in a given situation.

The guidebook provides a flexible approach to delivering these activities within the resource and time constraints that often prevail in homelessness service settings. The approach allows for brief interactions of around five minutes, longer interactions of 15 minutes, and planned interactions where workers and service users are able to develop an overall plan for managing trauma impacts using whichever skills are most appropriate.

Finally, this model recognises that recovery occurs within a wider service system which can make critical contributions to the resolution of complex biopsychosocial difficulties. These service systems may hold specific knowledge, skills or expertise (e.g., access to psychiatry or specialist trauma-focussed psychological therapies), or may provide specific services (e.g., inpatient services or alcohol and drug specialist services). These specialist supports and treatments can have considerable barriers to entry and engagement for people who have been exposed to trauma, have compromised mental health, and experience social disadvantage and homelessness.

In contributing to psychosocial stability and the overall recovery from the impacts of trauma, homelessness services need to be engaged with and connected to this wider service system. At both the service and worker level it is critical to understand what specialist services can provide and how and when these services are best utilised. By supporting psychosocial stability with development of practical skills under a trauma-informed care approach, homelessness services may be more effective in supporting service users to access and get the most out of these specialist supports and treatments.

Support for the recovery model

The factors in the model of recovery are strongly supported by the literature, and the findings of the THI research. Importantly, they are also consistent with the existing philosophical and practical orientations of the THI agencies. The consultations carried out within these agencies identified strong endorsement and incorporation of TIC principles. There was recognition that there was a unique opportunity for homelessness service providers to engage with and work with people for whom other pathways to recovery are denied. There was also a desire to go beyond existing TIC to provide targeted supports and services which contribute to the development of sustainable psychosocial stability and create pathways to resolve long-term homelessness.

Recovery activities and the role of homelessness support agencies

Figure 3: A trajectory of recovery and support activities.

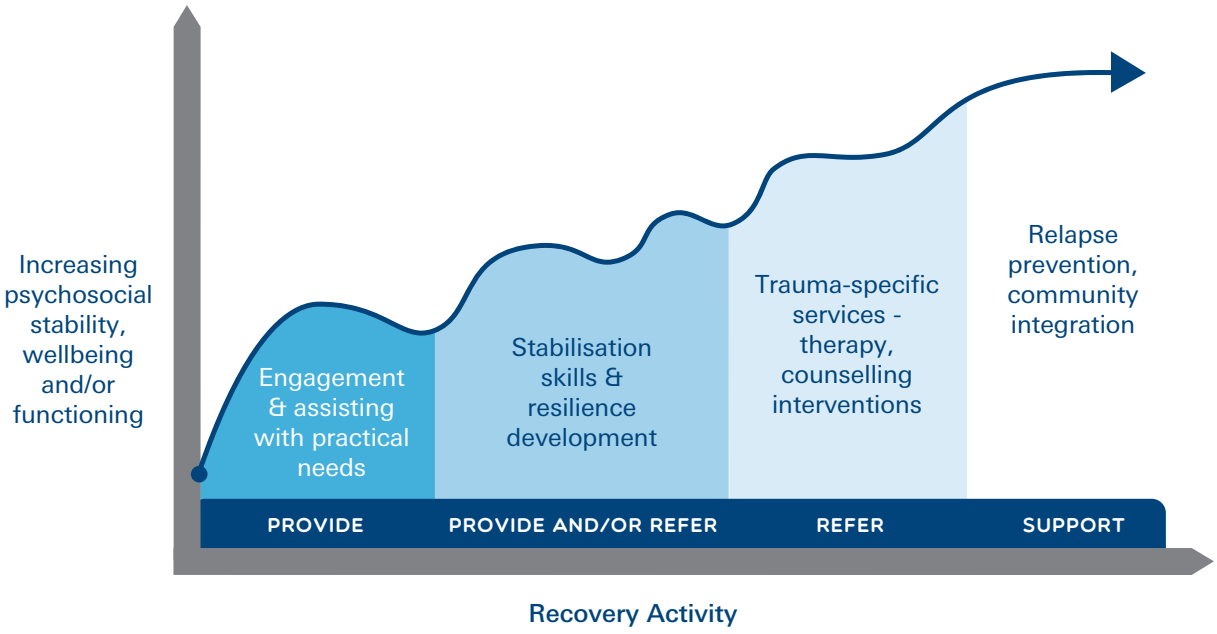


Figure 3 provides another way of conceptualising the relationship between provision of homelessness support services and an agency's role in contributing to overall recovery from trauma. The diagram outlines an 'archetypal' recovery trajectory from trauma for an individual receiving support and/or treatment services. In this representation, the dark blue arrow tracks recovery as measured by improvements in psychosocial stability, wellbeing and functioning, and the shaded areas under this line describe those activities that tend to build upon each other to support recovery.

This diagram is not intended to describe any given individual's recovery from trauma, but rather to illustrate the types of activities and supports that facilitate recovery for most people. Whilst some people experience recovery as a neat 'linear' progression through these stages, many others can cycle between phases (particularly if they experience significant barriers to recovery).

As has been argued in this framework, the two initial activity phases (engagement and assisting with practical needs, and provision of stabilisation skills and resilience development) are considered to be key support actions that are consistent with the primary mandate of homelessness agencies. Mediating these phases of recovery is consistent with the trauma-informed literature, as is being sufficiently connected to the wider service system to refer appropriately to trauma-specific services, and to support the longer term maintenance work of relapse prevention and community integration.

PRINCIPLES OF ACTION FOR AGENCIES AND WORKERS IN RESPONDING TO TRAUMA AND HOMELESSNESS

The previous section has provided a scientifically and practice-supported rationale for the provision of trauma-informed and trauma-specific services within homelessness agencies. In the following section, principles of action will be presented that will allow agencies to begin to make use of the findings of the THI research, and to apply them to practical programs, services and supports.

Services that support people experiencing homelessness are in a unique position to contribute to recovery from the consequences of exposure to trauma. Homelessness services offer critical supports around key areas of psychosocial vulnerability. They assist people in establishing and maintaining safe, stable and predictable lives not just through accommodation support, but also through development and maintenance of social connections, and importantly, via a holistic approach to addressing complex needs such as mental health and substance use difficulties.

Principle 1:
In providing access to supports for the most fundamental needs around safety and security, and in understanding the complexity of needs that maintain disadvantage, housing support agencies have a unique opportunity to engage and work with the key barriers to recovery from trauma.

The THI has conceptualised the nexus of homelessness, mental health difficulties, social disadvantage, and the consequences of trauma as a powerful system that impacts on recovery for people who have experienced trauma and homelessness.

Intervening around any one of these factors in isolation is unlikely to interrupt the interrelationships that maintain experiences of homelessness, difficulty and disadvantage. Where service systems and supports target any single factor (such as addressing the need for housing without addressing the destabilising effects of ongoing mental health difficulties and social disadvantage) they are unlikely to offer a sustainable pathway to recovery.

This recognition of the interrelationship of complex biopsychosocial factors in sustaining disadvantage is not a unique finding of the THI. In our consultations with the four partner homelessness agencies there was universal recognition of the complex interplay of contributory factors in understanding the initiation and maintenance of homelessness. There was also a powerful endorsement of comprehensive "whole-of-person" approaches to supporting recovery – both in philosophy and practice.

The THI has identified and quantified the centrality of trauma and its wide reaching consequences. For homelessness agencies that strive for a comprehensive approach towards providing support and services, the challenge is to meaningfully incorporate management of trauma.

Principle 2:
Homelessness agencies are in a unique position to contribute to recovery by offering whole-of-person services and supports that recognise the centrality of trauma and integrate trauma-informed delivery of services with appropriate trauma-specific supports and services.

Traditionally, trauma-specific services have been seen as separate from generalist case management or comprehensive service provision, and characterised in terms of long-term and more formal Type I counselling interventions. The evidence for the effectiveness of psychological therapies is substantial and compelling, but lack of widespread availability to these services and their inability to serve as a first line approach in assisting people experiencing homelessness are significant limitations to their impact.

It is possible to identify key aspects of trauma-specific services that are not dependent on traditional appointment-based counselling approaches. These key aspects relate primarily to capabilities, skills and strengths that lay the groundwork for psychosocial stability. They are viewed as critical preparatory steps in all evidence-based approaches to the treatment of posttraumatic mental health conditions across a variety of therapeutic modalities and across a range of

presenting psychological conditions.

These key aspects include:

- The development of safe relationships with a service provider or service providers
- Supporting the development of, or enhancing a stable psychosocial environment, for development or enhancement of physical and emotional safety, supporting self-management and self-determination
- Provision of accurate information about trauma, its effects and its management, and conveying a positive expectation for recovery from the effects of exposure to traumatic events
- The development of skills and capabilities that mediate psychosocial stability, such as skills for management of arousal and anxiety, development of safe and strong social connectedness, and enhancement of skills for problem solving. These skills are critical predictors of the success of evidence-based treatments for posttraumatic mental health conditions, and more generally, these skills also relate strongly to the cluster of capabilities that support management of other mental health difficulties and substance use problems.

The type of activities that support the development of these capabilities, and that lay the groundwork for recovery (or referral for more intensive support and treatment options) fall within the mandate, skill set and philosophical remit of homelessness service providers. These activities can be put into operation, delivered and supported within the existing orientation of homelessness service provision, and within consensus definitions of TIC.

Importantly, these evidence-supported aspects of comprehensive management of trauma can also address the key maintaining factors of the THI's explanatory maintenance model.

Additionally, this approach provides a set of activities that can be evaluated for efficacy and impact within the homelessness sector, and provide a language for development of more holistic approaches across the mental health, rehabilitation, alcohol and drug, and forensic service provision sectors.

Principle 3:
Strong engagement, provision of safe psychosocial environments, availability of accurate psychoeducation about trauma, and the ability to support psychosocial stability skills are central to supporting recovery from trauma, other mental health conditions, and the resolution of long-term homelessness. As such, these capabilities fall within the mandate of homelessness services, and are consistent with a holistic approach to supporting recovery.

APPLICATION OF THE PRINCIPLES OF ACTION

This section contains 27 practical considerations for providing trauma-informed supports and services. These considerations can be thought of as practical applications of the principles of TIC, and can be used as a guide for developing policies and procedures tailored to the specific needs and circumstances of different program types or service settings.

The practical considerations in providing trauma-informed care are grouped under themes of trauma understanding, managing barriers to care, establishing strong therapeutic relationships, providing predictability and control, and ongoing evaluation.

Translating these principles of TIC into specific actions, policies, procedures, attitudes and behaviours for a particular service setting should ideally be done with input from staff and service users. Additional guidance to agencies and individual workers for aligning their work to trauma-informed care principles can be found in the Worker Guidebook that accompanies this framework document.

Promote trauma understanding	
1.	In order to provide a consistent approach to TIC, there needs to be an organisation-wide shared understanding of trauma. All staff delivering or supporting the delivery of services should learn about trauma and the ways it affects people, as well as how trauma interacts with issues of mental health, social disadvantage, and long-term homelessness.
2.	All service users should be provided access to services in a trauma-informed manner without the need to disclose trauma experiences.
3.	Because of the very high rate of trauma exposure identified by the THI research, it is highly likely that service users at homelessness agencies will have experienced multiple traumatic experiences. Universal acknowledgement of the likelihood of trauma exposure, rather than universal screening, is recommended as a respectful entry to TIC. How services provide this acknowledgement, and/or integrate offerings of services and supports following a discussion of trauma impacts, should be determined on a case-by-case basis depending on the service delivery context.
4.	Assessment should not focus on problem identification, but instead be seen as a first step to understanding and normalising *an individual's trauma reactions and responses* and an opportunity to open up a dialogue about recovery.
5.	Service users should be given control over assessments of trauma experiences – to not participate, to delay, to nominate a preferred worker (where this is possible).
6.	Service users should be informed about *why* information is being sought, and only information necessary to the provision of services should be elicited.
7.	Because of the high likelihood of recent or ongoing exposure to trauma, a preventative and early intervention approach is recommended – with immediate safety and risk assessment and management, including strengthening of coping responses taking priority over unpacking past trauma experiences.
8.	Because there were few differences in presentation and need identified between service users who had experienced Type I versus Type II trauma, this distinction is not considered a priority in assessing trauma experiences. However, asking about different potential types of trauma experiences (like directly experiencing versus witnessing events), may be helpful to assist people in recognising the range of impactful events in their lives.
9.	Assessments of social connectedness and support, of capabilities to manage emotional dysregulation and risk taking behaviour, are also recommended, so that opportunities to build psychosocial stability skills can be offered consistently.

Manage barriers to recovery and accessing support services	
10.	Services should seek to manage the range of potential barriers that mediate outcomes in accessing care, including awareness of services, capacity for help-seeking and engagement, and experiences of social disadvantage.
11.	A person's needs and goals, readiness or capacity to engage with services, and expectations of recovery, vary over time and should be viewed as dynamic. Services should provide mechanisms of engagement and service provision which acknowledge this variability and are capable of meeting individual's requirements at any point in their recovery.
12.	Where multiple service systems are involved, differing definitions of recovery, stability or safety can act as barriers to care. Service-imposed recovery goals (even when well-meaning) can mimic experiences of being traumatised and serve to diminish an individual's control and self-efficacy. Expectations of recovery need to be individually determined, and communicated and aligned across different service sectors.
13.	Facilitating communication between services by sharing trauma-informed understandings, collaboratively formulating recovery goals, strategies and interventions, can help to alleviate barriers to care.
Establish strong relationships by managing engagement safely, providing clear boundaries, and clear role expectations	
14.	TIC recognises that some aspects of recovery from trauma are mediated by safe, consistent and effective therapeutic relationships with services and service providers (individuals and teams).
15.	Services can provide clear information about the parameters of what can and cannot be done within the service, by individual workers and via available referrals.
16.	Language and tone should be professional and effectively communicate empathy, respect, sensitivity to diversity of experience, and hope.
17.	Within reason, boundaries of time and space should be respected – such as starting and finishing on time, providing confidential spaces for interactions, providing physically safe and calm waiting spaces, and if appropriate, specific spaces for children and families. Lack of safety in physical spaces can cause triggers and reminders of trauma, and the needs of all service users to feel safe in accessing care should be prioritised over the needs of individuals.
18.	Correct and reliable information should be provided about how to access services, workers and other supports. If limitations are anticipated, this should be communicated clearly.
19.	Worker roles, capabilities and limitations should be spelled out consistently and clearly, from formal position descriptions to communications with service users.
20.	Boundary management is critical to establishing safe, sustainable and productive therapeutic relationships. Issues such as conflict of interest and the limitations of confidentiality should be understood and managed consistently at program, team and individual interaction levels. Workers should be mindful of issues such as personal disclosure and how their own histories of trauma may impact on the integrity of therapeutic relationships. Services and individual workers share responsibility for ensuring adequate support, supervision and training to manage the impacts of working with trauma.
Provide choice, control, and predictability in providing TIC – especially in managing crises and recovery-interfering behaviours	
21.	Services should maximise predictability by providing clear information about service guidelines or expectations, as well as client rights, responsibilities and expectations around issues like attendance, participation and behaviour.
22.	Services should enhance service user control. All interactions including assessment, case planning and delivery of specific supports, services or interventions should proceed only with informed consent. Constant attention to handing as much control and choice as possible to the service user should apply at the 'program level' – (i.e., the choice to enrol in a given program), as well as at the individual interaction level (i.e., to participate in a given activity right now).

23.	Services should enable opportunities for service users to participate meaningfully in the design, delivery and evaluation of programs. Participation enhances control and self-efficacy, and recognises the expertise and experience of service users. This can involve mechanisms for sharing authority and decision making, including peer workers in providing services, and drawing on peer expertise in evaluating program outcomes.
24.	Services should seek to maximise predictability and control in how they manage crises, overwhelming situations, and recovery-interfering and challenging behaviours. a. A TIC approach reframes challenging behaviours (like aggression) and recovery-interfering behaviours (like non-attendance) as understandable manifestations of a person's trauma experiences. In this model, trauma impacts on specific abilities to engage with the world and manage situations and aspects of the self. b. In a TIC approach, the person is understood to be dealing with a situation in the best way they know how, even though the outcomes of their best attempts may actually add to difficulties such as low self-esteem, feeling misunderstood, or being denied a service. c. TIC recognises that outcomes of trauma such as compromised capacities for trust, problem solving, and managing emotional reactions are predictable, and crises with service access relating to these difficulties should be planned for and managed. d. Services should assist people to foresee how trauma reactions and responses may act as barriers to recovery (i.e., how certain behaviours may breach behaviour expectations and involve consequences which lead to difficulties accessing services). e. Services can support control and choice for how to manage these situations by: • helping recognise crises and recovery-interfering behaviours, situations, feeling states, and unhelpful responses • helping identify helpful and unhelpful strategies for early intervention that are intrinsic to the person • helping identify helpful and unhelpful responses from the service environment and from workers • ensuring that policies and practices support consistent management of crisis presentations and challenging behaviours, (i.e., by facilitating effective team communication of management plans).
Engage in ongoing service improvement and evaluation	
25.	Providers have an ethical responsibility to strive to understand the needs and experiences of the people they support, to design and deliver effective services and supports, and work to ensure that those services are sustainable.
26.	This integrated model of service provision should be evaluated for efficacy, with the evaluation targets being not only resolution of long-term homelessness, but also recovery from trauma, as well as mental health and social connectedness outcomes.
27.	Such outcome research would enhance the capability of the homelessness sector to advocate directly for funding linked to these outcomes, and to advocate for an integrated trauma-informed/trauma-specific approach more widely across other health and social service sectors.

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GLOSSARY OF TERMS

Term	Definition
Accumulation of stressful life events	A series of events occurring in close proximity, such as a relationship breakdown, loss of a business, loss of a house, and death of a loved one, for example.
Alcohol abuse disorder	A maladaptive pattern of drinking, leading to clinically significant impairment or distress. To meet diagnostic criteria, the individual must have experienced recurrent use of alcohol resulting in a failure to fulfil major obligations; use of alcohol in a situation which is dangerous; alcohol-related legal problems; or social problems which are exacerbated by alcohol.
Alcohol dependence disorder	A maladaptive pattern of drinking, leading to physiological dependence on alcohol use and clinically significant impairment or distress. To meet diagnostic criteria, the individual must experience several of the following: (a) needing increased amounts of alcohol, or diminished effects with use of the same amount of alcohol; (b) drinking in larger amounts or over a longer period than intended; (c) desire to cut down or control drinking; (d) reduction of social or occupational activities because of drinking; (e) spending a great deal of time obtaining, using or recovering from drinking; and (f) continuing to drink despite knowing it is likely to cause problems
Axis I	'Axis I' was part of the Diagnostic and Statistical Manual of Mental Disorders multiaxial system for assessment prior to the introduction of DMS-5. Axis I disorders are the most familiar and widely recognised disorders, and included anxiety disorders, mood disorders, eating disorders, psychotic disorders, dissociative disorders, substance use disorders.
Axis II	'Axis II' was part of the Diagnostic and Statistical Manual of Mental Disorders multiaxial system for assessment prior to the introduction of DMS-5. Axis II disorders included personality disorders, intellectual and developmental disorders.
Comorbid	The concurrence of two or more psychiatric disorders in the same individual.
Couch-surfing	A general term for moving from one temporary overnight arrangement to another, usually reliant on the goodwill of family, friends or acquaintances. Sometimes such arrangements may involve an exchange of sex. The term originally related to casual arrangements made by travellers to stay on someone's couch while touring, however, this term is now regularly used to describe a level of homelessness.
Depression	A period of two weeks or longer where the individual experiences persistent feelings of sadness or loss of pleasure, coupled with a range of other physical and psychological symptoms including fatigue, changes in sleep or appetite, feelings of guilt or worthlessness, difficulty concentrating or thoughts of death.

Posttraumatic stress disorder (PTSD)	PTSD is a set of reactions that can develop in people who have experienced or witnessed an event which threatened their life or safety, or that of others around them, and led to feelings of intense fear, helplessness or horror. A person with PTSD has three main types of difficulties: (a) re-living the traumatic event; (b) being overly alert or wound up; (c) avoiding reminders of the event and feeling emotionally numb. **Current PTSD:** Means that the criteria for PTSD diagnosis has been met within the last 12 months **Lifetime PTSD:** Means that the criteria for PTSD diagnosis has been met at some time point during the participants lifetime.
Psychotic disorder	Psychotic disorders are severe mental disorders that cause abnormal thinking and perception. Two of the main active symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing or feeling something that is not there. **Current psychotic disorder:** Means that the criteria for psychotic disorder diagnosis have been met within the last 12 months. **Lifetime psychotic disorder:** Means that the criteria for psychotic disorder diagnosis has been met at some point during the participants lifetime.
Substance abuse disorder	A maladaptive pattern of substance use, leading to clinically significant impairment or distress. To meet diagnostic criteria the individual must have experienced recurrent use of substance(s) resulting in a failure to fulfil major obligations; use of substance(s) in a situation which is dangerous; alcohol-related legal problems; or social problems which are exacerbated by substance(s).
Substance dependence disorder	A maladaptive pattern of substance use, leading to physiological dependence and clinically significant impairment or distress. To meet diagnostic criteria the individual must meet several of the following criteria: (a) needing increased amounts of the substance, or diminished effects with use of the same amount of substance; (b) taking the substance in larger amounts or over a longer period than intended; (c) desire to cut down or control substance use; (d) reduction of social or occupational activities because of substance use; (e) spending a great deal of time obtaining or using the substance or recovering from its effects; and (f) continuing to use the substance despite knowing it is likely to cause problems.
Type I trauma	Traumatic events include (but are not limited to) natural disasters, serious motor vehicle accidents, sudden death of a parent or child, and sexual assault. When the trauma involves a single incident, it is termed Type I trauma.

Type II trauma	Type II trauma involves prolonged and/or repeated trauma. In childhood, Type II trauma typically occurs within the child's primary caregiving system and/or social environment, and has the following characteristics: (i) trauma may involve direct harm and/or neglect by caregivers, or witnessing direct harm and/or neglect by caregivers; and (ii) trauma occurs at developmentally vulnerable times for a child. Exposure to this trauma occurs within an environment where escape is impossible (especially when the trauma is perpetrated by a primary caregiver). Type II trauma involving prolonged and repeated exposure to trauma where escape is impossible can also occur in adulthood, for example, in the case of political torture.
Sleeping on the streets or sleeping rough	Refers to sleeping outdoors where shelter from wind and rain is sought where possible. This may include sheltering between buildings, under bridges, large clothing bins and rubbish bins and in “squats”. A squat is a vacant building or house used for sleeping in by a number of people experiencing homelessness.


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Posttraumatic
Mental Health

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MISSION

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COMMUNITY HEALTH

VincentCare
Victoria

mind
Supporting mental health recovery

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