

In the Business of Trauma:
An intersectional-materialist feminist analysis of ‘trauma informed’ women’s
refuges and crisis accommodation services in Sydney and Vancouver

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of the requirements for the degree of
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Author's Declaration

This is to certify that:

To the best of my knowledge, the content of this thesis is my own original work. This thesis has not been submitted for any degree or other purposes.

I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and all sources have been properly acknowledged.

The thesis does not exceed the word length for this degree;

This thesis meets the University of Sydney's Human Research Ethics Committee (HREC) and the University of British Columbia's Behavioural Research Ethics Committee (BREC) requirements for the conduct of research.

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ABSTRACT

This study is informed by intersectional and materialist feminist theories and utilises a qualitative feminist methodology to explore the implementation of 'trauma informed care' and the 'trauma informed' principle of 'cultural safety' in women's refuges and crisis accommodation services located in Sydney and Vancouver. This theoretical framework guided a critical exploration of the trauma informed practice framework in the context of the dominant political economies operating in Sydney and Vancouver; settler colonialism and neoliberalism. Trauma informed care aims to increase staff members' understanding of the high prevalence of 'trauma' experienced by women who are 'homeless' (experiencing housing injustice). Staff are also trained to understand the correlation between 'trauma' and alcohol and other drug use, mental health concerns, aggressive and self-harming behaviours. This model aims to improve outcomes for women who are experiencing housing injustice by reducing the potential for services to re-traumatise victims/survivors. This thesis was guided by the following research questions: 1) How do staff understand and experience 'trauma informed care' in women's refuges and crisis accommodation services? 2) How do these understandings shape their work with women who are victims/survivors of gendered violence, systemic racism and housing injustice? 3) How do staff understand 'cultural safety' (a key principle of trauma informed care) in women's refuges and crisis accommodation services and how do these understandings influence their work with women? 4) How does an espoused trauma informed care/cultural safety model shape women's experiences in women's refuges and crisis accommodation services? 5) What service gaps and contradictions are addressed or unaddressed by the implementation of trauma informed care? Research data were collected through one women's refuge and two crisis accommodation services located in either Sydney or Vancouver and involved 32 in-depth interviews with key informants (N=2), staff (N=22) and women (N=8) who had worked within or accessed at least one of the participating services. Interview data were analysed using a thematic analysis in two stages. Key findings indicate that trauma informed care was broadly interpreted across participating services. Two findings chapters report on a continuum of trauma informed care and cultural safety ranging from politicised to behaviour management models of practice. A third findings chapter reports on women's experiences of trauma informed services and their ongoing experiences of housing injustice. While all models of trauma informed care were constrained by settler-colonial and neoliberal processes, resistance from First Nations, feminist, and peer identifying staff suggests that trauma informed care is a site of social and political struggle with significant implications for women surviving gender-based violence, systemic racism and housing injustice.

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The listening, thinking, researching and writing involved in this thesis project took place across multiple stolen and colonised lands. This thesis has grappled with the meaning of responding to trauma in the context of gendered violence and homelessness (housing injustice) in two settler-colonial states. The study of ‘trauma’ necessitates an engagement with the historical, social, economic and political roots of injustice and mass violence (Herman, 1992). The study of ‘homelessness’ must also begin with an acknowledgment that the settler colonial state has been founded on the dispossession of First Nations peoples from their homelands. For these reasons it is especially important that this work begins with an acknowledgement of the traditional custodians of these stolen and colonised countries and of First Nations peoples ongoing resistance to settler colonisation.

I would like to acknowledge the Darug and Bidjigal peoples (Sydney, Australia), the traditional custodians of the lands on which I have lived and worked for much of my life. I would also like to acknowledge the Musqueam, Squamish and Tsleil-Waututh peoples (Vancouver, Canada) whose homelands I visited in 2014 to conduct the field work research I refer to in this thesis. I pay my respects to Darug and Bidjigal and Musqueam, Squamish and Tsleil-Waututh Elders past and present. I would also like to acknowledge and extend this respect to all First Nations peoples around the world and to past and ongoing resistance movements against settler colonisation. The sovereignty of the Darug and Bidjigal lands and the Musqueam, Squamish and Tsleil-Waututh lands have never been ceded.

Homelands:

Darug and Bijigal peoples and the Musqueam, Squamish and Tsleil-Waututh peoples, have many shared experiences. The Darug and Bidjigal peoples on the south-eastern coast of Australia share the Pacific Ocean with Musqueam, Squamish and Tsleil-Waututh peoples on

the antipodal north-western coast of Canada. Both First Nations territories have rich and extensive pre-colonial histories. The Darug and Bidjigal peoples along with hundreds of other First Nations peoples across the Australian continent are recognised as the oldest continuous cultures on earth with evidence of occupation spanning over 80,000 years (Pascoe, 2014; Rasmussen et al, 2011). The Musqueam, Squamish and Tsleil-Waututh societies and cultures among hundreds of other First Nations lived and continue to live on the land known as British Columbia, Canada for an estimated 13,500 years (Morin, 2015).

The Darug and Bidjigal First Nations and the Musqueam, Squamish and Tsleil-Waututh First Nations also share a common approach to ‘home’ that emerges from an enduring spiritual connection to land, sacred sites and sacred histories (Memmott & Chambers, 2010). From Darug to Musqueam country the spiritual connection to land was and continues to be central to First Nations peoples’ concepts of home, family and belonging. Indeed, the term ‘homeland’ is often used to describe the intimate relationship with country characterised by a sense of belonging to the land. This belief starkly contrasts the British settler colonial notion of having ownership of the land and treating land as an object for resource exploitation. First Nations peoples’ relationship with their homelands also extends into social structures and cultural practices. Undoing the racist, settler-colonial narrative that First Nations peoples (from Australia and Canada) were “mere hunter-gatherers” there is clear evidence that Australian First Nations peoples developed a pancontinental system of governance known as Kinship, which facilitated peaceful and egalitarian relations between hundreds of First Nations (Pascoe, 2014 p.129). From a Yankunytjatjara First Nations perspective, Kinship has been described as inseparable connections: to Ngura, the land; Walytja, family; Tjukurrpa, culture; and Kurunpa, spirituality (Randall, 2003; Pascoe 2014; Morin, 2015). Kinship also supported an “ecologically sustainable built environment” and the development of sustainable agriculture practices (Pascoe, 2014 p.129). While settler colonisation has attempted to erase the Kinship

system, it is still lived and practiced today. Similarly, Musqueam, Squamish and Tsleil-Waututh First Nations peoples actively promoted the wellbeing of environmental resources and ecosystems through careful and considered cultivation and harvesting practices and through ceremonies and oral traditions that conveyed moral teachings about the interconnectedness of all life (Morin, 2015; Lepofsky, et al. 2005). The phrase 'Mitakuye-Oyasin' from the Lakota First Nations language is translated into English as 'we are all related' or 'all my relations'. This phrase represents a nuanced system of ethics instructing people to respect all life forms, including the earth, as living beings, as kin, as family (Wall Kimmerer, 2013).

Human relationships with land are central to socially located concepts of home and therefore of homelessness. Bundjalung woman, Melissa Lukashenko (2014) argues that prior to the British invasion and occupation, 'homelessness' did not exist under her First Nations', traditional lore:

The central idea of British life is that some people's lives are worthless, and that is the idea that came on those (First Fleets) ships. Totemic lore gives a system of valuing each other each bird, each insect...People aren't thrown away, banishment is extreme and is not taken lightly.

The British settler colonial occupation of First Nations countries in Australia and Canada imposed a regime of private property relations and commercially driven resource acquisition and exploitation. Private property relations facilitated the expulsion and exclusion of First Nations peoples from their homelands resulting in permanent "dispossession" and "homelessness" (Altamirano-Jimenez, 2014 p. 30).

British Settler Colonial Invasion, Dispossession and Genocide:

Darug and Bijigal Nations were invaded by the British army militia led by James Cook in 1788. The doctrine of 'Terra Nullius' meaning 'a land belonging to no one' was invoked in order to

seize the entire continent of 'Australia' as property of the British Crown. This invasion was resisted by First Nations peoples in a war, referred to as the Frontier Wars, which spanned approximately 150 years. A few years later, James Cook also led reconnaissance expeditions on Musqueam, Squamish and Tsleil-Waututh territories in 1792. In 1843, Musqueam, Squamish and Tsleil-Waututh Nations were violently displaced as the borders of the state of British Columbia were imposed by the British. This invasion was also resisted by Musqueam, Squamish and Tsleil-Waututh Nations. First Nations people's resistance to the waves of French and English settler-colonial invasions on the East Coast of the continent (now Canada and the USA) were known to the West Coast First Nations peoples who prepared for invasion. During the 1780s-90s First Nations peoples in Australia and Canada including Darug and Bijigal Nations and Musqueam, Squamish and Tsleil-Waututh Nations were devastated by outbreaks of small pox which significantly undermined resistance efforts against settler-colonisation (Gapps, 2018).

Following invasion, the central tactics used by the settler colonialists to divide First Nations peoples from their lands included; genocide, massacres, slavery, dispossession, control of human movement through forced migration and the establishment of camps or missions. Gendered violence including sexual assault was also used by the British to assimilate and wage war against First Nations women and children (Smith, 2002). Assimilation included theft and exploitation of First Nations children who were placed in residential schools in Canada (Truth and Reconciliation Commission of Canada, 2015), and in orphanages and in the homes of white people during the Stolen Generations in Australia (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families Australia, 1997). The policies that gave rise to the residential schooling system in Canada and the Stolen Generations in Australia explicitly aimed to eliminate First Nations peoples, their histories, languages, governance systems and cultural practices. British settler colonialism also introduced and

enforced hetero-patriarchal gender relations which materially and socially privileged white, middle and upper class, heterosexual men, initially over women and First Nations people and later over; refugee and new migrant people, poor and working-class people, lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) identifying people and those unable to participate in the labour market including people with disabilities and older people and Elders (Morgenson, 2011). Settler-colonial hetero-patriarchal gender relations attempted to erase diverse First Nations gender identities such as two-spirit identifying people (Canada) and brother-boy and sister girl identifying people (Australia) by imposing a gendered system limited to male and female identities and heterosexual relationships (Morgenson, 2011). The history of resistance against the British settler-colonialism on Darug and Bijjigal countries and Musqueam, Squamish and Tsleil-Waututh countries spans centuries and continues into the present (Reynolds, 2013; Gapps, 2018).

A widespread disavowal of these truths is common among the political classes who continue to produce racist Canadian and Australian nation-state narratives and mainstream or “whitestream” media representations that seek to legitimise and justify settler-colonial occupation (Grey, 2004, p.10). The genocidal violence of the settler-colonial past is not marginal or irrelevant, rather it is central to the ongoing reproduction of systemic and institutionalised racism, sexism and classism of present-day settler colonial societies. The violence of the settler colonial past and of the present are lived and survived each day by First Nations peoples, women, poor and working-class people, refugee and new migrant people and LGTBIQ identifying people.

Neoliberal capitalism, an expression and extension of settler-colonisation, is embedded within every facet of social, political life in modern-day Australia and Canada. On Darug and Bijjigal countries (Sydney) and Musqueam, Squamish and Tsleil-Waututh (Vancouver) neoliberal

capitalism has escalated gentrification and revanchist projects. Revanchism has been defined as an ongoing project of ruling classes, those most economically privileged in society:

To regain, by force if necessary, territorial dominion...to reclaim prime spaces (such as parks, train stations and pavements) from homeless people for the benefit of international capital, local businesses and affluent consumers. Homeless people excluded by these responses are incarcerated (or warehoused), spatially contained or entirely displaced from the area (Scullion, Sommerville & Brown, 2014, p.419).

Lack of housing affordability due to soaring housing and rental prices and lack of long term social housing, have pushed working-poor and working class, 'homeless' and rough sleeping people out of urban areas to more impoverished margins of city centres and regional areas. Lack of affordable housing also structurally coerces women victim/survivors of domestic and family violence to return to or stay with, a violent partner or family member(s).

Despite the affluence of Sydney and Vancouver, cities voted 'most-liveable in the world', both have increasingly large populations of people who are sleeping rough and who are homeless. First Nations women, their children and young people, are over-represented in victims of violence and in homelessness statistics in Sydney and Vancouver. In the most recent Australian census, First Nations people accounted for 20% (approximately 23,437 people) of the overall population of people experiencing homelessness (ABS, 2018). These trends in homelessness are echoed in Canada. According to the National Canadian Shelter Study (2013) 103, 000 women were experiencing homelessness (Gaetz, Donaldson, Richer, Gulliver, 2013), with First Nations people accounting for between 10% and 70% of those experiencing homelessness (Patrick, 2014). All people, but especially women, First Nations people, refugee and new migrant and LGTBIQ people who are experiencing homelessness are likely to be subjected to

extreme violent assaults and are at a higher lethality risk in comparison to domiciled, economically and socially privileged populations (Montesanti & Thurston 2015; Berman et al, 2009).

Sovereignty Never Ceded: Ongoing First Nations' Resistance

It is important to acknowledge First Nations people's ongoing resistance to settler colonisation, dispossession and housing injustice. It is not possible to detail or even mention all the contemporary First Nations movements and campaigns involved in struggles for First Nations housing rights and sovereignty. A significant protest, the *Women's Memorial March*, is held in Vancouver each year on 14th February (Valentines' Day). This protest remembers the murders and abductions of approximately sixty women and thousands of women who were stalked and assaulted in the city centre since the inaugural protest march in 1992 (Women's Memorial March, 2014). Most women who were assaulted, killed or abducted from the Downtown East Side area were First Nations women surviving extreme poverty, housing insecurity and homelessness. (Royal Canadian Mounted Police, 2015). In Vancouver, the central thoroughfare area known as the Downtown East Side area is one of the 'poorest' areas in Canada with close to 2500 rough sleepers on any given night. Between 1980 and 2015 the number of 'missing and murdered' women across Canada rose to 1750 women (Royal Canadian Mounted Police, 2015). The *Women's Memorial March* protest traverses all the sixty sites across downtown Vancouver where a woman 'went missing' or was murdered and makes visible the intersections between violence against women, State-based racism, settler-colonisation, neoliberal revanchism and gentrification. The protest also seeks to expose the lack of political will required to adequately respond to and to prevent gendered, racialized and classed based violence.

In Sydney, First Nations led protests for housing justice, land rights and sovereignty are also held regularly. For instance, the *Redfern Aboriginal Tent Embassy* (2014 – 2016) demanded

dedicated affordable housing for First Nations peoples among the city's rising commercial housing developments. The *Redfern Aboriginal Tent Embassy* was led by many strong First Nations women, including Wiradjuri woman and respected Elder, Aunty Jenny Munro, who, while standing on the unceded lands of the Darug and Bidjigal peoples, demanded that the settler-colonial state acknowledge and return full sovereign power to First Nations peoples. This thesis attempts to extend this acknowledgement of countries through all sections of writing and thinking. This always was and always will be Darug and Bidjigal land and Musqueam, Squamish and Tsleil-Waututh land.

Introduction:

Trauma Informed Care: Rendering visible housing injustice and gendered violence?

On one level this thesis is concerned with the implementation of the trauma informed care practice framework into crisis accommodation and women's refuge services in Sydney and Vancouver. Trauma informed care aims to improve how human services respond to women who are understood to be 'traumatised' due to a range of experiences including but not limited to; childhood sexual assault, neglect, emotional and physical abuse, adult sexual assault, domestic and family violence, and periods of homelessness and housing insecurity. On a deeper level, this thesis also interrogates and unsettles many of these categories. Following the lead of critical social work, post-colonial, intersectional and materialist feminist literature, 'homelessness' in this thesis is (re)conceptualised as 'housing injustice' (Willse, 2015). The neoliberal discourse of 'homelessness' attributes homelessness to a problem of a few unfortunate individuals who have been unable or unwilling to survive within a competitive job/housing market (Roy, 2014). Conversely, the discourse of 'housing injustice' understands 'living without safe shelter' as a complex interplay of social, economic and political injustices that are produced and maintained by gendered, classed and racialized dynamics specific to settler-colonial, hetero-patriarchal and neoliberal capitalist societies (Willse, 2015). Victims/survivors of gendered violence, feminists and critical social work researchers have also argued that the concept of 'homelessness' reflects only one aspect of systemic and institutionalised gender inequality (Zufferey, Chung, Franzway, Wendt & Moulding, 2016). Male violence against women/gendered violence, including domestic and family violence and child/adult sexual assault are key drivers of women's 'homelessness' in Australia and internationally. Gendered violence undermines "women's ability to participate in civil society and their ability to exercise their agency as citizens, by compromising the quality and stability of women's housing, their mental health, and employment opportunities" (Zufferey et al, 2016,

p.463). Again, the unitary concept of being without shelter, being insecurely housed or 'homeless' does little to convey the complexity of housing injustice. More than an issue of being without a 'home' or 'shelter', the lives of people experiencing housing injustice are often additionally constrained by intersections of institutionalised and systemic racism, gendered violence, homophobic and transphobic violence.

The embodied 'trauma' caused by housing injustice and gendered violence, is complexly associated with the use of alcohol and other drugs, significant distress and mental health concerns, aggressive behaviours and perpetrating violence/harm against others, self-harm and suicide, chronic illnesses and autoimmune diseases (Maté, 2008; Robinson 2010). These behaviours and physical outcomes are often not well understood by human service staff or by social workers, and are often viewed as 'challenging', 'distressing' and as evidence of 'non-compliance' with service rules leading to the early and punitive withdrawal of human service supports (Hopper et al., 2010). This often means that 'homeless' women who are significantly 'traumatised', repeatedly have crisis accommodation and other housing service supports withdrawn, only granted services with accompanying coercive mandatory conditions and or are denied service supports out-right (Robinson, 2010). Many crisis accommodation services are so "time poor" and overwhelmed by service demands, that people in need of shelter are often asked to leave early or are expediently dismissed as "too hard to help" (Robinson, 2010 p.60). It is not an exaggeration to suggest that the consequences of the punitive and premature withdrawal of housing services, often contributes to tragic and untimely deaths (Robinson, 2010; Willse, 2015).

A qualitative biographic Sydney based study indicated that people experiencing housing injustice are likely to be victims/survivors of repeated physical and sexual assaults (Robinson, 2010). Robinson (2010) argues that for people experiencing housing injustice, none become "desensitised to trauma through its repetition, but only came to accept lives of escalating stress,

injury and illness and tried to mediate their own suffering often through means such as drug and alcohol abuse and ultimately through suicide” (p.22). These qualitative insights challenge the widespread belief that homelessness is predominately a lifestyle choice, a product of laziness or of poor decision making. Furthermore, these findings prompted Robinson (2010) to recommend that the trauma informed care practice framework be implemented across all human services working with people experiencing housing injustice including crisis accommodation services and women’s refuges.

Initially this research project sought to explore the implementation of trauma informed care as an emerging area of practice in crisis accommodation services and women’s refuges in Australian and Canadian contexts. This has remained an important focus of this study. However, during the research period, key social policies were introduced in Australia and Canada which radically reconfigured the women’s refuge and crisis accommodation service sectors. In Australia, the state of New South Wales (NSW) introduced policy changes that resulted in the widespread closures of women’s domestic and family violence refuges. Feminist women’s refuges were largely replaced with a gender-neutral human service system geared to respond to ‘homelessness’ and not gendered violence and not housing injustice. These significant social policy changes prompted the inclusion of a materialist feminist analysis which understands that all human services, including the crisis accommodation and women’s refuges that participated in this study, are produced through the dynamics of settler-colonisation and neoliberalism. For instance, settler colonialism and neoliberalism perpetuate and mediate unequal, racialized and classed power relations between crisis accommodation staff and women who are seeking shelter. Whilst these class-based power relations are rarely scrutinized in social work literature, there is an emerging body of literature interrogating the relationships between social work, human services, social policies and the neoliberal political economy in settler colonial societies (Webb, 2006; Willse, 2015; Ready, 2012). This literature

deeply interrogates who benefits from the many social work interventions, programs and services and demonstrates how services can further marginalise women experiencing housing injustice.

There is a need to question the implicit assumptions that underlie human service organisational cultures and social work practices. Unexamined institutional cultures and social work practices have historically (re)produced oppressions, facilitated abuse and violence in institutional contexts, enabled overt and covert forms of discrimination, and engendered ineffective responses leaving many disenfranchised people to ‘fall through the gaps’ (Fook & Askeland, 2007). While many human services provide meaningful, life-sustaining supports to people who are living through and surviving intersecting and multiple oppressions, the human service system and individual service programs, cannot be viewed as inherently benign. Evidence of the scale and severity of violence and discrimination perpetrated within and by human/welfare services designed to ‘help people’, has been acknowledged in the findings from the *Australian Royal Commission into Institutional Responses to Child Sexual Abuse* (2017) and the *Bringing Them Home Report* (2007) which reported on the Stolen Generations in Australia. In a Canadian context, widespread institutional violence and the complicity of human services in violence against children and First Nations Peoples have been documented in the system of Residential Schooling (Truth and Reconciliation Commission of Canada, 2015; Woolford, 2015).

This thesis locates an exploration of the implementation of trauma informed care within an analysis that accounts for the systemic violence produced by neoliberalism and settler colonisation. This thesis draws from intersectional and materialist feminist theories to interrogate concepts such as ‘homelessness’, ‘trauma’ and ‘trauma informed care’. Even in the attempt to be ‘caring’ and ‘trauma informed’, neoliberal responsabilising and victim-blaming discourses can still be used to justify punitive practices (Schneider & Remillard, 2013).

Ultimately this thesis is concerned with ways in which services can ‘do-justice’ by actively minimising the tendency for services to re-traumatise and re-oppress women (Reynolds, 2012). This thesis also supports critical solidarity work that acknowledges the resistance of women victims/survivors of gendered violence and of housing injustice and supports positioning women victims/survivors as leaders in the field.

What is trauma?

Before introducing the trauma informed care practice framework, it is important to briefly delve into the complex and contested theories of ‘psychological trauma’. How trauma is conceptualised is inexplicably linked to how responses can be ‘trauma informed’. The concept of ‘psychological trauma’ in the post-enlightenment era Western societies has not followed a linear progression, rather ‘trauma’ has been articulated through several distinct historical and political movements, ideological and disciplinary lenses (Herman, 1992). The first significant attempt to theorise psychological ‘trauma’ has been attributed to the early psychoanalytic movement in Vienna during the 1860s. The psychoanalytic work of Charcot, Breuer, Jung and Freud initially constructed ‘Hysteria’ as complex physical and psychological reactions or ‘symptoms’ to traumatic childhood events including child sexual assault.

The second phase emerged through medical and psychological investigations into ‘shell shock’ or ‘combat neurosis’ experienced by veterans from the First and Second World Wars and the Vietnam War (Herman 1992). Widespread, public opposition to the Vietnam War, prompted the inclusion of Post-Traumatic Stress Disorder (PTSD) in the Diagnostic and Statistical Manual (DSM) III (1987), which gave rise to the specialised psychological and psychiatric treatment of PTSD. More recently, neuroscientific research has focused on the brains of victims/survivors. For instance, neuroscientific research indicates that a single or repeated ‘exposure’ to a ‘traumatic’ event(s) causes physical and often long-term changes to the brain (Doidge, 2007).

The third distinctive phase arose with the women's refuge movement and the second-wave Feminist movement in the 1960s/1970s to the present. The feminist and women's refuge movements developed in conjunction with other social movements including (although not limited to); "gay and lesbian pride movements, anti-Vietnam war movements, anti-racism, civil rights movements" and First Nations sovereignty, "land and human rights movements, the trade union movement and university campus activism" (Murray, 2002 p.23). These social movements were critical in articulating the role of structural and ideological oppressions (i.e. anti-black racism/white supremacy, apartheid/colonisation, sexism/patriarchal dominance, heterosexism/heteronormativity, classism/ruling class dominance) in creating the context for the violation and subjugation of certain groups and the social, political and economic privileging of others. Therefore, these social movements were pivotal in politicising violence against women and children and for criticising victim blaming discourses including psychiatric and psychological discourses of 'psychological trauma'. Feminist activists (Chappell, 2002; Hopkins & McGregor, 1991) did not initially prioritise responding to 'psychological trauma', rather, they identified, and resisted violence enacted and permitted through institutional, legal, social, political and economic systems. However, feminists have also campaigned for the cumulative effects of repeated gendered violence and child victimization to be recognized by the medical and psychiatric establishments (Herman, 1992).

The inclusion of Complex Post Traumatic Stress Disorder (CPTSD) in the DSM IV and V editions, represents a fourth phase of trauma theory development. The DSM is an authoritative handbook categorising mental illness and personality disorders and is primarily used by psychiatrists, psychologists and other medical and allied health care professionals. The psychiatric recognition of CPTSD was largely championed by feminists and specifically by feminist psychologists/psychiatrists. Furthermore, recent theoretical work exploring the relationship between trauma and the microbiome in the human 'gut' has 'repositioned' biology

as a site of feminist concern (Wilson, 2015). Beyond the brain and the gut, feminist psychologists have also developed body-based trauma therapy aimed at alleviating somaticized responses to (repeated and ongoing) traumatic events. However, materialist and intersectional feminists and critical social work theorists have argued that the heightened focus on theorising the neurological and other somatic-bodily reactions in the aftermath of trauma, does little to prevent gendered, classed and racialized forms of violence and inequalities nor do these approaches achieve justice for victims/survivors (Tseris, 2014). Furthermore, materialist feminists have argued that the focus on encouraging victims/survivors to ‘resolve’ their ‘trauma symptoms’ insidiously reproduces the neoliberal discourse of individual responsibility, which recasts victims/survivors as ‘the problem’, while providing social and judicial latitude to perpetrators of violence (Stringer, 2014).

Feminist and First Nations trauma theories have been subjected to numerous political backlashes and lengthy periods of “social amnesia” and social indifference (Herman, 1992, pp. 7 - 32). Social amnesia refers to political, social and cultural minimisation and forgetting of the magnitude of gendered, raced and classed violence in Western settler-colonial societies. These backlashes and periods of social amnesia have contributed to marginalising politicised trauma theories while psychiatric and psychological theories have gained dominance and a degree of social legitimacy.

These theories of trauma, key historical and political debates will be explored in further detail in the second half of the literature review in chapter 2.

Trauma Informed Care?

It is important to emphasise that there is currently no consensus regarding the definition of trauma informed care and there are tensions within the literature regarding the translation of trauma informed principles into practice. However, to provide a general introduction to this

model of practice, the following trauma informed principles are often, although not always described:

- 1) Providing a physically and emotionally safe environment.
- 2) Sharing power with people who are accessing the service, maximising their choice and control over service decisions that affect their lives.
- 3) Providing training and education for staff about the impacts of trauma and developing safety and crisis plans.
- 4) Providing ongoing supervision support for staff to mitigate against the impacts of vicarious trauma.
- 5) Providing culturally safe services.
- 6) Ensuring communication is open and respectful.
- 7) Staff aim to support the goals, strengths and interests of people accessing the service (Hopper et al., 2010, Cusack et al., 2008, Falloot and Harris, 2006, Hummer et al., 2010).

Trauma Informed care also draws from many well established and evaluated practice approaches including; the strengths-based approach, the recovery model, consumer participation and anti-oppressive practice. These broad principles are intended to be implemented as a generalised rather than as a specialised intervention. Trauma informed care is intended to be a service wide framework and therefore requires all staff including; administration workers, case workers and managers to receive trauma informed education and training. However, as a generalist model, trauma informed care aims to augment rather than to replace specialist services and roles:

Case managers still perform case management. Therapists and psychiatrists still provide mental health services. Physicians and nurses still focus on physical health.

Housing is still a priority for people in homelessness. But, when delivering these needed services, organizations and providers can maintain an awareness and sensitivity to the traumas that impact clients (Coleclough, 2015 p.9)

Trauma informed care has been described as a “paradigm shift” in human service provision (Elliott et al., 2005a, p. 462). This framework aims to reverse the tendency for services to blame victims and locate deficits and pathologies within people who access human services. This victim-blaming approach has been articulated in the rhetorical question; “what’s wrong with you?” (Bloom 1994 p. 476). Instead, the trauma informed care practice model aims to frame service responses around the rhetorical question “what happened to you?” (Bloom 1994 p. 476). This practice framework recognises that the majority of people accessing human services are survivors/victims of gendered violence, adverse experiences during childhood, such as child sexual assault, domestic and family violence (Cusack et al., 2008, Falloot and Harris, 2006, Hopper et al., 2010, Hummer et al., 2010). Therefore, the trauma informed care model is meant to support staff to work with each person as though they may be a trauma victim/survivor as “providers have no way of distinguishing survivors from non-survivors...best practices rely on procedures that are most likely to be growth-promoting and least likely to be re-traumatizing” (Elliott et al, 2005, p. 463). An emerging body of trauma informed care literature recommends applying an intersectional approach, such that, while all people who access human services may be victims/survivors, the likelihood of victimisation increases with multiple and intersecting experiences of social marginalisation and exclusion:

Even if women don’t disclose violence in their current relationships, many have histories of violence. These may be within their family of origin or within the foster care system, at school, especially if they are not Caucasian, heterosexual or differently abled; working in the survival sex trade; or just trying to make ends meet and living in poverty (Dechief & Abbott, 2002 p.331).

The trauma informed practice framework also aims to provide better supports for social work and human service staff by recognising that many staff are also likely to be victims/survivors of gendered violence and other intersecting oppressions. Bloom (2010) argues that the human service system, is itself in a “perpetual state of crisis” and is therefore not able to meet the “needs of people in crisis” (Bloom, 2010, p.2). Just as individuals can be traumatised, so too can crisis services and workers, who feel “hopeless”, “helpless”, “overwhelmed” and “confused” and therefore unable to work to meet the needs of traumatised people (Bloom, 2010 p. 3).

Trauma informed care, is implemented through training and ongoing supervision. Training, although not standardized, aims to build workers’ knowledge of the high prevalence of ‘trauma’ experienced by women who are experiencing homelessness and to develop understanding and skills for working with women who have difficult and challenging behaviours, including drug and alcohol use, aggressive and self-harming behaviours. Difficult behaviours viewed through a trauma informed lens are understood as normal responses to trauma or coping mechanisms (Maté, 2008). This focus aims to change the organisational cultures of services and to prevent staff from responding punitively to behaviours that are perceived as ‘challenging’, for example; aggression, self-harm and alcohol and other drug use (Maté, 2008).

Trauma Informed Cultural Safety:

There are many practice principles associated with trauma informed care, and therefore many aspects of trauma informed care for human services research to potentially focus on. This thesis focuses in part, on the trauma informed principle of cultural safety. Given the over-representation of First Nations women, refugee and new migrant women in ‘homelessness’ statistics in Australia and Canada, it was necessary to specifically explore the implementation of cultural safety in trauma informed services.

The term ‘cultural safety’ is often described in the trauma informed literature as ‘cultural sensitivity’, ‘cultural awareness; and ‘cultural competency’. Despite some attention to cultural safety, there is a gap in the trauma informed literature specifically exploring the translation of cultural safety and trauma informed care as intersecting models of practice. The term ‘cultural safety’ is used in this thesis in preference to cultural ‘competency’, ‘awareness’ and ‘sensitivity’, as the later terms have been criticised for failing to identify systemic and institutionalised racism and for maintaining the privileging of white Western people and worldviews in human services and therapeutic modalities (Lauw et al, 2013). In settler-colonial Australia and Canada, First Nations peoples often under-utilise human services, including shelters, due to the histories of invasion, occupation, genocide and assimilation as well as ongoing racism and discrimination against First Nations peoples (Lauw et al, 2013). Institutionalised racism has been identified as the leading cause of health injustice and preventable deaths for First Nations people in Australia (Holland, 2016). The *Closing the Gap Progress and Priorities* report (2016) has recommended a National Inquiry into institutional racism against First Nations peoples in health care and human service settings in Australia (Holland, 2016).

Conversely, the trauma informed principle of cultural safety, begins with an acknowledgement of the crimes associated with invasion and settler-colonisation, systemic and institutionalised racism and the ongoing impacts of ‘intergenerational trauma’. Cultural safety encourages staff, especially non-First Nations staff to take a proactive stance against racist and discriminatory attitudes and to reflexively critique their assumptions, worldviews that may lead to overt or covert racist practices against First Nations peoples, refugee and new migrant peoples and LGBTBIQ identifying people (Lauw et al, 2013). Many human services can perpetuate practices which covertly criminalise, pathologise and medicalise already disenfranchised communities

and that “increase the surveillance technologies of the State” (Clark, 2016b p.59). Covert racism is often embedded in the neoliberal discourse of ‘risk management’ (Clark, 2016b).

First Nations people have also argued that mainstream/or whitestream (Grey, 2004) human services need to implement First Nations Worldviews into service delivery, design and evaluation (Land & Foley, 2015). There is an assumption that the implementation of First Nations, refugee and new migrant, LGTBIQ worldviews is best directed by people and community members who identify with the above identities and lived experiences. Therefore, cultural safety is primarily enacted through employing, valuing and supporting of First Nations, refugee, new migrant and LGTBIQ identifying people. For example, many mainstream/whitestream human services work solely with individuals. However, the implementation of First Nations Worldviews may be reflected in working with and “supporting whole families and often times the broader communities” (Wathen et al, 2014 p.139). First Nations feminists, informed by diverse cultural and traditional identities, have described a need for 'healing, balance and the reclamation of what was stolen, altered or co-opted through colonialism'... for self-determination, land rights, social and political equity (Grey, 2004). Others have argued that cultural safety is a limited aim and that there is greater political urgency in ending the regime of settler colonisation – the structural condition which cause ongoing harm, dispossession and violation of First Nations peoples and lands (Land & Foley, 2015).

Trauma Informed Care – Responding to Service Siloing?

The term ‘siloing’ refers to the tendency for human services to operate with limited inter-organisational/inter-sectoral communication and coordination. Service ‘siloing’ has been criticised for creating confusing, inadequate and fragmented service system which creates service ‘gaps’ (Dubin, Goering, Streiner & Pink, 2002; Ehrlich et al, 2009). Feminists have argued that service gaps or systemic “blind spots” creates a service system that is largely

inactive and non-responsive to gendered violence and facilitates numerous opportunities for injustice and the repeated victimisation of survivors (Taylor, 2004 p.39).

Hester (2011) explored the impact of these ‘blind-spots’ in her analysis of the ‘systemic contradictions’ between ‘domestic violence services’, ‘child protection services’ and ‘child contact work’. Hester’s work is relevant to this thesis which explores the implementation of trauma informed care, across two distinct service types, women’s refuges and crisis accommodation services. Hester (2011) argues that the ideological positions of distinct service types can be so divergent, it can be as though they operate from separate planets. Drawing from Pierre Bourdieu’s work on ‘Habitus’, Hester accounts for these significant organisational contradictions by suggesting each sector has a differing organisational “cultural history”, governing laws, policies, assumptions and populations including “sets of professionals” (Hester, 2011 p. 839). This view is shared by Mumby and Clair (1997), who argue:

Organizations exist only in so far as their members create them through discourse. This is not to claim that organizations are nothing but discourse, but rather that discourse is the principal means by which organization members create a coherent social reality that frames their sense of who they are (p.181).

Therefore, habitus is a useful framework for understanding not only ‘service gaps’ but *service contradictions*. The concern Hester (2011) expresses is that the contradictions between the service ‘planets’ in her research, ‘domestic violence services’, ‘child protection services’ and ‘child contact work’, creates risks for children and mothers. For instance, while both the domestic violence and child protection ‘planets’ are informed by an ‘ethos to deal with further risk of violence or harm’ the child contact planet is governed by private law and the notion that the state should not intervene in domestic affairs. The child contact planet is also governed by the assumption that a father has a right to contact his children regardless of his history of perpetrating violence. The differences in worldviews are particularly stark between these

planets, given, “child contact is often the major flashpoint for post separation violence and provides a context for (mainly male) perpetrators to continue to abuse and harass both women and/or children” (Hester, 2011 p.847).

Hester’s work to conceptualise the human service sectors as planets with alternate epistemological and ontological backgrounds is a useful metaphor to explain the confusion and risk women (and their children) face while navigating between services. This metaphor is particularly useful for explaining and understanding how violence against women and children continues to be a blind spot in siloed human services. Extending Hester’s planetary metaphor, the space between the planet of homeless crisis accommodation services and the planet of women’s refuges remains particularly vast.

In contrast to women’s refuges, generalist crisis accommodation services have not traditionally prioritised responding to gender-based violence, domestic and family violence and or sexual assault. This is primarily due to the divergent histories, political imperatives and ideological underpinnings of women’s refuges and crisis accommodation shelters. For instance, women’s specialist refuges understand gender-based violence, (domestic and family violence) to be the main cause of housing injustice for women and children. Crisis accommodation services, have predominately originated out of religious, faith-based charities where the service mission centred on the provision of basic ‘alms’; accommodation, food, shelter, case-management, basic clothing and, more recently, welfare-to-work initiatives. The implementation of trauma informed care into crisis accommodation services aims to bridge the gap in service provision to improve supports for victims/survivors of violence. Trauma informed care is a generalist practice framework that can be introduced into any area of service provision. Therefore, as a transferable, flexible practice model, trauma informed care aims, in part, to respond to the intersectoral and service ‘siloing’ by introducing shared conceptual understandings and practice principles.

Implementation and evaluation of Trauma Informed Care:

Trauma Informed approaches in the field of homelessness/crisis accommodation is a relatively new area of practice and as such research commenting on the effectiveness of the model is limited (Hopper et al., 2010). The bulk of literature evaluating the implementation of trauma Informed care and practice is derived from studies in mental health and alcohol and other drug use settings. A meta-analysis of quantitative and qualitative studies including program evaluations of trauma informed care in 'homelessness' services in the US emphasized the finding that, many homelessness "providers felt that they need to be better informed about trauma and violence" and managers and staff felt 'unprepared' to respond to women who have complex needs, abuse histories and who are survivors of domestic violence (Hopper et al., 2010, p. 84). The authors of this meta-analysis indicated that staff members perceived multiple benefits for the trauma informed care framework, including enhanced skills (Hopper & Bassuk 2010). Similarly, people who accessed trauma informed homelessness services tended to report positive experiences, such as an; "increased sense of safety, better collaboration with staff, and more significant 'voice' while accessing services" (Hopper & Bassuk 2010, p.87). Coleclough (2015), explored the implementation of trauma informed care in a homeless health clinic based in the US. Coleclough (2015), conducted in-depth interviews with 30 participants who had accessed the service and conducted an agency-wide assessment to identify ways in which the clinic was already sensitive and responsive to work with trauma victims/survivors. The main findings from this research were 1) that the 'lobby' or reception area of a service was significant to building trauma informed safety. 2) Homeless healthcare clinics that integrated disciplines into a holistic team, were the most prepared and efficient in addressing complex trauma 3) Trauma informed services which aimed to share power and control with people experiencing 'homelessness' was 'central to long-term trauma recovery'. Power-sharing

strategies in the homelessness healthcare clinics included patient-centred care and peer groups; “‘client’ input to the agency and ‘client’ involvement in advocacy” (Coleclough, 2015 p.10).

The implementation of a trauma-informed model in an Australian mental health service was found to have improved staff responses to disclosures made by women who were victims/survivors of domestic and family violence (Laing & Toivonen, 2010). The absence of proactive and believing responses to women who disclosed domestic and family violence was associated with ongoing and escalating risk of violence and compromised mental and physical health (Laing & Toivonen, 2010). A related study showed that the inclusion of a trauma informed Domestic Violence Mental Health Worker (DVMH) in the mental health team had numerous beneficial outcomes for women including the alleviation of mental health illness/concerns (Laing et al, 2012). Women reported having overwhelmingly positive experiences of the trauma informed mental health service and most significantly, women reported having a greater understanding of the impact of violence on their mental health and developed resources and strategies to ‘move away from violence’ (Laing et al., 2012). This study also suggested that the trauma informed DVMH worker helped to engage women who frequently face multiple barriers to the mental health care system, including women experiencing “complex domestic violence and mental health concerns, young women, Aboriginal and Torres Strait Islander women and women from culturally and linguistically diverse backgrounds” (Laing & Toivonen, 2010, p.42). Through qualitative interviews with women who had accessed the service, the researchers identified the following critical aspects of the trauma informed DVMH worker role; 1) Women accessing the service felt the trauma informed DVMH worker had “actively built trusting relationships with them”. The women reported that they felt “listened to and validated”, 2) The trauma informed DVMH worker utilised a holistic approach with “multi-level advocacy”, 3) trauma informed DVMH worker “consistently demonstrated flexibility and availability” (Laing & Toivonen, 2010, p. 35).

An evaluation of Trauma Informed strategies in an adolescent psychiatric inpatient unit concluded that following the implementation of the strategies there was a “marked reduction” of the use of seclusion and restraint practices for children and adolescents (Azeem et al., 2011, p. 14). The authors emphasised that the trauma informed strategies facilitated the rapid decreased rates of seclusion which were sustained over time (Azeem et al., 2011).

Key criticisms of Trauma Informed Care:

Over the last five years an emerging body of critical literature from social work academics, feminists and activists have argued that trauma informed care practice framework ultimately reinscribes blame onto the victim/survivor who is accessing services. This criticism may appear to be paradoxical, as one of the key explicit aims expressed in trauma informed care literature is to shift blame away from ‘service users’ who are, understood to be victims/survivors of violence. However, the criticism that trauma informed care is a victim blaming and pathologising discourse is attributed to 1) the dominance of psychiatric and psychotherapeutic discourses used in trauma informed care literature 2) the obfuscation of gender-based violence and structural oppression and a lack of focus on violence prevention and responses. Several authors (Burstow, 1992, McKenzie-Mohr et al., 2012) have argued, the dominant conceptualisation of trauma Informed care utilises a psychiatric and psychological framing of distress which undermines the espoused trauma informed aim of de-pathologising women surviving gendered violence and housing injustice (Robinson, 2010). The psychiatric language “implicitly lays the blame on marginalised people for the difficulties they experience in living, instead of accounting for structural factors that shape women’s experiences” (Paradis, 2000, p.850). The focus on biomedical and psychiatric constructions of trauma arguably avoids “the social and political roots of a problem, the experiences and effects of oppression and shared forms of trauma” (McKenzie-Mohr, Coates & McLeod, 2011 p. 136).

A recent Australian qualitative study exploring the use of trauma informed discourses in adolescent mental health services, suggested that the ‘trauma’ discourse used by social workers had been medicalised and reinscribed with psychiatric meanings and responses/treatments (Tseris, 2014). Tseris (2014) interviewed 18 adult women who had experienced abuse/sexual assault as an adolescent, perpetrated by a family member or carers and social workers who had worked within adolescent mental health services. Tseris (2014) argued that the medical/psychiatric model of trauma made young women responsible for healing their “damaged self under the gaze of an expert professional” such as a social worker or psychologist (p.212). This self-healing was found to be consistent with a discourse of “responsibilisation” - a neoliberal discourse of individual responsibility (Tseris, 2014 p.212). Tseris (2014) argues that dominance of psychiatric trauma discourses undermines feminist social change agendas. These observations can be applied to contemporary local and international trauma informed care literature which is biased towards psychiatric and psychological discourses. The following excerpt from the US-based Substance Abuse and Mental Health Services Administration (SAMHSA), suggests an uncritical use of psychiatric and psychotherapeutic language in the description of trauma informed care:

A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for *healing*; recognizes the *signs and symptoms of trauma* in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings (SAMHSA, 2014, p.9).

The emphasis on the words ‘healing’ and ‘signs and symptoms of trauma’ provides an example of the psychiatric language embedded within a trauma informed text. This is also the view taken up by some Australian politicians who have argued that, when attributed to the psychiatric problem of ‘trauma’, ‘homelessness’ is not an issue of systemic social, political and

economic inequality and oppression, and therefore, not the responsibility of governments. For instance, Kevin Andrews (2014), the former Minister for Social Services provided an opening address to *The Australian National Homelessness Conference* in which Andrews described ‘trauma’ as a mental health problem that is responsible for creating homelessness. Andrews argued that “the seeds of a homeless future can be sewn by earlier trauma...traumatic childhood experiences such as family conflict and neglect can increase the chance of homelessness” (Andrews, 2014). Andrews utilises psychiatric, responsabilising ‘trauma’ rhetoric that displaces the Federal government’s responsibility for the provision of public housing, the regulation of affordable housing and the commitment of funding to violence response and prevention services, including women’s refuges. Instead, Andrews offered a purely psychological account, “It is also important to be reminded that issues like homelessness rarely just happen...That the incubation period can start a long way back” (Andrews, 2014). The use of the phrase “incubation period”, likened ‘trauma’ to a physical illness such as a virus or cancer. Again, Andrews locates the problem of ‘homelessness’ within the minds and bodies of unfortunate individuals who become ‘unwell’ with trauma - the origin of this traumatic disease belonging to a distant and unfortunate childhood.

Trauma informed care discourses have also been criticised for borrowing from the language and conceptual work of women’s refuge movement without the political analysis. For example, trauma informed care literature emphasises the physical, emotional and cultural safety for women (and their children), however is ultimately not a violence prevention or social justice framework, rather it is primarily a therapeutic modality:

And yet while offering a framework at individual and organisational levels in which to better address the needs of youth who are homeless, the trauma-informed care framework is incomplete, falling short in attending to needs at the community and

societal levels. The gap in most trauma-informed programming remains one of lack of attention paid to primary prevention (McKenzie-Mohr et al., 2012, p.137).

Much of the literature on trauma informed care does not reflect feminist understandings and practice for responding to and preventing gendered violence (Tseris, 2013). Trauma informed care literature evades any explicit reference to social change, legislative change, social policy recommendations or community development strategies (McKenzie-Mohr et al., 2012). This partially explains why most women's refuges continue to draw from feminist theory, while the relatively new term trauma informed care is not widely used to describe their services and programs. For instance, a Canadian research project concluded that although many women's refuges did not explicitly refer to the term trauma informed care, they "were taking steps to offer supports which take into account women's experiences of violence/trauma" (Talbot et al, 2011). Furthermore, many Canadian crisis accommodation services also apply an intersectional feminist lens to understand 'trauma' the in the context of interlocking systems of power such as settler-colonisation, sexism, classism and racism (Talbot et al, 2011).

This introduction traces the historical, conceptual and political complexities surrounding 'homelessness', 'trauma' and 'trauma informed care'. While it would have been an easier and simpler undertaking to take homelessness, trauma, and trauma informed care as A-political and A-historical givens, this would have been a disservice to the women at the centre of this research project. Instead, this thesis grapples with these concepts in the context of settler-colonialism, neoliberalism, racism, gendered violence, homophobia and transphobia. Furthermore, as a piece of human service and social work research, the implementation of trauma informed care is interrogated through historical, political and economic lenses,

Human services have a powerful role in defining and responding to social problems. According to Willse (2010a; 2015), the focus on the role of social services in producing and reproducing discourses and cultures tends to be neglected. According to Giroux "culture not only reflects

larger forces but also constructs them...culture not only mediates history but shapes it” (Giroux, 2004 p. 111). The analysis of organisational cultures and discourses are also inextricably linked to the study of power (Giroux, 2004). According to Gramsci “every relationship of hegemony is necessarily an educational relationship” (Gramsci in Giroux p.114). Organisational cultures and discourses, can therefore be understood as the vehicles of education and contested sites of power. Questioning or troubling the cultures and discourses embedded in human services can potentially reveal the underpinning political motives and ideological assumptions. A critical exploration of the ideological positions and the discourses that are utilised within workplace and services, allows ‘us’ to ask the question; what are the effects and consequences of the construction of social problems and responses? The following research questions guided this study which explored three trauma informed women’s refuges and crisis accommodation services in two settler-colonial neoliberal societies based in Sydney and Vancouver.

Research questions:

- 1) How do staff understand and experience ‘trauma informed care’ in women’s refuges and crisis accommodation services?
- 2) How do these understandings shape their work with women who are victims/survivors of gendered violence, systemic racism and housing injustice?
- 3) How do staff understand ‘cultural safety’ (a key principle of trauma informed care) in women’s refuges and crisis accommodation services and how do these understandings influence their work with women?
- 4) How does an espoused trauma informed care/cultural safety model shape women’s experiences in women’s refuges and crisis accommodation services?

5) What service gaps and contradictions are addressed or unaddressed by the implementation of trauma informed care?

Theoretical Framework:

This draws from intersectional feminism and materialist feminisms. Both feminisms originate from ‘a lineage that views cultural articulations of gender, class and race specifically through the lenses of economics, political struggles, and anti-imperialist, anti-hetero-patriarchal and anti-racist agendas’ (Campbell & McCready, 2014). The intersectional feminist framework arose in response to Black feminist, post-colonial and First Nations feminist theorists and activists who critiqued the unconscious white racism (white supremacy), heteronormativity and middle-class assumptions embedded in the second wave feminist movement of the 1970s. Intersectional feminism also conceptualises and resists interlocking systems of sexual and gender identity oppression; heterosexism, bi-phobia, cis-sexism/trans-misogyny (Spade, 2015).

Materialist feminism also takes up these ‘intersectional’ concerns (Hennessy, 1993). However, materialist feminists, from a Marxist Historical Materialist perspective, also understands the roots of gender-based oppression within the neoliberal capitalist political economy (Hennessy, 1993). Debates exist between these feminist theories, making for an uneasy alliance within this theoretical frame. However, the use of both feminist theories aims to address some of the theoretical limitations associated with intersectional and materialist feminisms. An elaboration of this theoretical framework and how it has been applied to this study is discussed in Chapter 3.

Brief Description of the Methodology:

This research project employed a qualitative feminist methodology. In each participating service site, participants were recruited to participate in in-depth interviews including women

over the age of 18 years who had recently accessed crisis accommodation services (within the previous 3 months), service managers and workers, key informants (social work academics and anti-violence against women activists). A total of 32 people participated in in-depth interviews including key informants (N=2), staff (N=22) and women (N=8) who had accessed at least one of the participating services. The multi-sited data was initially coded using a heuristic based on Coates and Wade's (2007) *Interactional and Discursive view of Violence and Resistance*. This was followed by a second stage of thematic analysis grounded in intersectional and materialist feminisms.

Key Terms:

Gender-based Violence and Gendered Violence:

The terms, 'gender-based violence' and 'gendered violence' refer to the pattern of male violence against women (including transgender women and gender non-conforming people) and is used throughout this thesis to refer to (although not an exhaustive list): (child) sexual assault, physical assault, psychological torture (for example 'gaslighting'), threats and intimidation, control and abuse of children, forced marriage, marital rape, exploitation of domestic labour, financial exploitation, stalking, (sexual) harassment, domestic and family violence and murder (Laing & Humphreys, 2013; Almeida & Durkin, 1999).

First Nations Peoples:

This thesis uses the term 'First Nations people' to describe Indigenous people of Australia and Canada. In an Australian context, the term 'First Nations' is used to refer to Aboriginal and Torres Strait Islander peoples and in the Canadian context, this term is used to refer to Métis and Inuit and First Nations people. However, I acknowledge the limitations of the term 'First Nations' which is an English settler colonial term. The term 'First Nations' also risks falsely

collapsing the significant diversity among hundreds of Nations and societies into a singular, homogenous group identity.

Women:

This thesis focuses on the specific gendered impacts of housing injustice, systemic racism and violence against women. The author recognises the limitations and potential lines of exclusion created by reducing gender to a biological given. As such the chapter the terms ‘woman/women’ intend to be inclusive of all who identify as being a ‘woman’ including transgender women.

Women accessing services:

This thesis uses the term ‘women accessing services’ in place of the more commonly used term ‘clients’ or ‘consumers’. This resists labelling and pathologising women experiencing housing injustice: “We don’t call women ‘clients’ or ‘patients’ ...when it’s absolutely necessary to make a distinction we just call them ‘women’” (Dechief & Abbott, 2012 p.333).

Victim/survivor:

The term ‘victim/survivor’ is borrowed from Laing and Humphreys (2013) who argue that this term “highlights the complex coexistence of both agency and victimization” (Laing & Humphreys, 2013 p.6).

Housing Injustice and ‘homelessness’

This thesis uses the term ‘housing injustice’ instead of ‘homelessness’. Housing injustice offers a critique of neoliberal settler-colonial societies and the regime of property relations. Beyond the narrow concept of ‘homelessness’, ‘housing injustice’ encapsulates: systemic state anti-black racism, housing insecurity/precarity, revanchism and gentrification. The term ‘housing injustice’ also aims to resist conferring blame on people living in poverty for living without

shelter. The term 'housing injustice' also aims to name the systemic, settler-colonial causes of living in inadequate housing or the absence of housing.

Hetero-patriarchy:

The term 'hetero-patriarchy' is used to refer to both the socio-political and economic privileging of heterosexual identifying people (heteronormativity) and the systemic privileging of (white, cis-gendered, able bodied) men (patriarchal) in Western, settler colonial societies. Furthermore, heteropatriarchy relies on "very narrow definitions of the male/female binary, in which the male gender is perceived as strong, capable, wise, and composed and the female gender is perceived as weak, incompetent, naïve, and confused" (Arvin, Tuck, & Morrill, 2013, p.10).

Settler-Colonisation:

Settler colonialism is distinct from other forms of colonialism such as extractive colonialism, as it is a continuous and permanently self-replicating regime (Jimenez, 2013). Settler colonialism does not seek to negotiate with First Nations peoples but rather, seeks to replace them with a settler-colonial; population, language, culture, economic and political systems (Jimenez, 2013). As such, settler-colonisation is inherently genocidal (Lindqvist & Tate, 1996). In contrast, extractive colonialism, focuses on extracting and exploiting resources.

Settler colonialism historically has relied on two main genocidal strategies to gain access and control of land. The first strategy is mobilised around militarised, targeted assaults on First Nations peoples including; massacres, rape, bio-warfare, control of First Nation's people's movements, displacement, dispossession, seizure of land, theft of children, starvation, enslavement, incarceration, regulation and surveillance. The second central strategy involves cultural, linguistic and psychological techniques of assimilation. Assimilation can be understood as the forced indoctrination of the 'occupied' group of people into the settler-

colonial social-political, social, religious and economic systems (Davidson, 2012). Assimilation also functions through the erasure, derision and objectification of First Nations people's history, cultures, societies and political economies (Kirmayer, Gone & Moses, 2014). In addition, the British settler colonial state in Australian and Canadian contexts coupled displacement and dispossession of First Nations peoples with intensive state-based regulation, surveillance and control (Woolford, Benvenuto, & Hinton, 2014).

Sub-ordinated groups: Subordinated by socio-political and economic inequalities that give rise to intersections of systemic violence and everyday expressions of racism, colonialism, classism, ageism, negative social constructions of (dis)ability, heteronormativity, homophobia and transphobia (Spade, 2015).

Significance of the Study:

Trauma informed care had already been implemented in many human services internationally including Vancouver, Canada (Poole & Greaves, 2014; Torchalla et al, 2015). However, while calls for the implementation of trauma informed care in 'housing' and crisis accommodation services have emerged in the literature (Robinson, 2010), only a limited number of studies have explored the implementation of this practice framework in an Australian context (Wilson, Hutchinson, & Hurley, 2017). There is limited research exploring the implementation of trauma informed care in crisis accommodation services and women's refuges (Coleclough, 2015; Prestidge, 2014; Hopper et al, 2010). There is also very limited research that has focused on the trauma informed concept of cultural safety (Johnson, 2014). This research aimed to respond to these gaps in the literature by exploring the implementation of trauma informed care (cultural safety) framework in crisis accommodation and women's refuge services from the perspectives of staff and women who have accessed the service and key informants.

However, possibly, the greater contribution to the field of social work, is in the attempt to provide a critical analysis of trauma informed care as experienced by women, staff and key informants. Critical trauma literature has called for further research to expose the systemic and institutional constraints on women's "freedom and agency" (Bumiller, 2009 p.161). Some authors have responded to this by focusing on the influence of neoliberal capitalist ideologies and policies on human services engaged in 'trauma work' and the development of the 'trauma' discourse (Tseris, 2014). Emerging research has provided a critical analysis of the medical model/psychiatric trauma discourse and the new psychological model of trauma informed care in mental health settings (Tseris, 2013) and in services working with First Nations peoples (Clark, 2016b). However, there are no known international studies which critically explore trauma informed care in women's refuges and crisis accommodation services in the context of settler-colonialism and neoliberalism. This thesis aims to contribute to the body of social work literature, advocacy/activism and research making visible intersections of gender-based violence, systemic racism and housing injustice.

Finally, this research project aims to contribute to the development of qualitative intersectional feminist research methodologies, and the use of the *Interactional and Discursive View of Violence and Resistance* (Coates & Wade, 2007) as a heuristic for coding data. This methodological approach aims to explore trauma informed practice framework in the context intersections of globalised ideologies such as neoliberalism, settler-colonialism, systemic racism, housing injustice and gender-based violence.

Overview of the thesis

Chapter 2 provides a literature review in two parts to explore the epistemological roots of 'homelessness' and 'trauma'. This genealogy of trauma describes the bio-medical and psychological constructions of 'trauma' including literature from allied health (social work and public health) perspectives. This is followed by a review of literature describing politicised

constructions of ‘trauma’, through feminist and First Nations epistemologies. This highlights the dialectic relationship between psychiatric/biomedical and politicised theories of trauma. These genealogies provide context to the implementation of trauma informed care in services working with women who are experiencing housing injustice. Chapter 3 provides a detailed account of the theoretical positions that have guided this research and analysis, namely intersectional and materialist feminisms. Chapter 4 describes the qualitative feminist methodological approach and analytical frameworks used in this research.

The next three findings chapters explored the discursive, ethical and practice based tensions between women’s refuges and crisis accommodation services in Sydney and Vancouver.

Chapter 5, ‘A continuum of Trauma Informed Care Models’ explores the significant differences in the ways trauma informed care was conceptualised and implemented across the three participating service sites. The models of trauma informed care are described as a continuum, ranging from politicised models to behaviour management models of trauma informed care.

Chapter 6, ‘Trauma informed cultural safety?’, argues that dominant and historically located discourses about who, how, and why women experience housing injustice continue to operate and place blame on women. The slippage of hegemonic, settler colonial and neoliberal discourses appeared to undermine and contradict the aims of trauma informed care and trauma informed cultural safety.

Chapter 7, “‘Like my own home’”: Listening to women’s experiences of trauma informed refuges and shelters’, this chapter explores women experiences of different models of trauma informed care. This chapter looks at the finding that despite receiving trauma informed service supports, many women continued to experience housing injustice and gendered violence. This

chapter also explores staff perspectives regarding the potential limitations of the trauma informed care practice model.

Chapter 8. ‘Beyond the not-for-profit-industrial complex: Responding to gendered violence, systemic racism and housing injustice?’, provided a discussion on the key theoretical, methodological and practice based implications arising from the findings. This chapter also considered explores trauma informed care as a site of struggle between politicised discourses and praxis and what has been termed a neoliberal psy trauma discourse and behaviour management approach. This chapter also considers how neoliberal victim-blaming, individualising, responsabilising and pathologising discourses are resisted within trauma informed services. This chapter provides recommendations for practice, education and training, policy directions and further research as well as reflections on the limitations of this study and concluding thoughts.

Chapter 2:

Conceptualising 'homelessness' and 'trauma': A literature review in two parts

Introduction:

This chapter incorporates a literature review divided into two parts. This thesis was centrally concerned with how services using a trauma informed care practice framework responded to women experiencing housing injustice. As such, this literature review encompassing theories of 'homelessness' and theories of 'trauma' was produced to provide context to the 'trauma informed' practice framework in crisis accommodation and women's refuge services. The first half of this review considers the construction of the concept of 'homelessness'. This review also includes contextual information about the intersections between gendered and racialized housing injustice and the ideological and historical differences between women's refuges and crisis accommodation service in Sydney and Vancouver. The second part of this literature review explores the genealogy of the concept of 'trauma'. How 'trauma' is conceptualised is intimately linked to how it is responded to, including how responses can be 'trauma informed', as is the focus of this study.

Literature Review Strategy:

Literature theorising 'trauma' encompasses a broad field of epistemological and disciplinary orientations. For instance, the concept of 'trauma' has been defined within a range of health fields including but not limited to; behavioural science, public health, social work, psychiatric, psychological and neurological epistemologies. Trauma has also been defined by victims/survivors, First Nations peoples, post-colonial, anti-racist and anti-war activists and feminists.

For the ease of reading, the term ‘biomedical’ is used to refer to; behavioural science, public health, psychiatric and neurological perspectives. Similarly, following Tseris (2014), the term ‘psy’, is used to encompass the disciplines of; psychotherapy, psychoanalysis, psychodynamic therapy, counselling and psychology. However, it is important to recognise that there are no essential biomedical, psychiatric or psychological trauma discourses. Rather, multiple disciplinary and ideological tensions exist within and between these ‘psy’ theories. Similarly, there is no unified or singular feminist, anti-racist or First Nations theory of ‘trauma’, however there are shared and overlapping political aims to end the structural conditions that give rise to housing injustice, gendered, classed and racialized violence.

Literature for this review was sourced from reports, conference papers, journal articles, abstracts and doctoral dissertations. A range of online academic databases were utilised in the literature searches including: Web of Science, CINAHL, Family Studies Abstracts, Family & Society Studies Worldwide, Indigenous Australia, Indigenous Collection, Informit, JSTOR, Medline (Ovid), Project Muse, ProQuest, PsycInfo and PubMed.

Multiple searches were conducted using the following combination of search terms: homelessness, housing injustice, housing insecurity, neoliberalism, settler-colonisation, trauma, trauma informed care, trauma informed, cultural competency, cultural safety, First Nations, systemic and institutional racism, colonisation, colonial trauma, Aboriginal, Indigenous, domestic/family violence, gendered violence, feminist trauma theory, feminism, women’s refuge, women’s shelter, crisis accommodation, homeless shelter. Initially, these search terms were used prior to the literature search being refined to Australian and Canadian geographic locations.

Extracting Qualitative Data:

An inclusive approach was taken to extracting qualitative data for this review (Noyes & Lewin, 2011). Therefore, all literature that referred to the above search terms were included. I did not assess or screen the literature for the rigour and quality of research as the purpose of this literature review was to explore the conceptual terrain of 'homelessness' and of 'trauma'. From the available literature, I conducted a narrative synthesis and coded concepts into 'dominant claims', 'marginal-claims' and 'counter claims'.

SECTION 1: Theories of Homelessness and Defining Responses to Housing Injustice

The dominant conceptualisations of 'homelessness' in settler-colonial Australia and Canada arguably imposes and consolidates English/Western notions of housing, ownership of land and private property relations. For example, The Australian Bureau of Statics (ABS), draws on Anglo/European concepts of home when defining homelessness. For a person to be considered homeless they must fulfil at least one of the conditions below:

- 1) When a person does not have suitable accommodation alternatives they are considered homeless;
- 2) If their current living arrangement is in a dwelling that is inadequate, or has no tenure, or if their initial tenure is short and not extendable; or
- 3) Does not allow them to have control of, and access to space for social relations, they are considered homeless (ABSa, 2012).

The ABS emphasise that being homeless is contingent on not having access to accommodation alternatives that are 'safe, adequate and provide space for social relations' (ABSa, 2012). Challenging settler colonial definitions of homelessness and the political amnesia surrounding colonial invasion, genocide and dispossession, Memmott (2014), describes a dimension of 'spiritual homelessness'. Memmott (2014), argues that all First Nations peoples experience spiritual homelessness regardless of whether First Nations people are 'housed' or have access

to 'shelter' or not. The term 'spiritual homelessness' refers to the ongoing loss and trauma stemming from dispossession and the ongoing separation of First Nations peoples from their ancestral homelands and Kinship networks (Memmott, 2014). The violent dispossession from land was especially devastating for First Nations people for whom connection to land was, and continues to be, a spiritual relationship (Memmott & Chambers, 2010). Conceptually, the term 'spiritual homelessness' critically reorients the issue of 'responding to homelessness' towards a concern for land rights, decolonisation and sovereignty. Ultimately, Memmott's (2014) use of 'spiritual homelessness' challenges the legitimacy of the Australian settler colonial state. Memmott and Chambers (2010) argue, that many First Nations peoples and communities who continue to live according to traditional lore and customs today, may choose to 'sleep rough' but do not identify as homeless as the sense of 'home' is intrinsically tied to site specific land and Kinship rather than to residential buildings (Memmott & Chambers, 2010).

The experience of 'homelessness', in settler colonial Australia and Canada, is thought to involve a complex dislocation from socio-cultural connection, belonging and civil participation. In other words, 'homelessness' is more than 'rooflessness' (ABS, 2012). To be without a home, to be 'roofless', is to experience extreme marginalisation from social citizenship rights (Walsh & Klease, 2004). The loss of domiciled "security, stability, privacy, safety and the ability to control living space" is also associated with profound emotional and psychological distress (ABS, 2012). For this reason, researchers have argued that 'homelessness' is inherently, a traumatic experience (Goodman, Saxe & Harvey 1991).

These ideas shaped Chamberlain and Mackenzie's definition of 'cultural homelessness' meaning, 'homeless people' live below or outside of what is considered to be a minimum standard of housing and living. Chamberlain and Mackenzie argue this 'minimum standard' is culturally located and is relative. In an Australian context, the minimum standard of housing is defined as "a small rental flat with a bedroom, living room, kitchen and bathroom and an

element of security of tenure provided by a lease” (Johnson, 2014, p.156). Chamberlain and MacKenzie’s (2008) three tier typology of homelessness is broadly used in social policy and research in Australia. These authors argue that there are three main forms of homelessness: 1) primary homelessness which includes rough sleeping in public spaces and squatting, 2) secondary homelessness referring to people staying temporarily with friends and acquaintances, and 3) tertiary homelessness referring to people staying in boarding houses regardless of this being medium or long term (Chamberlain & MacKenzie, 2008).

The way in which homelessness is defined also influences the way in which homelessness is measured by official statistics. Many ‘homelessness’ studies draw from quantitative, epidemiological methodologies focused on ‘counting the homeless’ such as the annual inner city of Sydney ‘street counts’. These quantitative methodologies have been criticised for producing data that underestimates the rate of homelessness in Australia (Robinson, 2012). This is partly due to the difficulties associated with finding and involving people experiencing homelessness in data collection. Researchers often struggle to locate homeless people, particularly those who are sleeping rough and who are transient/itinerant populations of people who stay in improvised shelters or public dwellings across numerous geographical locations (Memmott & Chambers, 2010).

In Canada, up until recently there has been no consistent, national method of enumerating the prevalence of homelessness across the country (Gaetz, 2013). In 2018, a nationally coordinated Point-in-Time (PiT) Count of homelessness persons named *Everyone Counts* was conducted across every province and territory in Canada. Prior to *Everyone Counts*, homelessness statistics were based on data compiled from violence against women shelters, emergency accommodation shelters, provisional accommodation services (hospitals, prisons and boarding houses) and aggregate data from PiT street counts of unsheltered rough sleeping people in major Canadian cities. Based on these aggregate data, an estimated 30,000 people are homeless

on any given night and an estimated 200,000 people experience homelessness in Canada each year (Gaetz, 2013). Again, these figures are likely to underestimate the true extent of homelessness in Canada. Gaetz (2013) and colleagues argue that secondary homelessness (staying with friends and relatives and ‘couch surfing’) comprise a hidden population of homeless people for which there is no existing reliable method for ascertaining how many people live this way. Similarly, in Australia, the ABS (2018) reported that the increase in homelessness could be attributed to the increase of people living in overcrowded dwellings who do not have access to the minimum standard of living. However, the true number of people living in over-crowded accommodation, couch surfing and living in dwellings that are below the minimum standards for housing environments, is not known.

Beyond the limitations associated with estimating the prevalence of homelessness, the emphasis on quantitative methodologies bypasses the qualitative ‘lived and felt’ diversity of homeless experiences (Robinson, 2012). Statistics do little to expose, for example, the embodied experiences of violence and abuse frequently experienced by homeless people (Robinson, 2012). Similarly, statistics often report on, for example, the ‘over-representation’ of First Nations peoples in homelessness measures, however this does not convey the intergenerational trauma and injustice that is associated with dispossession and ongoing separation from homelands. Some quantitative homelessness studies have focused on the structural causes of homelessness (Johnson, Scutella, Tseng & Wood 2015). However, the quantitative emphasis on ‘the prevalence of homelessness’ and can divert attention from the structural causes of homelessness. Furthermore, as Willse (2015), argues, the State’s emphasis on ‘counting the homeless’, is further evidence of the attempt to reconstruct ‘homelessness’ from a social justice concern into a neoliberal governance and management concern.

Official data collection instruments such as the Australian census, have also been criticised for leaving out key demographic information which would provide a more nuanced overview of

homeless populations in Australia (Robinson, 2011). The Australian census captures a narrow range of demographics, age, binary gender identities ('male', 'female' or 'other'), First Nations identities and Culturally and Linguistically Diverse identities. However, official ABS census data fails to capture the rate of homelessness experienced by lesbian, gay, transgender, bisexual, intersex and queer (LGTBIQ) identifying people as the census forms do not give people the option of recording a diverse gender identities or sexual orientations. The National LGBTI Health Alliance argues that this omission leads to significant gaps in social and health policy development particularly regarding policies aimed at preventing homelessness experienced by LGBTIQ people (2012). Studies from the US and UK suggest that LGBTIQ identifying people experience a disproportionately high rate of housing insecurity and homelessness in comparison with heterosexual and cis-gendered people (Cochran, Stewart, Ginzler, Cauce, 2002). One study compared experiences of homeless LGBTIQ young people with heterosexual young people and reported that LGBTIQ young people experience higher rates of violent victimization, substance use, self-harm and mental health problems (Cochran, Stewart, Ginzler, Cauce, 2002). Also, LGBTIQ people experiencing homelessness are less likely to seek and access crisis accommodation support due to experiences of homophobic and transphobic harassment and discrimination in religious, faith-based crisis accommodation services and negative perceptions of shelter accommodation (Maccio & Ferguson, 2016). Without methods of recording the rate of homelessness and violence against LGBTIQ identifying people, issues of homophobia and transphobia remain veiled.

These examples uncover the relationship between the ways in which social problems are conceptualised/measured and how social problems are responded to, or neglected, across legislative, social policy and human service provision levels. Official homelessness statistics and dominant concepts about who 'the homeless' are and what causes people to become 'homeless', powerfully shape government policies. These theories of homelessness guide

expenditure on public housing and ‘homelessness initiatives’ including service models and programs. It is also apparent that human services have a powerful role in conceptualising homelessness and guiding both service and policy responses. According to Willse (2010b), human services also actively shape the ways in which social problems are conceptualised and responded to. For example, providing shelter and basic alms to ‘the homeless’ can displace a concern for challenging the systemic causes of housing injustice such as; gendered violence, systemic racism, settler colonialism, gentrification, homophobia and transphobia. As such the ideological framing of social problems and ‘solutions’ are inherently political and are important sites of social struggle.

[A gendered analysis of housing injustice:](#)

A gendered analysis of homelessness reveals differences for men and women. Housing injustice experienced by women has been described as a double invisibility (Robinson & Searby, 2006). This is in part due to the public perception that ‘homeless people’ are typically, hardened, rough-sleeping men. Many homeless women avoid sleeping rough and or staying in shelters, preferring instead to stay temporarily with relatives, friends and partners and as such are less ‘visible’ than men (Walsh, Rutherford et al. 2009). Due to this lack of ‘visibility’ the actual prevalence of women who are experiencing housing injustice in Australia and Canada is unknown (Robinson & Searby, 2006; Whitzman, 2006). However, there is clear, global evidence indicating that women represent a significant proportion of those who are experiencing homelessness (Kirkman, 2010).

The latest Australian census data indicates that the rate of ‘homelessness’ experienced by women increased from 45,813 in 2011, to 49,017 in 2016 (ABS, 2018). The Australian Institute of Health and Welfare (AIHW) has reported that approximately 31,000 children (aged under 18 years) and 56,000 adult women are homeless in Australia (AIHW, 2015). A significant proportion of women experiencing homelessness are young women (Mitchell,

2011). Approximately 30% of all people who accessed a specialist homelessness service between 2014 and 2015 were young people and children aged under 18 years of age (Australian Institute of Health and Welfare, 2016). Of these young people, just over half (52%) were young women and girls and one third identified as a First Nations person (Australian Institute of Health and Welfare, 2016). Single mothers with children under the age of ten comprise one of the fastest growing 'homeless' populations in Australia (Kirkman, 2010). However, there has been a significant increase (31%) in the number of older women over the age of 55 years who have become homeless in Australia since the 2011 census (ABS, 2018).

Domestic and family violence is recognised as the leading cause of homelessness for women, their children and girls (Australian Institute of Health and Welfare, 2016; Mitchell, 2011; Robinson, 2010; Collins, 2010), more so than for men (Tischler et al., 2007, Tully, 2008, Walsh et al., 2009, Williams, 1998, Williams, 2007). The lack of affordable housing options, especially for women who are socially and economically disenfranchised, in conjunction with domestic and family violence, pushes many women into positions of 'chronic' housing injustice and 'homelessness'. The AIHW (2016), reported that between 2014 to 2015, 36% of all people requesting assistance from specialist homelessness agencies were escaping domestic or family violence (approximately 92,000 service users). An Australian study exploring the experiences of 29 'homeless' women, reported that the majority of women participants identified domestic and family violence as the reason that they had become homeless and all women also described being assaulted during periods of homelessness (Murray, 2009). In North America, over 70% of young women living on the streets reported becoming 'homeless' after they had run away from violence perpetrated by their husbands, partners, fathers, step-fathers, brothers and or other family members (Goodman 1991 cited in Jennings, 2006). Furthermore, women often endure abusive relationships to avoid staying in crisis accommodation shelters or sleeping rough which are perceived and are often experienced as

unsafe options (Acosta & Toro, 2000; Evans & Forsyth, 2004; Rahder, 2006). According to the United Nations Committee on Economic, Social, and Cultural Rights (UNCESCR; 2006) “women in Canada are often prevented from leaving abusive relationships due to the lack of affordable housing and inadequate assistance”, the only alternative being “homelessness” (Walsh et al., 2009, p.300).

According to the ABS definition of homelessness, a person who is “displaced from their home due to domestic violence” becomes homeless if they do not have access to accommodation “alternatives that are secure, safe and adequate” (ABS, 2012). In terms of this definition, if a person is subjected to violence and abuse committed by a partner or family member, then their ‘home’, cannot be considered a ‘safe alternative accommodation’. Due to the profound isolation, financial loss/exploitation and deprivation caused by domestic and family violence victims/survivors have no safe, adequate, accommodation alternatives to the ‘home’ and may experience compromised relationships or loss of contact with supportive relatives and friends. However, the ABS (2012) indicates that measuring the prevalence of this form of homelessness would be extremely difficult and instead argues that domestic violence places victims at a higher risk of becoming homeless and experiencing housing insecurity. The way the ABS constructs ‘homelessness’, therefore, dangerously excludes gendered violence and domestic and family violence.

Public health data reveals, that 1 in 4 women have experienced violence perpetrated by a partner or family member in their lifetime and the ‘highest lifetime prevalence of gender-based violence was highest (35.8 per cent) for women aged 30 to 49 years and lowest (14.5 per cent) for women aged 65 years or older’ (Rees et al, 2011). Feminist researchers have also measured the economic losses sustained by women victims/survivors of domestic and family violence (Zufferey et al, 2016). A recent study involving 658 Australian women, found that gender-based violence was directly linked to women’s loss of housing (including home ownership),

significant financial and educational losses and a devastated sense of safety within the community:

First, the financial responsibility ascribed to women for their violent partners' property damage and debts they left behind affected women's ability to access and afford adequate rental housing. Second, women who were home owners reported feeling frightened and bullied into accepting unequal property and financial settlements. Consequently, following separation, women were forced to 'downsize' into poorer quality housing (Zufferey et al, 2016 p.469).

The financial losses associated with domestic and family violence extended through the years and decades following separation from a violent partner and/or family member(s). This Australian study reported that half of the respondents experienced post separation violence, the average length of ongoing violence spanned 2.78 years after separation (Zufferey et al, 2016). One woman reported being violently victimised by her ex-partner "25 years post-separation" (Zufferey et al, 2016 p.469). In addition to "living in constant fear" women experiencing post separation violence were forced to move frequently, leaving their home/s often with "nothing" and "nowhere to go", (Zufferey et al, 2016 p.469). To escape post-separation violence, women relocated lengthy distances (including moving overseas and interstate). The impact of moving frequently in the attempt to increase personal safety means that many women and their children lose access to employment, education, support services and meaningful connections to their "communities and feelings of connection to home" (Zufferey et al, 2016 p.467). Zufferey et al, (2016) conclude that across all categories of postseparation housing, including access to private rental, services, public housing assistance, property settlement, and home ownership, women's ability to negotiate and maintain their standards of living, and rights to safety and security were eroded due to intimate partner violence (IPV). In a similar study based in the USA, women also frequently lost their welfare-to-work payments/benefits as a direct

result of their “partners harassment, stalking behavior, emotional abuse, unreliable parenting, and physical violence” (Roschelle, 2008, p. 197). In recent years, domestic and family violence policies (for example, Staying Home, Leaving Violence), have attempted to support victims/survivors to stay in their home whilst the perpetrator is relocated (Diemer et al, 2017). Recent research suggests that while this approach helps to reduce housing injustice and homelessness caused by perpetrators of domestic and family violence, “women, staying in their own home” were left “more open to breaches of intervention orders, than those (women) who re-located” (Diemer et al, 2017, p.32). Therefore, a significant body of theory and research over the last 40 years has also described perpetrator tactics.

Feminist academics have argued that perpetrators of domestic and family violence use a range of tactics including “isolation, secrecy, responsibility, protection and loyalty” which are intentionally mobilised to gain access, power and control over victims/survivors (Laing, 2003, p.142). Laing and Humphreys (2013) have provided the following nuanced analysis of domestic and family violence perpetrator tactics:

Perpetrators typically attempt to isolate their victims through tactics (fear or threats) because secrecy enables ongoing abuse of power and evades accountability. Perpetrators deny, minimize and excuse their violence, blaming their victims, making victims responsible for the violence. Victims often are made to feel loyal to the perpetrator and responsible for others often risking their own safety and wellbeing to do so (Laing & Humphreys, 2013 p.142).

Feminists have argued that human services and human service workers can also mirror these perpetrator dynamics, thus (re)traumatising victims/survivors including workers who are also victims/survivors (Bloom & Farragher, 2011).

There is also growing recognition of the association between abuse in childhood, in particular sexual assault, and long-term housing injustice in adulthood (Collins, 2010). This is in part, related to the association between adverse childhood experiences and the development of severe mental health concerns and drug and alcohol use. Child sexual assault is complexly associated with severe mental illness (Golding, 1999, Mueser et al, 1998, Herman, 1992,) and alcohol and other drug use (Maté, 2008; Ferlitti, 2002; Schneider, Burnette, Ilgen, & Timko 2009) which can challenge women's capacities to maintain employment and housing. Most women who are experiencing housing injustice and who live with mental health concerns have experienced severe physical and or sexual abuse in their lifetime (Goodman, Dutton and Harris, 1997 in Jennings 2006). Approximately 87% of women experiencing housing injustice and homelessness reported abuse during childhood and as adults during periods of 'homelessness' (Goodman, Dutton and Harris, 1997 in Jennings 2006).

Women often experience ongoing harassment, intimidation tactics and violence from abusive family members and (former) partners during periods of 'homelessness' (Roschelle, 2008, Tischler et al., 2007, Williams, 1998). Homicide statistics indicate that women are most likely to be killed by a current or former partner or family member in the immediate period following an attempt to leave the violent relationship (Cussen & Bryant 2015; Roberts, 2005). Women who are experiencing homelessness, who are sleeping rough or who are staying in crisis accommodation services are often targeted and sexually assaulted by perpetrators, both known and unknown to them (Goodman, Fels & Glenn, 2006; Murray, 2011). In Sydney, a study found 50% of women (N = 38) and 10% of men (N = 119) reported that they had been sexually assaulted by a stranger(s) whilst homeless (Buhrich, Hodder & Teesson, 2000). The study compared the lifetime prevalence of trauma for men and women experiencing homelessness in Sydney with prevalence of violence amongst the general population in the USA and reported that 'homeless' women "appear to be at an eightfold risk of lifetime experience of physical

threats” (Buhrich, Hodder & Teeson, 2000 p. 964). Literature has also emphasised the impacts of multiple oppressions along social stratifications of gender, gender-identity, race, sexuality, age, migration status, and disability/able-bodiedness, which increases the severity of violent victimisation and housing injustice (Willse, 2015; Spade, 2015).

Similarly, social policies have arguably permitted and perpetuated gender-based violence and housing injustice is through: 1) “underfunded and unsafe homeless services” (Robinson, 2010, p.46), 2) fiscal cuts to social welfare (Goodman, 1991) and 3) affordable housing (Willse, 2010a). Housing insecurity is itself considered to be a risk for homelessness for women; this can include “unwanted moves, not paying other bills in order to pay rent, eating less or skipping meals to pay rent, doubling up with family or friends, being threatened with eviction, or experiencing rental or credit problems” (Baker, Billhardt, Warren, Rollins & Glass, 2010, p.431).

A lack of crisis accommodation services has been identified as a significant gap in service provision failing to meet the needs of single women experiencing housing injustice/homelessness in Western Sydney (Robinson and Searby, 2005) and in the urban inner city of Sydney (Morris, 2017). Women experiencing housing injustice have stressed that there is a “lack of safe accommodation at all points of the (crisis accommodation) service system” (Murray, 2009, p. 348). Access to crisis accommodation services were typically time and resource-limited, which meant that opportunities for early intervention were lost (Murray, 2009). This study highlighted the clear need for crisis accommodation services to be better funded and resourced to provide “respectful, long-term support that was tailored to individual women’s circumstances” and that also responded to the trauma experienced during and prior to homelessness (Murray, 2009). Furthermore, due to the lack of crisis accommodation services and affordable housing located in Western Sydney many women felt forced to access

services located in urban ‘service hubs’ which are often far away “from their stabilising network of familial and spatial connections” (Robinson and Searby, 2005). The report highlighted “unnecessary compounding of single women’s housing injustice and ‘trauma’ through displacement” (Robinson and Searby, 2005).

Through the women’s refuge movement, feminists have argued against government definitions of ‘homelessness’ which have emphasised being without shelter. The women’s refuge movement argued instead that ‘homelessness’ is one form of violence against women (Flynn et al, 2018). Conceptually, the feminist women’s refuge movement repositions ‘women’s homelessness’ under the more accurate concepts of ‘gendered violence’ and ‘domestic and family violence’.

[Women’s refuge movement and feminist theories of gendered violence:](#)

This section focuses on the emergence of the feminist women’s refuge movement from second wave feminism, which theorised and actioned responses to the intersection between ‘gendered violence’ and housing injustice. The second wave feminist movement in Australia during the 1960s and 1970s was less concerned with the psychological trauma experienced by women and more concerned with the task of dismantling the social, political and economic injustices that subordinated women. Specifically, ending systemic male violence, male entitlement and privilege, rape culture and child sexual assault/child abuse and the economic ‘privileging’ of men over women which permitted the scale of male violence against women and children (McGregor & Hopkins, 1991; Saville, 1982; McFerran, 1990; Laing & Humphreys, 2013). For instance, Qureshi (2013) argues that domestic violence and family violence is comparable to torture and war-trauma due to the “repetition, power and severity” of abuse (p.37). Qureshi (2013) argues that domestic violence should be renamed domestic torture to emphasise the severity and urgency of gender-based violence. Feminist theories of gendered violence also

emerged alongside LGTBIQ social movements which have illuminated the role of homophobia and transphobia in the over representation of transgender women, gender-non-conforming and non-binary identifying people in physical and sexual violence, homicide and housing injustice statistics (Willse, 2015).

The feminist women's refuge movement emerged during the 1970s alongside second wave feminist movements. These movements also challenged forms of systemic and institutionalised sexism such as the gender pay gap and the limited political representation of women and LGTBIQ identifying people (Herman 1992). In an Australian context, women's refuges began to receive Federal government funding in 1975 through the establishment of a national women's refuge program (Murdolo, 2014). This program led to the expansion of the sector beyond the capacity of churches and welfare programs which provided temporary housing to women and their children escaping domestic violence (Murdolo, 2014). Similarly, in a Canadian context, the first women's refuges opened in 1973 (Wathen, Harris, Ford-Gilboe & Hansen, 2014). The women's refuge movement also expanded beyond residential support to include advocacy, crisis telephone support lines (such as rape crisis), short term counselling, domestic and family violence support groups, parental support programs, outreach and follow-up services (Wathen et al, 2014).

The feminist women's refuge movement, while not homogenous or necessarily politically unified (Mueller, 1995), articulated and implemented feminist theory and ways of working with women victims/survivors seeking shelter in the aftermath of domestic and family violence and sexual assault. The feminist refuge movement emphasised:

- 1) The gendered nature of violence
- 2), described the high prevalence of gender-based violence and the impacts of violence
- 3), reframed traumatic 'symptoms' as coping skills
- 4), raised the importance of bearing witness and testimony
- 5), fundamentally critiqued psychiatry (Burstow, 2003 p. 1295).

Ending gendered violence, or more specifically, ending male violence against women and the ideology of the ‘patriarchal, nuclear family’ was and continues to remain, a central objective of the feminist women’s refuge movement (Murdolo, 2014). This movement also identified the need to establish physical safety from violence as the basis for effective responses to victims/survivors of gender-based violence (Herman, 1992).

Similarly, a collaborative international research project evaluating 15 women’s refuges in Ireland, Portugal, and Scotland, identified three key goals of women’s refuges, none of which explicitly referred to trauma informed care or the need to respond to ‘trauma’. The main benefits identified by the authors of this study included: (1) increased women’s and children’s safety; (2) increased survivors’ access to community resources that enhanced their wellbeing; and, (3) empowered women (Sullivan et al., 2008). This study reported that 85% of women ‘felt a lot safer’ and 81% “felt much more protected from the abuser” following a period of 6-12 months staying in the shelter (Sullivan et al., 2008, p.303). Furthermore, 95% of women reported that they felt “a lot or somewhat more confident about their decision-making” (Sullivan et al., 2008, p. 303).

Access to safe and affordable housing and short-term crisis accommodation was viewed as a key strategy in preventing male violence against women. Therefore, the feminist refuge movement was among the first to articulate domestic and family violence and other forms of gender-based violence as the leading cause of housing injustice, homelessness, poverty, physical and psychological injury and early death for women (Bulmiller, 2008).

Some authors have suggested that women’s refuges aimed to be more than institutions for short term housing as they aimed to respond to the impacts caused by gender-based violence and were part of a broader strategy to end male violence against women (Bumiller, 2008; Tripp, Ferree & Ewig, 2013). Women’s refuges were designed to feel like “homes” and were formed through collective action to provide a “safe haven” from male violence and where “women

could exercise their own strength and autonomy outside relationships of domination” (Bumiller, 2008, p.3). Feminist women’s refuges also aimed to be “centres of consciousness raising and were staffed by feminist volunteers” (Bumiller, 2008, p.3). Many staff/volunteers had lived experiences of domestic and family violence and as such there were limited demarcations and divisions between women accessing the services and women working/volunteering at the service. Furthermore, “the shelters often utilised a co-operative and collective structure as opposed to a hierarchical corporate model” (Bumiller 2010, p.4). Therefore, the initial shelter movement could be considered “fundamentally anti-state” in its organisational philosophy, as the State was viewed as being invested in (re)producing a hetero-patriarchal system of women’s oppression and violence against women (Bumiller 2010, p.4).

The feminist refuge movement sought to increase the awareness of violence against women in services working with women. The feminist women’s refuge workers understood the dynamics of abuse and argued that this awareness was critical to reducing the risk that services may inadvertently re-traumatise women victim/survivors by for example (re)producing the imbalance of power experienced by women in abusive relationships and or institutions (Deegan, 1996, Herman 1992).

Criticisms of the Women’s refuge movement:

In a qualitative research project involving 68 directors of women’s shelters based in Ontario Canada, the researchers identified that “differences in service philosophy, including how abuse is defined, influenced decisions about who receives services and the shelter’s role in the broader community” (Wathen et al, 2014, p.125). For instance, the researchers found that some women’s shelter directors distinguished between women who were accessing the shelter as a direct result of ‘abuse’ such as domestic and family violence, and women who were accessing the service due to ‘homelessness’, mental health or alcohol and other drug use (Wathen et al, 2014). This distinction often led to prioritizing shelter support for domiciled women who were

victims/survivors of domestic and family violence over women who were (long-term) 'homeless'. Conversely, other women's shelter directors held the belief that all women experiencing housing injustice and homelessness were likely to be victims/survivors of gender-based violence even if they "may not currently be in abusive situations but have a lifetime history of various kinds of abuse and trauma" (Wathen et al, 2014 p.139). This perspective translated into an attempt to accommodate all women regardless of the specific situations of current or historical gender-based violence (Wathen et al, 2014). However, constraints on resources, such as limited accommodation, often meant that women with immediate risk of current and ongoing violence were prioritised over homeless women with historic experiences of violence or who are at ongoing risk of violence due to living without shelter.

Summary of Section 1:

This section has explored ways 'homelessness' has been conceptualised, defined and measured. This section has highlighted several limitations of 'dominant' theories and ways of measuring homelessness such as the marginalisation of First Nations people's experiences of dispossession and 'spiritual homelessness' and the lack of 'visibility' of women and LGBTIQ identifying people in homelessness statistics. This section also explored the gendered impacts of homelessness and housing injustice in the context of domestic and family violence, child and adult sexual assault and argued that these issues are inextricably linked. The discussion then traced the emergence of the women's refuge movement as a response to both gendered violence and housing injustice. The limitations of the women's refuge movement were briefly explored. The following section, Theories of Trauma, explores the multiple historical, political and conceptual debates surrounding the term 'trauma'.

SECTION 2: Theories of Trauma:

The history of individual and collective human distress, grief and suffering is as lengthy as human history. Approaches to understanding and responding to distress are not universal,

rather they are culturally and historically located (Watters, 2010). The concept of ‘psychological trauma’ in European-Western societies has a relatively short history.

The rise of industrial capitalism was accompanied by large-scale industrial accidents such as ‘railroad accidents’. Railroad accidents were frequent in industrial England and passengers who survived such accidents often experienced acute psychological distress such as nightmares, headaches, anxiety and suicides following the accident (Lembcke, 2013). From the 1850s physicians began to use the term ‘railway spine’ to describe this form of ‘nervous shock’ that effected the emotions but had no overt physical origin (Harrington, 2003).

However, the experience of profound human distress or ‘trauma’, received greater attention within the medical sciences through the psychoanalytic work on ‘Hysteria’ during the late 1880s and 1900s. Sigmund Freud was among the first to codify Hysteria as a psychological rather than physiologically rooted problem (Fassin & Rectman, 2007). Freud (1985), described Hysteria as the ‘conversion’ of psychological distress into somatic symptoms. The somatic symptoms of hysteria were typically marked by vomiting, anxiety, insomnia, muscle spasms and ‘seductive behaviour’ (Freud, 1895). The term ‘Hysteria’ is derived from ‘hystera’, the Greek word for uterus (Bogousslavsky, 2014). It was thought that the Hysterical physical and emotional ‘symptoms’ were caused by disturbances of the womb. Specifically, in the ‘hysterical patient’ the uterus was thought to dislodge and move around the female body (Micale, 2008). Men were also considered to be ‘susceptible’ to Hysteria, however it was primarily conceptualized as the “archetypal psychological disorder of women” (Herman 1992, p.9). Early psychologists and psychiatrists believed that women were more likely to become Hysterics and that men were more likely to become Hypochondriacs (Micale, 2008). However, while Hypochondria was considered to be a nervous illness it did not throw the rationality of the sufferer into question as did Hysteria. These gendered diagnoses were political; during the 1700s and 1800s, patriarchal power was reinforced through the construction of middle-class,

bourgeois, men as ‘civilized and rational’ and therefore of women as inherently “irrational and uncivilized” (Micale, 2008 p.280). For example, Charcot (1892), believed that all women were innately susceptible to Hysteria, and as such required continual surveillance, monitoring and treatment by their husbands and the medical establishment.

Charcot (1892) was influenced by the early work on ‘railway spine’. He hypothesised that the roots of Hysteria were grounded in responses to ‘traumatic events’ (Bogousslavsky, 2014; Fassin & Rectman, 2007). Charcot (1905) also believed that the initial shock caused by a traumatic event would be followed by a period of dormancy eventually leading to a delayed emergence of ‘Hysterical symptoms’ and psychological disturbances. Pierre Janet (1887) extended Charcot’s idea by hypothesising that ‘traumatic neurosis’ in adulthood was caused by early, external, traumatic events experienced during childhood (Fassin & Rectman, 2007). Janet (1887) was also among the first of his peers to describe ‘dissociation’ following traumatic events (Van Der Hart & Dorahy, 2006). These views challenged the prevailing view that psychological disturbances originated from purely physiological conditions – such as the gynecological determinism which attributed an ‘innate’ pathology to women’s reproductive organs. Freud initially hypothesized in his ‘seduction theory’ that the sexual assault and specifically child sexual assault, were antecedents of Hysteria in women (Freud, 1985). Freud was the first of his peers to name ‘sexual abuse’ of children under the age of ten as the primary cause of Hysterical symptoms in adulthood:

In some eighteen cases of hysteria I have been able to discover this connection (child sexual assault) in every single case and, where the circumstances allowed, to confirm it by therapeutic success. (Freud, 1896, p.199)

This represented a significant departure from the narratives used by Freud’s predecessors and contemporaries. For instance, while most of Charcot’s ‘Hysterical patients’ were poor and working-class French women (Bogousslavsky, 2014), Charcot did not ascribe any meaning to

the role of social location, poverty and gender-based violence in his accounts of Hysteria. Yet, Charcot's *Clinical Lectures on Certain Diseases of the Nervous System* (1888), contains multiple transcripts of women who describe being repeatedly sexually assaulted, physically and psychologically tortured by their fathers, brothers and husbands. Despite this, Charcot maintained a focus on 'symptomology' which subsumed any concern for the political context of violence against poor and working-class women (Bogousslavsky, 2014).

Freud's suggestion that many parents and carers perpetrate sexual assault against their children outraged Venetian society (Herman, 1992; Mason, 1984). Freud was ostracised by *the Society for Psychiatry and Neurology* in Vienna following the delivery of his paper *The Aetiology of Hysteria* in 1896 (Mason, 1984) in which he presented the argument that sexual assault during childhood caused the presentation of Hysteria in adulthood (Herman, 1992). This paper was the basis of Freud's 'seduction theory' (Mason, 1984).

Amid pressure from his contemporaries, Freud disavowed his 'seduction theory' in favour of the 'fantasy theory' and the 'intra-psychic conflict' model. In the revised 'fantasy theory' Freud proposed that children initiate sexual contact with their parents and care-givers and treated any reports of sexual violence as mere sexual fantasies (Mason, 1984; Herman, 1992). By repudiating the original seduction theory, Freud and his colleagues reinforced the endemic social denial of violence against women and children (Herman, 1992). Freud's disavowal of the widespread reality of violence against women and child sexual assault not only silenced victims/survivors, but also firmly entrenched the study of 'trauma' within the paradigm of psychiatry. For many subsequent decades, up until the emergence of feminist and women's refuge movements, psychiatric discourses disavowed gendered violence, seeking to 'treat' human distress and 'trauma' with behavioural and drug-based therapies. As will be argued in this thesis, the refusal to view the centrality of gendered violence and child sexual assault continues to influence discourses on 'trauma' today.

Shell Shock and the Psychiatric framing of trauma from the Diagnostic and Statistical Manual (DSM) to neuroscience

Evidence of “intense psychological duress” following war-combat trauma has been traced, “as far back as the seventeenth century, and the mental effects of battle on combatants were recognized even during biblical times” (Montgomery 2017, p.28). However, the interest in ‘treating’ veterans from the two World Wars and Vietnam is considered to be a uniquely Modern phenomenon inextricably linked to the development of the post-Enlightenment era medical model and Western psychiatry (Montgomery, 2017). Accounts documenting the distress of returned veterans from these wars frequently describe; nightmares, reliving specific atrocities from the battlefield, motor paralysis, mutism, loss of memory, ongoing emotional distress and suicidal thoughts and behaviours (Herman, 1992). Civilian victims/survivors of wars have also described the ongoing psychological effects in the aftermath of genocide and mass violence. For instance, Frankl (1946), a Jewish survivor of the Holocaust and psychiatrist argued that survivors of the concentration camps and forced labour suffered upon their release from 1) disillusionment 2) bitterness 3) feeling estranged from and misunderstood by those who did not have shared experiences of atrocities 4) a tendency to perpetrate violence against others where “they became instigators, not objects, of wilful force and injustice. They justified their behaviour by their own terrible experiences” (Frankl, 1947, p.97).

The psychological distress and behaviours of war veterans and civilian survivors resembled the women who were labelled as Hysterical (Wilkin & Hillock, 2014; Herman, 1992). The association between Hysteria, women, the poor and working classes, facilitated the social construction of psychological ‘trauma’ as a sign of moral weakness and of perversion (Mosse, 2000). This meant that veterans of the First World War and the Second World War were

viewed “at best as constitutionally inferior human beings and at worst, as malingers and cowards” (Herman, 1992 p.20).

Echoing the old ‘railway spine’ theories, ‘combat neurosis’, ‘barbed wire sickness’ or ‘shell shock’ were initially viewed by Western doctors as an illness resulting from a physical injury, specifically from concussion following exploding mortars (Herman, 1992). However, this view was disputed as evidence for the correlation between physical injury and psychological distress could not be found (Herman, 1992). The apparent psychiatric causation of long-term veteran’s distress and high rates of self-harm and suicide intensified debate over the masculinity and moral character of veterans (Mosse, 2000; Wilkin & Hillock, 2014). The prevailing view during the early half of the twentieth century was that “war was the supreme test of manliness, and those who were the victims of shell-shock were thought to have failed this test” (Mosse, 2000 p. 104). It was only following the mass anti-war social movements and broad public condemnation of the Vietnam War in the mid-1970s that the psychological impacts of war gained recognition and legitimacy among the medical and emerging psychiatric professions (Herman, 1992).

In 1980, the American Psychiatric Association categorized Post Traumatic Stress Disorder (PTSD) among the anxiety disorders in the Diagnostic and Statistical Manual III (DSM-III). Under this initial categorization, PTSD was said to be caused by ‘stressors outside the range of normal human experience’ (American Psychiatric Association, 1980). Thus, traumatic events were distinguished from ‘commonplace misfortunes’ as they were thought to “involve threats to life or bodily integrity or a personal encounter with death’ that ‘overwhelmed the ordinary systems of care that give people a sense of control, connection and meaning” (Herman 1992, p.33). Subsequent editions of the DSM abandoned the criteria of external stressors beyond the ‘normal human experience’ in part due to a feminist analysis which drew attention to the high

prevalence of extreme violence and harassment experienced by women in their everyday lives including; the workplace, public spaces and in the family home.

The current edition of the DSM, the DSM, V, categorises traumatic events as an ‘exposure to actual or threatened a) death, b) serious injury, or c) sexual violation’ (American Psychiatric Association, 2013). The DSM-V states that an individual may develop PTSD by experiencing a traumatic event directly or indirectly, for instance by; 1) witnessing another person or group experience a traumatic event; 2) learning that a close friend or relative was subjected to a traumatic event; 3) experiencing repeated or extreme exposure to aversive details of a traumatic event (American Psychiatric Association, 2013). The most recent edition of the DSM, volume 5, (2013), describes four main ‘symptom clusters’ associated with PTSD, including: Numbing, Avoidance, Re-experiencing, Hyperarousal and Hypervigilance (American Psychiatric Association, 2013). These traumatic ‘symptoms’ may last from a few days to weeks, and for some, these ‘symptoms’ have been reported months, years and decades following the traumatic event(s).

Within the biomedical literature, post-traumatic ‘symptoms’ have been associated with the development of a range of psychiatric disorders such as; depressive disorders, anxiety disorders, eating disorders, somatoform disorders, substance use disorders, and personality disorders (Satyanarayanaa, Chandraa & Vaddiparti, 2015). The experience of overwhelming ‘helplessness and terror’, has been described as the first ‘symptom’ that precipitates trauma related ‘disorders’. The experience of helplessness and terror has also been described as the most “salient characteristic of a traumatic event” (Herman, 1992 p.34). However, Ross (2007), contends that some victims/survivors of traumatic events may not experience intense ‘fear, helplessness or horror’ but may instead experience one or more of the following ‘symptoms’: “numbing, detachment, absence of emotional responsiveness, a reduction in awareness of his or her surroundings, de-realisation, de-personalisation or dissociative amnesia and depression”

(Ross, 2007 p.60). These initial symptoms are usually followed by a combination of the following more complex, secondary ‘symptoms’ which have different presentations and features to those described during the traumatic event. These symptoms include: “flashbacks (re-experiencing of the traumatic event), avoidance of trauma reminders, numbing, hyperarousal and sleep difficulties” (Stark, Parsons, Van Hartevelt, Charquero-Ballester, McManners, Ehlers, Stein & Kringelbach, 2015, p.207) and depression (Ross, 2007). The association between health problems and ‘trauma’ will be explored in further detail in the ‘public health and psychology literature on the somatization of trauma’ section of this review.

Criticisms of PTSD and the inclusion of CPSTD:

The inclusion of PTSD in the DSM received initial criticism from psychiatrists and psychologists (Brewin, 2013). The focus on mental distress caused by external events challenged the Western psychiatric narrative that mental illness is caused by combinations of bio-chemical imbalances, physiological and neurological abnormalities. Furthermore, as PTSD encompasses a range of psychiatric diagnoses (e.g. depression, anxiety, personality disorders), some critics have argued against an independent category for PTSD (Lembcke, 2013). However, the experience of traumatic ‘flashbacks’ warranted the inclusion of a separate diagnostic category as flashbacks had not been accounted for under any existing psychiatric diagnosis (Lembcke, 2013).

The category of PTSD has also been criticized as there is no definitive list of traumatic stressors or events known to cause PTSD. Similarly, while there are strong associations between PTSD and traumatic experiences such as sexual assault, war and refugee trauma, the threshold of ‘exposure’ to a traumatic event(s) has not been quantified. However, Ross (2007) argues that this is a ‘technical problem’ and that psychometric tools such as the Dissociative Experiences Scale can be used to assess the degree and severity of trauma dosage, which may include:

Age at onset, duration, number of acts, number of perpetrators, degree of intimidation, threats and violence, degree of intimidation, bizarreness of acts, how closely related the perpetrator is to the victim, whether the victim is dependent on the perpetrator for basic care and survival, secrecy of acts, and combination of the sexual abuse with other forms of trauma (Ross, 2007, p.64).

The concept of ‘trauma dosage’ aims to facilitate an objective measure of the correlation between the severity and frequency of ‘trauma dosage’ and the development and presentation of psychiatric illnesses including serious mental illnesses, personality and anxiety disorders. However, it is also possible for a group of people to be subjected to the same traumatic event or ‘dosage’ and for these individuals to experience a diverse range of traumatic reactions/symptoms (Ross, 2007). The lack of uniformity in the experience and expression of post traumatic reactions has prompted some psychologists and psychiatrists to view reactions to ‘trauma’ as inherently subjective (Ross, 2007) and mediated by cultural and social meanings (Watters, 2011). As such, ‘trauma’ may best be understood as a “complex interaction of external events” and the “physiological and psychological responses to them” (Ross, 2007 p.61). However, while trauma is a subjective experience, some feminist psychologists and psychiatrists have agitated for the specific impacts of repeated and systemic gendered violence to be recognized by medical and psychiatric fields.

Many feminists have vehemently opposed the use of biomedical and psychological perspectives to describe gendered violence. However, a fundamental critique of biomedical and psychological discourses is not universally shared across all who identify as feminist. For example, Herman (1992), argues that the psychological trauma caused by gender-based violence, is comparable to the psychological distress and ‘trauma’ soldiers and civilians’ victims/survivors of war and conflict. Feminist psychiatrists have argued that the category of PTSD is insufficient and have historically campaigned for the inclusion of Complex Post

Traumatic Stress Disorder in the DSM IV and V (Herman, 1992). Complex Post-Traumatic Stress Disorder (CPTSD) was included under the PTSD category in the Diagnostic and Statistical Manual IV. The inclusion of CPTSD aimed to provide a more accurate diagnosis and acknowledgement of repeated and cumulative exposure to traumatic incidents, for instance; child and adult sexual assault, abandonment and neglect, domestic and family violence, gendered experiences of genocide, war, torture and slavery (Courtois, 2008). CPTSD is defined in the DSM V as the prolonged and repeated exposure to traumatic events (American Psychiatric Association, 2013). The repetition of traumatic events distinguishes CPTSD from the single incident PTSD. The ‘symptoms’ of CPTSD incorporate the descriptions of ‘symptoms’ associated with PTSD, with the addition of seven areas of ‘impairment’; 1) alterations in the capacity to regulate emotions 2) alterations in consciousness and identity (i.e. dissociation and memory difficulties) 3) alterations in self-perception (such as feeling guilt, helplessness, feeling inherently bad or different), 4) alterations in perception of the perpetrator 5) somatization 6) alterations in perceptions of others 7) alterations in systems of meaning (American Psychiatric Association, 2013).

The broad acceptance of PTSD and C-PTSD as psychiatric diagnoses have been hailed by some feminists and victims/survivors as victory as this categorization is seen to legitimise the profound, often life-long effects of domestic and family violence and child sexual assault. However, as will be explored in the following section, the psychiatric construction of trauma has also been criticized for de-politicizing violence and the impact of violence and for therefore failing to intervene in the perpetration of gendered, racialized and classed violence (Burstow, 2003). This genealogy will return to feminist critiques of psychiatric and psychological constructions of trauma. However, the following section will trace the field of neuroscience and neuro-plasticity and the (re)construction of psychological trauma as a form of brain injury.

The Neuroscience of Trauma:

Since the introduction of Positron Emission Tomography (PET) and functional Magnetic Resonance Imaging (fMRI), technology in the 1990s, researchers have attempted to chart the impacts of trauma on the neuroanatomy and neurochemistry of the brain (Stark et al, 2015; Glover, Phifer, Crain, Norrholm, Davis, Bradley, Ressler & Jovanovic, 2011; Van Der Kolk, 2006; Karl, Schaefer, Malta, Dörfel, Rohleder & Werner, 2006). Although the empirical data for the neurological bases for PTSD and CPTSD are inconclusive, it is hypothesized that repeated stress and trauma can lead to permanent changes in brain structure and function including; hyperactive amygdala, hippocampus, atrophy, and reduced regulatory control (Stark et al, 2015).

The neuroscience discourse challenges the Enlightenment era Cartesian split (the belief that mind and body are fundamentally separate), by suggesting that the impact of trauma not only belongs to the immaterial mind (human psychology), but also re-orientes neural circuitry. In other words, for neuroscientists, psychological trauma is in fact a form of physical brain injury. For instance, stress appears to affect neurological functioning and anatomy regardless of whether an individual develops PTSD ‘symptoms’ or not (Stark et al, 2015). A meta-analysis of Functional Magnetic Resonance Imaging (fMRI) studies reported that there is strong evidence to suggest that individuals who do not have PTSD, yet have been ‘exposed’ to a traumatic event, show changes in cognition and neuro-anatomy (Stark et al, 2015).

Exposure to a traumatic event is associated with the hyperactivity of the amygdala in the subcortical region of the brain and this is considered to be a neurobiological antecedent to anxiety disorders including social anxiety and panic disorders (Forster, Novick, Scholl & Watt, 2012). Neuroscientific research has also demonstrated through fMRI scans, how specific cues such as sights, sounds and smells reminiscent of sensory experiences at the time of the traumatic event could ‘trigger’ reactions in victims’/survivors’ brains (Van Der Kolk, 2014).

When ‘triggered’ by specific stimuli, victims/survivors’ brains “react as if the traumatic event were happening in the present” (Van Der Kolk, 2014, p.45). This ‘re-experiencing’ of trauma within the brain is expressed in the body with an elevated heart rate and blood pressure, increased cortisol and adrenaline (Van Der Kolk, 2014).

There is speculation as to whether atrophy of the hippocampus is related to the severity of trauma experienced by the victim/survivor, whereby prolonged and repeated exposure to trauma results in a smaller than average hippocampus (Conrad, 2009). Atrophy of the hippocampus is implicated in memory difficulties, intrusive thoughts, mood disorders (Conrad, 2009), “attention problems, irritability and sleep disorders” (Van Der Kolk, 2014, p.46). This is reinforced by people diagnosed with PTSD who report deficits in declarative memory and who experience dissociative amnesia (Bartsc, 2012). A primary implication of this research is that people previously exposed to a traumatic event may be more ‘susceptible’ to developing PTSD following secondary traumatic events.

[Psychological Perspectives: Trauma in the mind and body:](#)

A broad range of psychological theories have been employed to theorise ‘trauma and recovery’ (Herman, 1992) and the assessment of trauma, such as Attachment Theory, Psychodynamic and Psychotherapeutic Theories and Cognitive-Behavioural, Dialectical-Behavioural Formulations of PTSD and CPTSD, and sensory-motor therapies. It is beyond the scope of this review to provide a discussion on the available psychological trauma ‘treatments’ and ‘interventions’ such as (although not limited too); hypnosis, Eye Movement Desensitization and Reprocessing (EMDR), Cognitive Processing Therapy (CPT), Cognitive Behavioural Prolonged Exposure (PE), Stress Inoculation Training (SIT), psychotherapy and pharmacological therapies. It is important to emphasise, that from the available evidence, none of the approaches and treatments listed above are effective for all people with post-traumatic stress (Ehring et al, 2014). There is acknowledgement from the field of psychology, that trauma

leaves “an imprint so indelible” and subjective that it is “immutable by current methods” (Shalev, Omer & Eth, 1996, p.178).

Psychological literature augments the psychiatric and bio-medical theorisations of PTSD and CPTSD. However, psychological trauma theories and psychological ‘interventions’ are not necessarily unified. Psychological literature tends to focus on ‘interventions’ and ‘strategies’ to assist victims/survivors to reduce post-traumatic ‘symptomatology’. A significant body of psychological trauma literature has been devoted to psychotherapy and other forms of ‘talk therapy’, encouraging victims/survivors to ‘talk through’ their traumatic experience(s) as a way of developing understanding and meaning. For instance, Cognitive Behavioural Trauma Therapy aims to reduce the phobic traumatic reactions experienced by victims/survivors by encouraging the retelling the ‘trauma story’ (Moloney, 2013). According to this theory, victims/survivors gain mastery over the traumatic memory such that they no longer experience traumatic ‘symptoms’ (Moloney, 2013). However, some critical literature indicates that this method can also ‘retraumatise’ victims/survivors resulting in a worsening of ‘symptoms’ (Lee, 2017). Recent neuroscientific research suggests that ‘talk-therapy’ such as psychotherapy, may not be useful for people with PTSD and CPTSD as the region of the brain, related to speech and communication, is affected by traumatic experiences (Michopoulos, Norrholm, & Jovanovic, 2015). Furthermore, First Nations trauma theorists have criticised Western psychological interventions for their emphasis on individual recovery from isolated incidents (Kirmayer, Simpson & Cargo, 2003). As will be explored in a subsequent section, First Nations trauma theorists have argued that the “treatment of mental health problems as well as prevention and health promotion among Aboriginal peoples must focus on the family and community, (not the minds of individuals), as the primary locus of injury and the source of restoration and renewal” (Kirmayer, Simpson & Cargo, 2003, p.21). Western psychological

trauma theories and interventions have also been criticised for colonising First Nations peoples and for marginalising First Nations centred healing and cultural practices (Clark, 2016).

Public health and psychology literature on the somatization of trauma:

Drawing from psychiatric, psychological and neuroscientific literature, public health literature tends to emphasise the physical and psychological ‘symptoms’ of trauma. However, public health literature tends to focus on epidemiological issues such as the prevalence of trauma symptoms and ‘traumatised’ populations. Public health literature has explored correlations between psychological trauma and the emergence of physical illness and psychiatric ‘disorders’ (Frueh, Grubaugh, Cusack & Elhai, 2009), drug and alcohol use (Schaumberg, Vinci, Raiker, Mota, Jackson, Whalen, Schumacher, & Coffey, 2015), suicide ideation and self-harm (Weiss, Dixon-Gordon, Duke, & Sullivan, 2015; Harned, Korlund, Foa, & Linehan, 2012), homelessness (Zabkiewicz, Patterson & Wright, 2014; Donovan, & Shinseki, 2013), under and unemployment (Kimerling, Alvarez, Pavao, Mack, Smith & Baumrind, 2009) and patterns of service usage (Belleville, Marchand, St-Hilaire, Martin, Silva, 2012; Grubaugh, Magruder, Waldrop, Elhai, Knapp & Frueh, 2005).

Traumatic events experienced in childhood and adolescence are regarded as one of the primary social determinants of health and wellbeing across the life course (Rich, Corbin, Bloom, Rich, Evans, & Wilson, 2009). Results from the longitudinal Adverse Childhood Experiences (ACE) Study, involving approximately 17,000 participants who volunteered health data between 1995 and 1997, suggests that having five or more traumatic experiences in childhood significantly increases the risk of self-harm and suicide, homelessness, risk taking behaviours including drug and alcohol use, early involvement in the criminal justice system, chronic physical and mental health problems and gambling (Ferlitti, 2002).

Public health literature has also focused on the correlations between PTSD and a range of specific medical concerns. For instance, Pacella, Hruska, & Delahanty, (2012) identify the following medical and health concerns with PTSD:

- 1) Gastrointestinal health problems; irritable bowel syndrome, ulcer, vomiting, and constipation/diarrhoea,
- 2) Cardio-respiratory problems; angina, heart disease, shortness of breath, asthma,
- 3) General Health concerns; nausea, constipation, angina, shortness of breath, dizziness, fatigue, headache, and back ache and,
- 4) Chronic pain problems; headaches/migraines, fibromyalgia and arthritis (Pacella, Hruska, & Delahanty, 2012). However, it is not clear whether health problems associated with PTSD and CPTSD are caused by chronic stress and allostatic load (Danese & McEwan, 2012) or caused by the emotional and psychological problems which may lead to use of alcohol and other drugs (Maté, 2008) and poor diet (Ross, 2007).

Public Health literature concerning domestic and family violence and women's homelessness typically draws from biomedical and psychiatric definitions and understandings of trauma (Modi, Palmer & Armstrong, 2014). The disciplinary concern for prevalence, demographics and impacts produces a quantitative representation of the impacts of trauma. Furthermore, public health literature tends to use gender neutral language such as 'intimate partner violence', 'inter-personal violence'. Conversely, feminist Social Work literature (to be discussed in the following section), often emphasises gendered dynamics in domestic and family violence and sexual assault through the terms; 'male violence against women and children' and 'gendered violence'. The following public health study exemplifies the impacts of gender neutral language and gender-neutral perspectives in framing responses to domestic and family violence and 'trauma'. Peters, Khondkaryan and Sullivan (2012), published a study exploring the

relationship between CPTSD in the context of ‘intimate partner violence’ and drug and alcohol use. The authors reported that 81% of victims/survivors of domestic and family violence had ‘post-traumatic symptoms’ meeting the criteria for PTSD. These authors reported that victims of domestic violence are more likely to increase the frequency and level of their alcohol and drug use as the severity of abuse increases (Peters, Khondkaryan & Sullivan, 2012). Furthermore, it was reported that PTSD symptoms could be controlled through a reduction in drinking and drug use. This study framed ‘trauma’ within biomedical and psychological discourses. The influence of the psychiatric and psychological trauma discourses prompted the authors of this study to position the management of trauma symptoms over responding to gendered violence in the ‘management’ of alcohol and other drug use.

[Decolonizing psychological trauma: First Nations theoretical perspectives](#)

The concept of ‘trauma’ has been extensively theorised by First Nations peoples, post-colonial theorists and activists. However, First Nations theories of ‘trauma’ generally extend beyond biomedical, psychiatric and (white-Western) feminist theories of trauma. Specifically, First Nations activists and theorists have focused on describing the collective and cumulative ‘traumatic’ impacts of invasion, dispossession, genocide, frontier wars, slavery, permanent settler-colonisation, assimilation and systemic and institutionalized forms of racism (Kirmayer, Gone & Moses, 2014).

The trauma of colonisation has been described as having four primary features:

- 1) Colonial Injury: As previously mentioned, the concept of colonial injury encompasses all colonial, state-based violations committed against First Nations peoples and their lands from invasion to the present day. In an Australian context the impact of colonisation on Australian First Nations peoples has been described as severing connections to Kanyini, to Ngura, the

land; Walytja, kin/family; Tjukurrpa, culture and belief systems; and Kurunpa, spirituality (Randall, 2003).

2) Collective Experiences: First Nations peoples share collective experiences of colonisation and experiences of collective resistance and resilience (Kirmayer, Gone & Moses, 2014). These shared experiences have profoundly shaped contemporary First Nations peoples' identities, languages, cultures and social structures.

3) Cumulative effects: This describes the intensification of psychological, emotional and spiritual 'trauma' through successive social policies and practices adopted by dominant settler societies (Kirmayer, Gone & Moses, 2014). The cumulative impacts of 'trauma' include although are not limited to: assaults and murders of First Nations People in custody; experiences of systemic and institutionalised racism; racist representations and stereotypes of First Nations people in the media; the over representation of First Nations children in foster care homes and in Juvenile Justice, high incarceration rates of First Nations adults. Continued exploitation, dispossession and contamination of First Nations peoples home land including; mining, uranium waste dumping and commercial farming.

4) Cross-Generational Impacts: The concept of 'cross-generational impacts' or 'intergenerational trauma' has been frequently used by First Nations peoples to describe the psychological trauma "within and across generations" (Atkinson, Nelson, Atkinson, 2010, p.138). Intergenerational trauma is also a concept used to describe the impacts of colonisation specifically on subsequent generations who are thought to 'inherit' the impacts of trauma from family member survivors. For instance, 'intergenerational trauma' is offered as an explanation for "the high prevalence of grief, loss and substance misuse" in First Nations communities in Australia and in Canada (Atkinson, Nelson, Atkinson, 2010, p.135). These impacts arise not only from the "cumulative trauma" associated with early colonisation and genocide, but also from ongoing systemic and institutionalized racism (Kirmayer, Gone & Moses, 2014 p. 301).

In an Australian context, First Nations survivors of the Stolen Generations experience significantly higher rates of depression and other mental health problems, self-harm and suicide as compared with non-First Nations people who were not subjected to the same genocidal social policy (Human Rights Commission, 1997). Similarly, in a Canadian context, the Residential School system caused ‘permanent damage’ to hundreds of thousands of First Nations, Métis and Inuit people (Truth and Reconciliation Commission of Canada, 2015). For over a century beginning in 1884, First Nations, Métis and Inuit children were compulsorily apprehended by Canadian state welfare officials and members of the Church and held captive in residential schools. Akin to the compulsory removal of First Nations children in Australia during the Stolen Generations, the aim of the Canadian residential schools was to assimilate First Nations people into the white colonial societies and to ‘eliminate’ First Nations languages, cultures and peoples (Truth and Reconciliation Commission of Canada, 2015). As such, both the government policies that gave rise to the Australian Stolen Generations and the Canadian Residential Schooling systems meet the United Nations criteria for genocide. The long-term and ‘intergenerational’ impacts of the Residential Schools on survivors also parallels the survivors of Stolen Generations; significant loss of First Nations history, languages, cultures, poor educational and health outcomes, including reduced life expectancy in comparison with privileged settler-colonial populations (Atkinson, Nelson, Atkinson, 2010). Sexual and gender-based violence were primary genocidal weapons used by the British to suppress the resistance of the First Nations people (Elder, 1988). Sexual assault was also used in a campaign aimed at the forced assimilation of First Nations people, including their children, into the settler colonial society’s system of heteropatriarchal private property relations (Smith, 2002).

However, some First Nations people have also criticised the use of concepts such as ‘trauma’ and ‘intergenerational trauma’ to describe the state-enforced and sanctioned violence against First Nations people. The trauma discourse within biomedical literature has been criticized by

First Nations people for depoliticising and de-historicising genocide, colonisation, assimilation, systemic racism and dispossession (Visser, 2015). Furthermore, Cindy Blackstock, a member of the Gitksan Nation, argues “it is not trauma, it is oppression” (Blackstock, 2014). Furthermore, Blackstock (2014) argues that the discourse of ‘trauma’ and ‘intergenerational trauma’ shifts attention away from the realities of ongoing colonial occupation and systemic racism to a focus on individuals and communities who are ‘traumatised’ (Blackstock, 2014). The construction of First Nations peoples as ‘traumatised’ positions First Nations peoples as potential subjects for ongoing state-based interventions and surveillance (Blackstock, 2014). Similarly, Clark (2016b) argues that the trauma discourse facilitates a (re)colonisation of First Nations health and communities as:

A focus on trauma as an individual health problem prevents and obscures a more critical, historically-situated focus on social problems under a (neo)colonial state that contributes to violence (Clark, 2016b, p.3).

Clark (2016a; 2016b) also argues that the trauma discourse legitimises intrusive state-based surveillance and medical/psychiatric interventions to justify the ongoing removal of First Nations children and young people from their families, communities and land. Therefore, psychiatric and psychological theories of trauma are regarded as a form of psychiatric colonisation (Watters, 2011). Watters (2011) argues that the concept of trauma and PTSD among other diagnostic categories within the DSM IV and V has become a colonising global discourse profoundly altering unique cultural meanings and responses to distress.

Post-colonial trauma literature often uses the term ‘historical trauma’ to describe the ongoing negative psychological and health effects of colonisation. However, as settler colonisation is a continuous and ongoing occupation, many First Nations activists and theorists have argued that colonisation cannot be considered, merely ‘historical’ (Kirmayer, Gone & Moses, 2014). The trauma of colonisation has also been compared with ‘war-trauma’. The language of ‘war

trauma' has assisted in emphasizing the serious harm caused by colonial state violence. This language also affirms that First Nations peoples in both 'Australia' and 'Canada' were engaged in armed resistance to the colonial invaders who were perpetrating mass sexual assault and massacres of First Nations peoples. In Australia this war is known as the 'Frontier Wars' (Reynolds, 2013). However, mirroring the critique of 'historical trauma', the concept of 'war trauma' does not adequately encompass the ongoing colonisation and ongoing war against First Nations peoples (Reynolds, 2013).

First Nations theorists and activists have called for 'trauma theory' to be decolonized (Dudgeon & Walker, 2015; Smith, 2014; Herring, Spangaro, Lauw & McNamara, 2012; Pollack, 2012; Gone, 2010; Benabed, 2018; Nelson, 2007). An anti-colonial or 'decolonising trauma theory' may encompass a rejection of Western discourses including psychiatry and white Western feminism (Visser, 2015). Many First Nations, feminist and critical/anti-psychiatry activists and theorists have adopted a focus on victim's/survivor's resistance and resilience in preference to the hegemonic psychiatric and psychological focus on trauma (Coates & Wade, 2007). A decolonizing trauma theory also resonates with the development of theories of Cultural Safety, First Nations worldviews and First Nations specialist 'trauma' workers (Herring et al, 2012). The concept of cultural safety will be further explored in the Principles of Trauma Informed Care Section.

[Feminist critiques of psychological and psychiatric trauma theories:](#)

What distinguishes feminist literature from biomedical literature is a focus on social, political and economic systems which perpetrate and sanction violence against women. Feminist commentators have critiqued biomedical (re)conceptions of gendered violence (Burstow, 1992), and presented new frameworks for conceptualizing and responding to 'trauma'. Feminist authors have also criticized the medicalization of human distress for universalizing and therefore limiting the range of possible human reactions within the psychological 'trauma'

paradigm and that of the medical model (Fassin & Rectman, 2007). For instance, dominant psychiatric texts such as the *Comprehensive Textbook of Psychiatry* (1974) claimed that child sexual assault is “is extremely rare and does not occur in more than 1 out of 1.1 million people” (Freedman & Kaplan 1974 cited in Van Der Kolk, 2014, p.188).

The biomedical ‘symptom/treatment’ model has been criticised for misrepresenting racialized, classed and gendered injustices as pathological anomalies located within the minds and bodies of individuals (Watters, 2011). Feminists argue that this misrepresentation occurs through the emphasis on the ‘impacts’ and ‘symptoms’ of trauma and the construction of trauma within a disease model (Tseris, 2013). If ‘trauma’ is primarily understood to be a psychological illness, disorder or neurological impairment, this centres both analysis and intervention around the reduction and management of individual post-traumatic stress symptoms or neurological changes. Therefore, the focus on ‘trauma symptomology’ obscures gendered, racialized and classed forms of violence and structural oppression.

Sontag (1978), in her work exploring Western, socio-cultural narratives concerning cancer and HIV/AIDS, argues that ‘Christianity imposed moralized notions of disease’ and this has given rise to the myth of modern disease in which the individual is responsible for their own disease. For Sontag, the ‘fit’ between disease and ‘victim’ gradually evolved, becoming inseparable, “diseases and patients become subjects for decipherment” (Sontag, 1978 p.48). In the context of violence against women, women have been historically blamed for inviting violence and, through the disease model of trauma, victims/survivors are tasked with managing their psychological recovery as the “cure is thought to depend on the patients sorely tested capacity for self-love” and “self-discipline” (Sontag, 1978 p.48).

Coates and Wade (2007) argue that the psychological and psychiatric literature has been utilized to conceal violence, minimise perpetrator responsibility and blame victims. For instance, PTSD has been described as “a failure to physiologically adapt to stressors and

reminders of stressors, such that the long-term activation of the stress pathways” (Pacella, Hruska, & Delahanty, 2012, p.34). The language of failure, within a biomedical context, arguably confers blame on the survivors. Similarly, the Self-defeating and Masochistic personality disorder, which appeared in the DSM-III-R (1987), exemplifies this trend in misdiagnosing gendered violence. The criteria for this disorder was:

A pervasive pattern of self-defeating behaviour, beginning by early adulthood and present in a variety of contexts. The individual may often avoid or undermine pleasurable experiences, be drawn to situations or relationships in which he or she will suffer and prevent others from helping him or her (American Psychiatric Association, 1987).

Up until 1994, this diagnosis was cited in the DSM. Feminist authors have argued that this diagnosis made women responsible for gendered violence “by seeing their ills as a function of their character; a fundamental masochism coupled with promiscuity, for instance, would be said to elicit violence from the male” (Appignanesi, 2008 p.481). Similarly, the Borderline Personality Disorder (BPD) diagnosis has also received significant criticism from feminists and victims/survivors. Much like Hysteria, Borderline Personality Disorder is a psychiatric label that is more frequently applied to women than men. Women in the United States are 75% more likely to receive this diagnosis than men (Ducsay, 2015). Evidence suggests that there is a strong association between women who have received a Borderline Personality Disorder diagnosis and experiences of violence, abuse and neglect (Pico-Alfonso, Echeburúa, & Martinez, 2008). This empirical and practice data has prompted feminists to argue that BPD be re-conceptualised as Complex PTSD (Herman, 1992), a position that has been criticized as the experience of Complex Trauma does not always result in BPD ‘symptoms’ (MacIntosh, Godbout & Dubash, 2015).

Feminist 'trauma informed' Social Work:

The Social Work literature on 'trauma' is eclectic drawing from a range of concepts including; psychiatry, psychology, neuroscience, public health and feminist and First Nations perspectives and the women's refuge movement against male violence. The Social Work discipline's commitment to social justice and human rights as outlined in the *International and Australian Social Work Code of Ethics*, perhaps accounts for the tendency for social work literature, in contrast to biomedical and public health literature, to emphasise the socio-political context of 'trauma'. For instance, Wilkin and Hillock (2014), argue that "categories of social inequality are created and maintained through structural and interpersonal oppression that often takes the form of violence, abuse, exploitation, exclusion and humiliation. These experiences are frequently referred to as trauma" (Wilkin & Hillock, 2014 p. 184).

Feminist social workers argue that violence against women should not be viewed as unfortunate, isolated incidences of violence perpetrated by one person against another (Radford, Kelly, & Hester, 1996) but rather, as a "social and collective problem that reflects the unequal gender power relations in patriarchal societies" (Damant et al, 2008 p.124). The translation of these political feminist perspectives into social work practice with women and children who are victims/survivors of violence and homelessness has become an accepted practice framework and core learning objective in qualifying social work degrees (Laing & Humphreys, 2013). Similarly, Wilkin and Hillock (2014) argue, "social work students and new practitioners would benefit from theoretical and practical education on trauma symptoms and the connection between trauma and oppression" (p.185). In this context, the focus on the 'impacts' of 'trauma' and 'trauma theory' are mobilised strategically to encourage "practitioners take into account the emotional problems that ensue from women's exposure to trauma" (Tseris, 2013 p.155).

Feminist social work literature has also been used to maintain a politicised focus on violence against women. The inclusion of serious accidents, illness, sudden death of a loved relative or friend and natural disasters as ‘traumatic events’ equivalent to for example sexual assault, child abuse and domestic violence has been criticised by feminists for diluting or minimising the impacts of interpersonal and gendered violence. While personal and large-scale accidents are ‘traumatising’, it is argued that these events should not be compared to the ‘trauma’ experienced by victims/survivors of, for example, repeated gendered and sexual violence, domestic and family violence, as these violations are involved in the use of power, coercion and control that always occurs within a social, political and economic context (Herman, 1992). Ross (2007) also argues that victims/survivors of gendered violence experience “betrayal of trust that is often more hurtful than the abusive event itself” (p.61). This dimension arguably distinguishes ‘trauma’ caused by humans within a relational and social context from natural disasters and accidents which are largely beyond human control.

Social work literature has provided some analysis regarding the institutional disbelief of the high prevalence of gender-based violence in the context of human services. For instance, one study reported that mental health social workers in Sydney perceived sexual assault ‘trauma’ experienced by young women as a “marginal concept” and “viewed abuse as a relevant, yet not the primary issue” in providing mental health support (Tseris, 2014, p.105). Mental health social workers also tended to focus on “the treatment of symptoms (of trauma), regardless of their cause” and staff “did not believe that the disclosure of abuse should significantly change the type of intervention offered” (Tseris, 2014, p.105). Another qualitative Australian study indicated that women are not asked by mental health professionals about their experiences of domestic and family violence (Laing, Toivonen, Irwin, & Napier, 2010). Women from this study reported that disclosures of gendered violence, domestic and family violence were routinely minimised by mental health staff (Laing et al, 2010). The authors concluded that the

‘don’t ask, don’t tell’ service culture placed women at risk of ongoing and escalating violence and compromised women’s safety as well as their mental health (Laing et al. 2010). The authors also argued that there is a critical need for mental health and related services to adopt a wide variety of strategies to “address the trauma caused by domestic violence” (Laing et al. 2010, p.33).

Conclusion to the chapter:

This literature review has explored the contested conceptual domains of both ‘homelessness’ and ‘trauma’. I have argued that it is necessary to understand the multiplicity of ‘trauma’ and ‘trauma informed care’ definitions, discourses, meanings, associations and approaches as it cannot be assumed that a shared language of ‘trauma’ and ‘trauma informed care’ equates to shared service aims and understandings. As discussed in this literature review, the political orientation of organizations including their philosophies and histories, have a direct bearing on the translation of trauma informed care into practice. Similarly, how ‘homelessness’ or ‘housing injustice’ is defined and understood shapes human services and their responses.

The next chapter, Chapter 3, will introduce the theoretical framework, intersectional and material feminism, that was used in this study.

CHAPTER 3:

Theorising gender-based violence, racism and housing injustice from intersectional and materialist feminist stand points

"If you have come here to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together"

- Lilla Watson and Aboriginal activists group, Queensland, 1970s.

Introduction:

This chapter introduces the theoretical and political positions adopted in this study, namely, intersectional and materialist feminisms. These feminist perspectives have fundamentally shaped this thesis and the research analysis.

This chapter engages with intersectional and materialist feminist theories, providing a critical theoretical background to the structural responses to housing injustice, racism and violence against women in urban, settler colonial, neoliberal societies. This chapter also provides context and a rationale for the qualitative feminist methodology used in this study. The qualitative feminist research methodology will be explored in the following chapter, Chapter 4.

Intersectional feminist theory:

Contemporary intersectional feminism is a broad theoretical framework that draws from: critical race theory, Black feminism, post-colonial theory and First Nations decolonisation movements, queer theory, post-structural feminism, social theories of (dis)ability and ageing and critical human/animal studies (Damant et al, 2008). Intersectional feminism is associated with postmodernism as it is “structured around the issues of differences, subjectivities and power” (Damant et al, 2008 p.125). However, the development of intersectional feminist

theory has a long history that predates the postmodern turn. Critical race theorist and activist Kimberlé Crenshaw is credited with coining the term, 'intersectional feminism' in the article *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics* (1989). A core assumption of intersectional feminist theory is that gender-based oppression is not a homogenous experience, rather, that violence and oppression are stratified along multiple, intersecting systems of inequality, such as settler colonisation, slavery, patriarchy, racism, classism, ableism, heterosexism and cis-sexism (Beverly Guy-Sheftall, 1995).

The development of intersectional feminist theory is also associated with the African American, lesbian feminist, Combahee River Collective (Taylor et al, 2017; Beverly Guy-Sheftall, 1995). During the late 1970s this collective criticised the dominance of white, middle class and heteronormative priorities and analysis which facilitated the reproduction of racism, heterosexism and classism within the second wave feminist movement. African American feminists such as bell hooks (1982; 2000) and Audrey Lorde (2007) also challenged the analysis and political aims of middle class, heteronormative, white women leaders of the 'feminist movement'. Thus, the feminist movement benefited and maintained the privilege of white women whilst continuing to marginalise the voices and political imperatives of First Nations women, women of colour, economically poor women, new migrant women, lesbian, bisexual and transgender women, and women living with mental and physical disabilities.

First Nations theorists and activists have argued that the theory of intersectional feminism is not 'new' and that it did not begin with African American feminisms (Clark, 2016). Rather intersectional feminism may be more closely linked to a First Nations ontology which is "inherently intersectional" (Clark, 2016 p.49). Since settler-colonial invasion, First Nations peoples have articulated the understanding "that violence has always been gendered, aged, and linked to access to land", (Clark, 2016 p.49).

Early Indigenous activists such as Zitkala-Sa and Winnemucca (1883) were central to fighting the issues of violence on the land and on the body as they witnessed it at the turn of the century (Clark, 2016 p.49).

White Western feminism has been viewed by First Nations women as “minimizing or failing to acknowledge the substantial privileges that non-First Nations, particularly Anglo (white) women benefit from as a direct result of colonialism” (Grey, 2004 p.15). The predominately white, second wave feminist movement has also been charged with obscuring the systemic settler colonial racism experienced by First Nations women and the resulting position of extreme social, political and economic disadvantage by 'subsuming the goals of Aboriginal women under the broader goals of feminism' and to a certain extent, normalising settler colonial Western, hetero-patriarchal gender relations (Grey, 2004). As such, white, Western feminism can be seen to perpetuate colonial relations by ‘discounting First Nations Worldviews and values while asserting white Western paradigms' via the assumption that white Western gender relations and gender identities are universal (Grey, 2004).

First Nations, post-colonial theorists and activists have argued that the pervasive experience of ‘trauma’ among First Nations communities, cannot be separated from the issue of colonial occupation, genocide, assimilation, dispossession and systemic racism (Moreton-Robinson, 2000; Lukashenko, 1994). Rather than conceptualizing and articulating gender-based violence within a regime of patriarchal oppression, First Nations activists have understood violence against women as one aspect of colonisation and systemic racism (Watson, 2011). Therefore, the political aims of First Nations peoples, involved in countering gender-based violence and housing injustice, is best described as anti-settler colonial, with the aim of decolonisation and sovereignty rather than gender equality alone (Grey, 2004).

Over the last 40 years intersectional feminist activism has sought to shape institutional and social policy responses to gender-based violence and housing injustice. Intersectional

feminists have criticised anti-violence against women policies' for collapsing multiple subject positions of 'being a woman' into singular overarching identities such as; 'homeless women' and 'victimised women'. From an intersectional feminist perspective, there is no singular or essential experience of 'trauma' or 'violence' experienced by women as there "is no essential category of woman" (Damant et al, 2008 p.125). While the argument that 'all women are affected by gender-based violence' is accurate, "this rhetorical framing of the problem obfuscates the reality that a woman's risk for sexual violence in all forms is highly dependent on her social identity...the most likely victim is female, black, unmarried, poor, living alone or with children" (Bumiller, 2008, p. 157).

Intersections of sexism, racism, poverty, homophobia and transphobia, frequently results in uneven access to health and human services, legal and statutory protections in settler colonial, neoliberal societies. An emerging field of intersectional inquiry has recently exposed the ways in which historical and contemporary settler-colonialism, slavery and the political economy of neoliberal capitalism, produces and maintains gendered and racialized violence and housing injustice (Spade, 2015; Willse, 2015). For instance, Willse (2015), argues that housing injustice and "homelessness" are manifestations of 'anti-black' State racism:

A house is a technology that makes live and lets die (SIC) – housing is a systemic form of State racism, making cuts that determine how the investments in health and life secured by homes will be distributed. As one form of private property, housing is produced by and reproduces projects of racialized subordination. The life that lives in systems of housing insecurity and deprivation is of born of that life that dies on its streets and sidewalks (Willse, 2015, p.34).

In this statement Willse (2015), makes the argument that all forms of housing, resting on the settler colonial assumption of private property and ownership of land, are inseparable from housing injustice and homelessness. Evidence supporting the argument that housing is a racist

‘technology’ used by the State which allows some to flourish while permitting others to die on the streets, can be found in the over-representation of First Nations people and people of colour in rough sleeping and homelessness services statistics in Australia, Canada and the US. In settler societies such as Australia and Canada, the violence of these colonial strategies continues to be disguised through dominant discourses, including ‘homelessness’, which portrays First Nations people “as the authors of their own poverty” propagating the racist narrative that poverty and homelessness in First Nations communities is caused by “dysfunctional culture” rather than the ongoing effects of settler colonisation and State racism (Howe Review Board in Watson 2011, p. 151). Anti-racist and intersectional feminist activists have criticized racist media representations and political discourses which have made poverty and criminality synonymous with people of colour (hooks, 2000; Davis, 2003; Alexander, 2015; Spade, 2015).

The following section will further explore critical theories concerning the intersections between settler colonialism, state or systemic racism, institutional racism, gendered violence and housing injustice.

Conceptualising and measuring ‘homelessness’ in settler colonial societies:

For many intersectional feminists, the issues of gender-based violence, racism and housing injustice are inextricably linked to the criminal justice system. Just as intersectional feminists have drawn links between the system of housing and systemic racism, the criminal justice system has also been understood as an extension of systemic anti-Black racism, slavery and settler colonisation (Alexandra, 2010). Intersectional feminists have criticised the feminist alliance with criminal justice and law enforcement responses to domestic and family violence as these strategies have been associated with increased State surveillance and higher incarceration rates of First Nations people and people of colour including women and young people (Alexandra, 2010; Davis, 2003; Crenshaw, 2012). Crenshaw (2012), argues that poor,

working-class, housing insecure women of colour simultaneously experience a lack of statutory protection from gender-based violence, while being subjected to higher rates of incarceration, police harassment and assaults while held in police custody. Crenshaw (2012) also argues that the mandatory arrest policy of domestic violence perpetrators in the United States was strongly associated with a “heightened risk of mortality for black women in particular” (Crenshaw 2012, p. 1455). Furthermore, women of colour who have used violence in self-defence are also more likely to be subject to arrest and incarceration than white women (Crenshaw, 2012). Most women who are incarcerated in settler colonial societies including Australia, Canada and the United States are victims/survivors of gender-based violence and many have a lived experience of housing injustice and homelessness (Green et al, 2016). A Canadian based study reported that of 71 women who were previously incarcerated, ‘56% stated that homelessness contributed to their return to crime (Elwood Martin et al, 2012). Finding housing upon release was a problem for 63% of women and 34% desired relocation to another city upon release (Elwood Martin et al, 2012). This study recommended that access to transitional housing for women upon release from prison would mitigate recidivism due to poverty and ‘homelessness’ (Elwood Martin et al, 2012).

Australian based prison abolitionist and prisoner advocacy groups also argue that most women, and specifically First Nations women, who are incarcerated in Australian prisons are victims/survivors of intersecting oppressions, namely gender-based violence, intergenerational trauma, childhood sexual assault and systemic racism. In an Australian context, First Nations women are incarcerated at a higher rate in comparison with all other groups (Cox, Young & Bairnsfather-Scott, 2009). Mirroring the USA, the introduction of ‘tough on crime’ policies such as mandatory sentencing, zero tolerance policing and ‘discriminatory bail and parole processes’ have led to the disproportionately high incarceration rate of First Nations people including women and young people (Young & Solonec, 2011; Cunneen, 1992).

These examples from housing injustice to the prison industrial complex highlight the global relevance of intersectional feminism in exposing the interactions between systemic and institutionalised ideologies including sexism, cis-sexism, anti-black racism, settler colonialism and heteronormativity in Australia and Canada.

Criticisms and limitations of intersectional feminism:

Through an intersectional feminist lens, it is possible to view the study of ‘trauma’ as an inherently political subject that “calls to attention the experience of oppressed” women (Herman, 1992, p.237) while recognising “...her shackles may look very different to my own” (Lorde, 1981). This analysis aims to expose the private and public ways in which the projects of settler colonialism and neoliberalism intersect and (re)produce; racism, classism, able-ism, homophobia, transphobia and sexism. The material consequences of these intersectional oppressions include; housing injustice, poverty, gendered violence, incarceration, exclusion from civil rights and ultimately, the early and violent deaths of women of colour, First Nations women, women with disabilities, queer and trans* women, ‘undocumented’ refugee and new migrant women, economically poor and working-class women (Burstow, 2003). One of the main strengths of intersectional feminism is that it does not risk collapsing difference under a universal category of ‘woman’ (Tong, 1989). This facilitates a nuanced analysis of gender-based oppression and violence stratified and intensified by intersecting forms of systemic and institutionalised oppressions. However, the very theoretical and political strength of intersectional feminism, also forms a potential limitation. In the attempt to account for complex subjectivities and positionalities, intersectional feminist research has been criticised for reproducing reductive and essentialising categories and identities of difference (Mooney, Ryan & Harris, 2014).

This has given rise to the movement of potentially self-referential identity politics (Zufferey, 2015; Laing & Humphreys, 2013). Identity politics emphasises a concern for individual victimisation/ and (neoliberal) individual responsibility in place of a focus on collective resistance to gender-based oppression and violence (Laing & Humphreys, 2013). Furthermore, Marxist and materialist feminists argue that intersectional and postmodern perspectives “rarely provide the basis for collective political actions” and that the focus on identity politics diverts attention from the issue of class-based oppression and the material subjugation of women (Ramazanoglu & Holland 2002, p.14). These theoretical limitations have prompted me to include a materialist feminist analysis which centres an analysis of trauma informed care services within a neoliberal capitalist, settler-colonial political economy.

Materialist Feminism:

Materialist feminism developed out of Marx’s Historical Materialism. Historical Materialism can be understood as a methodology used to describe the division of labour through the construction of class relations. Marx’s theory of Political Economy is concerned with the social relations, such as class, racialized and gendered relations that are (re)produced by economic systems such as (neoliberal) capitalism (Walby, 2007). Marxist Feminists argue that the capitalist political-economy structures and produces gendered roles and relations. These gendered roles and relations are enforced through a patriarchal ideology which privileges cis-gendered, white, middle class and ruling class men over women and everyone else who does not have membership to these specific identities and class-based privileges. Conversely, women are subjugated through State-based, economic, representational, institutional and domestic contexts. For example, the heterosexual nuclear family model (father, mother and child/children), is a normalised, ideology and social model within Western capitalist societies. The nuclear family model is inherently hierarchical, patriarchal and paternalistic, with the father figure traditionally occupying a position of power over women and children. Marx wrote

“the modern family contains in germ not only slavery but also serfdom...it contains in miniature all the contradictions which later extend throughout society and State” (Marx in Engels, 1884 p.88). The structure of ‘serfdom’ was replicated in the nuclear family through the institution of marriage which historically enshrined women and children as the legal property of husbands and fathers. Married women had to forfeit property to their husbands until the Married Women’s Property Law Act (1882) which was first introduced in the United Kingdom and then introduced in 1884 in Australia and 1884 to 1990 in Canada. The Married Women’s Property Law Act (1882) granted women the right to property ownership regardless of marital status. Despite the small victories achieved by first wave feminist movements including the Women’s Suffrage Movement and the changes to the Marriage Act, women continued to be subordinated in settler colonial, neoliberal/neoconservative capitalist political economies (Cooper, 2017).

Beyond the nuclear family, materialist feminists have also agitated against the political and economic disenfranchisement of women in neoliberal capitalist societies which perpetuate; a gender pay gap, limited political and corporate representation of women, unpaid labour in domestic and primary care giving roles, and domestic and family violence as a leading cause of women’s housing insecurity, financial and property losses (Zufferey, Chung, Franzway, Wendt & Moulding, 2016).

However, materialist feminists such as Michèle Barrett and Mary McIntosh (1979), Christine Delphy (1980) and Jackson (2001), caution Marxist feminism and Marxism for the emphasis on economic determinism (Hennessy, 1993):

Materialist feminism is not a form of economic determinism. As Delphy and Leonard (1992) remind us, one of the original strengths of Marx's materialism was that he did not conceive of the economic as an abstract system with its own internal laws, but as a realm of social relations, constructed through social activity. I want to argue for a

version of materialist feminism that foregrounds the social—social structures, relations, and practices—but that does not reduce all social structures, relations, and practices to capitalism. From my perspective patriarchal or gendered structures, relations and practices are every bit as material as capitalist ones, as are those deriving from racism, colonialism, and imperialism (Jackson, 2001 p.284).

Materialist feminists also view patriarchal male domination and entitlement as central to violence against women (Jackson, 2001). However, along with systemic patriarchal oppression, materialist feminists examine “both the explanation and the solutions to violence against women” within a broad socio-political and economic context including but not limited to an analysis of patriarchal oppression (True 2012, p.7). For Material feminists the explanation and the solutions are embedded in the social relations inscribed through neoliberal capitalism (neoliberalism). Therefore, an analysis of human services including, Women’s refuges and crisis accommodation services, cannot be understood outside of the neoliberal capitalist political economy.

[The Neoliberal Political Economy:](#)

From a materialist feminist perspective, it is necessary to outline the key historical and conceptual features of the political economies implicated in this study, Sydney (Australia) and Vancouver (Canada). The dominant contemporary political economies operating in Australia and Canada are characterised by neoliberalism.

Neoliberalism has been defined as radical form of capitalism developed by neo-classical economic academics such as Friedrich Hayek and Milton Freeman, from the Chicago University School of Economics (Cooper, 2017). Neoliberal political theory was also extensively developed at the University of Virginia, George Mason University, Virginia Polytechnic University, the UCLA Department of Economics, among others during the 1950s

(Cooper, 2017). Neoliberalism was extensively implemented in economic policies under the Margaret Thatcher and Ronald Reagan governments respectively in the UK and USA during the 1970s and 1980s (Cahill, 2014). Over the last 40 years, the neoliberal political economy has steadily emerged as the dominant global political and economic system. However, neoliberalism has emerged differently and unevenly across social, political and geographic contexts (Jimenez, 2013). Therefore, the consequences of neoliberalism and localised forms of resistance to neoliberalism have not been homogenous (Jimenez, 2013).

Neoliberalism can be understood simultaneously as a project, ideology and as a process (Ready, 2014). As an economic process, neoliberalism has enforced “deregulation, privatisation, individualisation and free trade” (Jimenez, 2013, p.5). One of the defining features of the neoliberal political economy was and continues to be, a strong ideological stance against the welfare State and responsibilisation; individual responsibility as opposed to government responsibility. Neoliberal policies have been explicitly designed to roll back the welfare State by replacing State responsibilities including provision of welfare payments, healthcare, social housing and education, with coercive and punitive strategies geared towards individual ‘initiative, enterprise, entrepreneurialism and responsibility’ (Willse, 2010a). According to Harvey (2007), as an ideology, neoliberalism proposes that “human well-beings can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade” (p.2). The extreme ideology of neoliberal individualism was exemplified in Thatcher’s Statement:

You know, there's no such thing as society. There are individual men and women and there are families. And no government can do anything except through people, and people must look after themselves first (Thatcher, 1987).

Even though neoliberalism is arguably the dominant, globalised political economy of the present day, the task of defining neoliberalism and identifying its operations of power, remains

elusive (Roy, 2014). It is also an area of significant academic and activist contention. Cloaked in the language of “normativity”, neoliberalism, is “no longer perceived as an ideology” but rather is accepted as the “natural way to be” as if there is no alternative (Roy, 2014 p.32). The normalisation of the neoliberal ideology is due to its pervasive social saturation. Neoliberalism has been described as a form of settler-colonialism – in that neoliberalism has colonized and assimilated all people under a neoliberal ‘civil society’ (Birch & Mykhnenko, 2009). However, Jimenez (2013), elaborates that neoliberalism is “hegemonic without being total” meaning, that the hegemonic success of neoliberalism is contingent on the subtle and pervasive way it saturates mass cultural, social and political realms and shapes subjectivity creating new norms, epistemologies and ontologies (p.30). Under neoliberalism, power relations are reconfigured such that individuals internalise the States’ ‘marketisation’ objectives through self-regulation and self-governance. Thus, market values become embedded in “all dimensions of human life”, including for example; “the soul of the citizen-subject, to education policy and the practices of empire” (Brown, 2003, p.39). As such, power is de-centred, as opposed to overtly hierarchical and authoritarian, and has become embedded in the beliefs, fears, desires and aspirations of the population. These processes have made neoliberalism almost invisible and the assimilation of citizens into the neoliberal political economy almost uncontested (Brown, 2016). The invisibility of this political economy primarily benefits those who profit from the deployment of neoliberal policies and global corporatism while disguising the economic and political causes of inequality and poverty and the human and environmental rights violations that have accompanied it.

Hartsock (1997) argues “power that is kept invisible, denied as existing or denied as being important can render systemic discrimination invisible, enabling and supporting vagaries such as colonialism, slavery and Western patriarchy” (p.239). The concept of ‘invisible power’, has been used by some commentators to view neoliberalism as an intentional technology designed

to restore class power by stealthily increasing and securing wealth and resources to a minority of ruling class members while depriving and entrenching poverty for the global majority (Harvey, 2007). The project to enhance the power of the ruling/political classes is reliant on government administration (Brown, 2015). This is one of the central paradoxes of the neoliberal political economy: Far from eliminating governments for the market to freely dictate using a purely 'laisse faire' economy, neoliberalism operates through an intensification and 'permanent vigilance' of State power and intervention (Clough & Willse, 2011). According to Harvey (2007) the role of the State in a neoliberal political economy is to "create and preserve an institutional framework appropriate to (neoliberal) practices" (Harvey, 2007 p.2).

The ideology of Neoliberalism has introduced "a new model of citizenship in which societal rights and responsibilities transform social problems into the failures of the individuals rather than that of society" (Birch & Mykhnenko, 2009 p.7). A central ideological facet of Neoliberalism is the discourse of 'individual responsibility'. That is, that the individual is responsible for their specific circumstances and through individual entrepreneurialism and participation in the workforce/investment, the individual 'secures' their future. Under neoliberalism human subjectivity has been reoriented and reformed into 'homo economicus' a purely entrepreneurial "self-interested, rational economic being, who is best left to calculate his, her (or their) own interests and needs" (Pollack & Rossiter, 2010, p.159). Inverting the feminist maxim, that the "personal is political", under a neoliberal, anti-welfare State political economy, the notion of governments providing public good is replaced with a purely "economic calculus" (Pollack & Rossiter, 2012 p.159).

The system of neoliberalism, also (re)conceptualises poverty as an "identity problem" which again distracts attention from the systemic causes of inequality: "Poverty too like feminism is often framed as an identity problem, as though the poor have not been created by injustice but are a lost tribe who just happen to exist" (Roy, 2014, p.37). Roy (2014) argues that the

discourse of individual responsibility (or responsabilisation) is, therefore, central to the neoliberal ideology and project. The discourse of individual responsibility has been accompanied by intensive networks of social welfare technologies that seek to “regulate the poor’ by intervening in individual behaviour” (Willse 2010a p.156). Individual responsibility also erases the structural causes of gendered violence, housing injustice and poverty. Through a discursive sleight of hand, individual responsibility (re)constructs social problems, such as violent victimisation, within the minds/psychologies of individuals who are viewed as deviant, pathological or criminal:

Neoliberalism promotes a conception of victimization as subjective rather than social, a State of mind rather than a worldly situation. As a result, victims of poverty, inequality, discrimination and violence are discursively constructed as the authors of their own suffering, or as genuine victims of incomprehensible crime (Stringer, 2014 p.7).

Neoliberalism has, therefore, profoundly shaped violence against women discourses, social policies and human service responses. Ready (2012), argues that neoliberalism has “shifted sexual violence discourses from a feminist frame which recognised issues of patriarchy and systemic oppression, to an anti-feminist view which individualized sexual assault and domestic and family violence” (Ready, 2012, p.45). Stringer (2014), also argues that neoliberal “individualising, psychologising and pathologising have redefined and renamed victimhood and feminism in the neoliberal era” (p.131). Under neoliberalism, victims/survivors of gendered violence are encouraged to avoid a “victim mentality” and to assume “personal responsibility for guarding against the risk of victimization, instead of focusing on their right not to be victimized” (Stringer, 2014, p.2). This transforms the experience of racialized, gendered and class-based violence from injustice into potentially economically profitable resources that support; fields of psychological and social research, and the development

industries geared towards treatment and personal recovery. This process “drains all legitimacy from the idea that suffering can be social, political and collective, rather than merely subjective, psychological and individual” (Stringer,2014 pp.2-3). According to Ready (2012), in the last 30 years the discourse on victims of gendered violence has moved away from an overt victim-blaming discourse to a new construction of victims as “pure and innocent” (Ready, 2012 p,49). Ready (2012) argues that “versions of victims that are acceptable are those which resonate with narratives about victims’ inherent helplessness, distress, and shame” (Ready, 2012 p.49). Furthermore, “victims who do not live up to the ideal of purity and innocence”, are relegated to the category of the undeserving poor and thus, are often criminalised and demonised (Ready, 2012 p,50). The category of ‘undeserving poor’ is continuous with neoliberal individual responsibility and diminished State responsibility.

The discourse of the undeserving poor “fosters the principle that people should be responsible for their own welfare and that those who cannot compete should be blamed for causing their own failures” (Ready, 2012 p.214). This view also absolves the State of any social responsibility for systemic inequalities while maintaining the illusion of an equitable and just society, a fair and accessible system of housing. It also shows how many contemporary social discourses are suffused with the discourse of individual responsibility (responsibilising). Responsibilising discourses blame individuals for living in poverty and for their own situations of ‘homelessness’ due to a personal lack of initiative and entrepreneurialism and other ‘poor life decisions’ such as gambling and alcohol and other drug use. Women experiencing housing injustice and homelessness who also occupy one or more of the following identities have historically been constructed as inherently ‘undeserving’: First nations women, refugee and new migrant women, women engaged in sex worker, single women with children, long-term homeless women, women using alcohol and other drugs, women with prison experience,

lesbian, bisexual and transgender women and gender non-conforming people (Burstow, 2003). While activists and social movements have shifted overt forms of discrimination, the pervasive neoliberal discourse of individual responsibility continues to mask ongoing structural oppression.

Neoliberal Governmentality:

Michel Foucault's theory of neoliberal Governmentality is widely used in literature attempting to theorise the implications of the neoliberal political economy on gender-based violence, housing injustice services (Willse, 2015) and the operations of NGOs/government institutions. Foucault defines governmentality as the "introduction of economy into political practice" including institutional practices (Foucault, 1977 p. 93). This theory provides a lens through which to understand the role of the State and institutions in the intensive disciplining of (the poor/working class) populations. Foucault (1977), argued that the economy disciplines populations through an interplay between "institutions, procedures, analyses and tactics that allow the exercise of this very specific complex form of power" (Foucault p.102). Bureaucratic welfare processes, the expansion of police powers, citizen surveillance, border and immigration control and statistical population analysis are contemporary examples of Governmentality in Australia and Canada.

Governmentality and the political rationality of neoliberalism are apparent in contemporary government and non-government human services including those for people experiencing housing injustice. For instance, neoliberal government discourses and policies intensively mobilise around the notion that that people experiencing housing injustice, homelessness and poverty require invasive and often permanent intervention and surveillance. In Canada and the USA, crisis accommodation services tend to be "focused on money management, job training and a wide range of other so-called life skills, (which aim to) make formerly 'shelter resistant' individuals 'housing ready'" (Willse, 2010b, p. 156). Similarly, in an Australian context,

punitive welfare control measures such as compulsory, *Government Income Management* and *work-for-the-dole* and other forms of mutual obligation welfare “routinize and codify” the neoliberal idea of “working on yourself” as a necessary part of securing and maintaining housing and income support (Willse, 2010a p.165). Through this critical lens, it is possible to perceive the potential role of crisis accommodation services and case-management in the “medicalization and management of homelessness” as a form of governmentality (Willse, 2010a p.165). Medicalising and individualising homelessness “conceptually and materially reorganises housing insecurity in terms of population dynamics and economic costs” (Willse, 2010a p.157).

Other theorists have identified strategies used by neoliberal governments, corporations and institutions designed to manage, monitor, coerce and punish working poor or ‘welfare poor’ people. According to Wacquant (2009), contemporary neoliberal States rely on three individualising strategies designed to manage welfare or working classes of people who are constructed as “undesirable, offensive and threatening” (Wacquant, 2009 p. xxi). These strategies include: 1) Socialising/assimilating, 2) Medicalising, and 3) Penalisation/criminalisation (Wacquant, 2009). Neoliberal policy responses to homelessness include attempts to 1) socialise or assimilate ‘homeless people’ into adopting normative behaviours and participating in the capitalist system as an entrepreneurial subject. Socialising/assimilating is facilitated through systems such as incentivising welfare schemes such as welfare-to-work 2) construct people who are homeless or insecurely housed as pathological and reconstruct ‘homelessness’ as a problem caused by individuals with mental health problems or alcohol and other drug use while deflecting responsibility for the right to affordable housing from the State. 3) Neoliberal States also criminalise homeless people, for example through bans on dwelling (particularly sleeping) in public places. Criminalising ‘homelessness’ obscures the visibility of housing injustice by ‘warehousing’ homeless people

and people with mental health concerns in prisons (Wacquant, 2009). According to Wacquant (2009) criminalisation and penalisation “serves as a technique for the invisibilisation of the social problems that the State or the bureaucratic lever of collective will, no longer can or cares to treat at its roots, and the prison operates as a judicial garbage disposal into which the human refuse of the market society are thrown” (p. xxii). These three neoliberal strategies in response to housing injustice are also mutually reinforcing and contribute to the individualisation and responsabilisation of social concerns.

The confluence of neoliberalism and neoconservatism:

The erosion of the welfare State in the neoliberal political economy has had direct implications for women victims/survivors of gender-based violence and housing injustice. To explore the dynamics of gendered oppression and violence under neoliberalism, it is important to consider the role of the family. While dismantling the welfare State and increasing individual responsibility, the neoliberal political economy is also associated with (re)creating a social reliance on the nuclear family (Cooper, 2017). The ideological reverence of the hetero-patriarchal, nuclear family and ‘family values’ is more strongly associated with neoconservative, right-wing, religious paternalism than it is with neoliberalism. However, as Cooper (2017) argues, “neoliberal economists and legal theorists (also) wish to re-establish the private family as the primary source of economic security and a comprehensive alternative to the welfare State” (p.9). This premise theoretically draws an analysis of neoconservatism and neoliberalism together (Brown, 2006; Cooper, 2017). The neoliberal-neoconservative agenda to reinstate the nuclear family emerged in reaction to the sexual, feminist, gay and lesbian liberation movements and AIDS activism of the 1970s and 1980s which fundamentally challenged the construction of the nuclear family as a central capitalist institution (Cooper, 2017). Under the neoliberal political economy, the institution of the family is used as a strategy to transform welfare “from a redistributive program into an immense federal apparatus for

policing the private family responsibilities of the poor” (Cooper, 2017, p.21). For instance, rather than redistributing wealth, alleviating poverty and housing injustice, neoliberal welfare introduced punitive policies such as welfare to work, which effectively coerces welfare recipients into the labour force either through employment or unpaid activities (i.e. the work-for-the-dole scheme in Australia and the USA). Welfare-to-work has been described as a “disaster for the country’s (USA) most economically disenfranchised women” (Roschelle, 2008, p.193). For instance given the rigid and inflexible welfare to work requirements, many women survivors of domestic violence lose their benefits as a result of their “partners harassment, stalking behaviour, emotional abuse, unreliable parenting, and physical violence” (Roschelle, 2008, p. 197). Welfare-to-work also compounds financial stress which may also contribute to periods of (re)incarceration for many women who are victims/survivors of domestic and family violence (Roschelle, 2008). Therefore, neoliberal welfare-to-work policies entrench rather than alleviate housing injustice (Roschelle, 2008). The confluence of neoliberalism and neoconservatism not only encourages women to stay with families and partners, which are intended to absorb the shock of the contracting welfare state, but has also given rise to religious rather than secular NGO organisations (Cooper, 2017).

Creation of economic industries out of social problems:

Materialist feminists have also been concerned with the ways in which the neoliberal political economy has shaped policy and service responses to social problems such as housing injustice and gendered violence. Materialist feminists and other critics have argued that neoliberalism has changed the human service system response by: 1) corporatizing the organisational structures of government and non-government human services 2) creating profitable industries out of social problems 3) neoliberalism has introduced a discourse of ‘risk’ and ‘managing risk’ has “become deeply embedded within our practice landscapes” (Stanford, 2009 p.210).

The neoliberal transformation and commodification of human services has been described by materialist feminists and anti-capitalist activists as the ‘not-for-profit-industrial-complex’. This not-for-profit-industrial complex is facilitated by multiple discursive, ideological and structural technologies that normalise and reinforce neoliberalism. Roy (2014) argues that neoliberalism transforms, co-opts and subverts the potential for not for profit Non-Government Organisations (NGOs) to enact meaningful social and political change. While many NGOs do important and meaningful work to alleviate poverty and gendered violence, NGOs are a central apparatus in the contemporary neoliberal political economy (Roy, 2014). Commentators such as Roy (2014) and Cooper (2017) argue that large NGOs have a conflict of interest in relying on social problems (such as homelessness) to justify the ongoing existence of NGOs and the human service workforce. Human services and researchers are funded to study, provide ameliorative services and to devise ‘innovative’ solutions to better manage impoverished and working-class people including those experiencing housing injustice. However, NGOs avoid campaigns and activist work aimed at long term systemic change, such as redistribution of wealth, sovereignty and land rights for First Nations peoples. Therefore, government and corporate philanthropic funding arrangements blunt the capacity for NGOs to contest intersecting institutionalised and systemic forms of violence and oppression (Roy, 2014; Willse, 2015).

Roy (2014) argues that NGOs borrow, or rather ‘co-opt’ the language and aesthetics used by progressive social movements so that they appear to be engaged in creating change without disrupting or even questioning the settler-colonial, heteropatriarchal, neoliberal political economy. Similarly, Willse (2015) argues that the expansion of federal government funding into the “homelessness industry” does so to gain “cultural legitimacy” and ultimately “to transform the illness and death that result from housing deprivation into productive dimensions of post-industrial service and knowledge economies” (p.50). Loewenstein (2013) also argues that with the collusion of governments, the ideology of corporations and corporate power are

transforming everything from prisons, to homelessness, to wars and environmental catastrophes into business opportunities. Loewenstein (2013) also highlights the trend of privatisation which corporatized former government welfare and human services including the onshore and offshore refuge detention centres. The commercial out-sourcing of the government responsibility's renders values such as 'human rights' and 'human dignity' almost unintelligible (Loewenstein, 2013). The (re)construction of social problems into industries reinforces the neoliberal ideology of individual responsibility, whereby NGO services, staffed by often middle-class people, are positioned to assist 'failed' citizens to work on themselves so as they can better compete in the labour market.

However, workers are also subjected to the same isolating and responsabilising effects of neoliberalism. Stanford (2009) argues that the neoliberal concept of 'risk management' in human services reinscribes the notion that "risk-based identities are flawed identities; to be 'at risk' is considered to be indicative of a moral lapse or failure to operate as a responsible, knowledgeable and rational individual" (p.210). Furthermore, human service workers, including social workers, often enact 'risk-averse' practices which mediate responses to people accessing services (Stanford, 2009). The effect of neoliberal 'risk management' on social work practice manifests in "defensive and morally timid practice" and also in the use of heightened strategies of control, mutual obligation and surveillance of people accessing services or 'clients' (Stanford, 2009, p.210). This is also produced through and by bureaucratic systems and the excessively litigious cultures of neoliberal societies.

Since the implementation of neoliberal policies, welfare and human service have increasingly become accountable to government monitoring frameworks and measures in order to maintain funding. Human/welfare services have also become contractual and therefore limited in terms of time and resources. Human/welfare services on contracts increasingly have had to compete with other services for funding – a neoliberal market-oriented process known as 'competitive

tendering'. Goodwin and Phillips (2015) argue that “in the context of competitive funding, policy capacity becomes more than a way to achieve social justice – it also becomes a way to win contracts” (p.14). However, it is important to highlight that under neoliberalism, services increasingly have to comply with strict statutory reporting and monitoring processes to maintain funding and to maintain a competitive advantage over other services. Despite the rhetoric of the need for enhanced service collaboration and service integration, competitive funding and short-term funding “packages” make these aims elusive:

In the NGO universe, which has evolved a strange anodyne language of its' own, everything has become a separate, professionalized, special interest issue. Community development, leadership development, AIDS, orphans with AIDS – have all been hermetically sealed into their own silos, each with their own elaborate and precise funding brief. Funding has fragmented solidarity in ways repression never could (Roy, 2014 p.37).

This has undermined the capacity for services such as ‘homelessness services’ to respond to the “the very human and complex nature of the issues they were originally created to address” (Rendo, 2014, p.220).

Within a neoliberal political economy, social workers are not only concerned with the ‘management’ of ‘clients’ who are ‘at risk’ but social workers are also constructed as ‘at risk’ (Stanford, 2009). Therefore, neoliberal risk-management creates significant dilemmas for social work/human service workers and managers who on the one hand may hold genuine person-centred ethics such as ‘care’, ‘justice’, ‘recovery’ and ‘hope’ for people accessing homelessness services and on the other hand “the pressures of depending on statutory resources and the statutory bureaucracies which detach them from the human encounters with clients” (Rendo, 2014, p.231). This paradox often creates significant ethical and moral tensions for workers who become frustrated and distressed working within services and systems that

fundamentally fall short and often fail to meaningfully intervene in violence, injustice and inequalities. The distress caused by bearing witness to systemic and institutional failure is often recast as an issue of individual weakness and failure. For instance, the discourses of worker 'burnout', 'compassion fatigue' and 'vicarious trauma' are constructed within a psychological paradigm in which workers become so emotionally distraught by social/welfare work that they are unable to remain effective and engaged. Reynolds (2011), argues that the idea of 'burnout' is a neoliberal individualising and victim blaming concept. Just as 'clients' of human/welfare services are constructed by neoliberal societies as 'failures', so too are workers who 'burn-out'. The accompanying discourse of 'self-care' for human/social workers also implies that individuals should guard against distress arising from "working in unjust contexts" and bearing witness to systemic injustice (Reynolds, 2011 p.29). The 'self-care' discourse urges workers to continuously engage in programs of working on oneself, such as having a 'good work/life balance', regularly attending 'counselling or workplace supervision' and engaging in stress relieving activities such as 'yoga' (Reynolds, 2011). The pervasive message of individual responsibility and the threat of psychological failure diminish the capacity for collective and even workplace responsibility for managing distress.

The trauma discourse and 'trauma informed' service provision in the context of neoliberalism:

Neoliberalism has fuelled the growth of psychiatric and psychological industries which profit from the medicalisation and commodification of distress. Furthermore, Watters (2011) argues that Western psychiatry and psychology are colonising global discourses, that profoundly alter the unique cultural meanings and responses to distress, 'trauma' and violence. Just as neoliberalism is offered as a no-alternative discourse, so too the DSM is a 'no-alternative', hegemonic and ultimately colonising discourse. Watters (2011) argues that along with other major diagnostic categories, such as depression, anxiety and schizophrenia, the psychiatric

concept of 'trauma'/PTSD, has been exported, like a brand, throughout the world. Watters (2011) considers the deployment of Western traumatologists, paid to counsel communities in post conflict locations throughout the world. Corporate interests encroach into previously untapped markets geared to treat formerly resilient communities as passive victims needing paternalistic intervention (Tietze, 2014).

There is limited research evaluating the impacts of neoliberalism on homelessness and anti-violence against women services and policy making. Of the available literature, authors have argued that neoliberalism has profoundly shaped service provision and practice philosophies (Ready, 2014). Neoliberalism has undermined feminist political aims, feminist theories of violence against women and feminist theories of trauma (Roy, 2014; Ready, 2014). In the context of women's refuges in Ontario, Canada, Ready (2014) argues that neoliberal policies have undermined the power of a "feminist agenda" (p.4). Ready (2014) used qualitative methods to explore three YWCA organizations in Ontario between 2003 to 2008 who experienced the McGuinty government's "new-neoliberal" violence against women policies (p.6). Over the course of the five-year study, neoliberal policies reconfigured YWCA's from feminist services into "targeted, individualized and de-gendered services and with greater connections with law-and-order" (Ready, 2014 p.218). Ready argues that neoliberal policies "consistently applied pressure on organisations to hide, rename or eliminate feminist terminology and concepts to using gender-neutral language" (Ready, 2014 p.220). As Ready identifies, service provision without a gender analysis carries dangers for women, such as obscuring gender-based violence.

Neoliberalism has introduced funding cuts to a wide range of government and non-government services. Funding cuts have placed pressure on women's services to fundraise for their existence, drawing time, energy and resources away from service delivery. The effort to secure funding has also "led women's services to form partnerships with those not always sharing

their feminist goals” (Ready, 2014 p.219). Ready (2014) reports that workers and managers described the impact of, competitive “funding agreements, accountability mechanisms, and fundraising” and funding cuts, which splintered alliances and collaboration within the sector (p.81). One of the key findings emerging from this study was that while YWCA workers identified significant changes to their anti-violence against women services, “neoliberalism was not commonly known, named, or recognised” (Ready, 2014, p.214). According to Ready (2014) YWCA workers also did not name neoliberalism as neoliberal policies, policies which inscribed and intensified poverty and inequality for women.

The project, ideology and processes of neoliberalism has implications for the services at the centre of this research project, crisis accommodation and women’s refuge services and the implementation of trauma informed care. Accounting for neoliberalism raises questions about the extent to which the participating services, and the model of trauma informed care, could do much more than offer women victim/survivors basic alms; the temporary alleviation of poverty and protection from violence.

Criticisms and limitations of Materialist feminism:

Materialist feminism has been criticised for emphasising the role of the (neoliberal) capitalist political economy in the systemic oppression of and violence against women. First Nations, post/anti-colonial theorists and Black feminists have argued that materialist feminisms preoccupation with ‘neoliberalism’ inadvertently marginalises an analysis of settler-colonialism, slavery and border imperialism (Walia, 2013). For instance, the Combahee River Collective (1974) were critical of Marxist and Socialist analysis of the oppression of ‘black women’:

Although we are in essential agreement with Marx’s theory as it applied to the very specific economic relationships he analysed, we know that his analysis must be

extended further in order for us to understand our specific economic situation as Black women. (The Combahee River Collective, 1974).

Similarly, Means (1983) argues that Marxism, and it is possible to conclude by extension, feminist Marxism and Materialist Feminism, reinforce not only the ideology of capitalism (by virtue of criticising it), but the entire European/Western ontology.

Hegel and Marx were heirs to the thinking of Newton, Descartes, Locke and Smith. Hegel finished the process of secularizing theology--and that is put in his own terms--he secularized the religious thinking through which Europe understood the universe. Then Marx put Hegel's philosophy in terms of "materialism," which is to say that Marx despiritualized Hegel's work altogether. Again, this is in Marx' own terms. And this is now seen as the future revolutionary potential of Europe. Europeans may see this as revolutionary, but American Indians see it simply as still more of that same old European conflict between being and gaining (Means, 1983, p.21).

Means's (1983) statement is a criticism highlighting the settler-colonial racism that often is perpetrated by white, Marxist activists and allies who unconsciously marginalise First Nations peoples worldviews (Land, 2015). Anti-slavery and post-colonial theorists have also argued that Marx's thought was incomplete and therefore the overarching premise of materialist feminism. While theorising the relationships between the ruling classes and the working classes, Marx side-steps an analysis of slavery which has constituted a "failure to adequately deal with the violent denial of human status for those who could never alienate their labour (like the working class) because they were already alienated from forms of property in life itself, in an enslaved life" (Willse, 2015 p.30). These criticisms point to the necessity of incorporating intersectional feminist and anti-colonial feminist perspectives and a focus on the role of ongoing settler colonisation alongside neoliberalism in perpetuating gendered violence, racism and housing injustice.

Conclusion to the chapter:

This chapter explored both intersectional and materialist feminisms to outline the theoretical approach used in this study. This study explicitly understands housing injustice, gendered violence and systemic racism as forms of violence caused by the intersection of patriarchal, anti-black-racism, settler-colonialism and neoliberalism capitalism as the dominant ideologies and political economies operating in Sydney and Vancouver. This theoretical approach has provided a critical lens through which to view the central role of neoliberalism, settler colonisation and hetero-patriarchy in shaping social policies, government and non-government organisational responses, including responses to ‘homelessness’ and ‘domestic and family violence’.

This chapter also traced the key theoretical limitations and tensions between intersectional and materialist feminism. For instance, the very strength of intersectional feminism, the focus on difference, subjectivity and identity, also forms a potential limitation of this framework, a dissolution into ‘identity politics’ and a concern for individual victimisation which can displace collective and unifying action against gendered oppression and violence (Laing & Humphreys, 2013). Identity politics and a concern for *individual* victimisation arguably mirrors (neoliberal) *individual* responsibility (Stringer, 1999). This theoretical limitation led to the inclusion of a materialist feminist analysis. However, critics have argued that the materialist feminist emphasis on (neoliberal) capitalism, lacks an intersectional analysis and specifically an analysis of the role of settler colonisation and anti-black racism in perpetuating housing injustice and gendered violence. This thesis addresses these political and theoretical limitations and criticisms by using both intersectional and materialist feminisms to provide a broad lens through which to interpret trauma informed care practices in crisis accommodation

services and women's refuges. The next chapter, Chapter 4, introduces the research methodology and analytic framework used in this thesis.

CHAPTER 4:

Methodology

Introduction:

This chapter provides an overview of the research questions, the qualitative feminist methodology and the research process. This chapter will also outline the analytical framework which involves: 1) a reflexive account of the subject positioning of the researcher, 2) ethical considerations and the processes for obtaining formal ethical approval from the human research ethics committees based at the University of Sydney and the University of British Columbia, 3) an outline of the recruitment processes, 4) a description of each of the three participating services including; brief, deidentified profiles of staff, key informants and women participants, 5) an outline of the data analysis process.

Research aims and questions:

A qualitative feminist methodology was employed in this study to explore diverse staff conceptualisations of ‘trauma’ and the practices of ‘trauma informed care’. This study was also concerned with how this practice model was experienced by staff and women accessing the service.

The following research questions guided this inquiry:

- 1) How do staff understand and experience ‘trauma informed care’ in women’s refuges and crisis accommodation services?
- 2) How do these understandings shape their work with women who are victims/survivors of gendered violence and housing injustice?
- 3) How do staff understand ‘cultural safety’ (a key principle of trauma informed care) in women’s refuges and crisis accommodation services and how do these understandings influence their work with women?

- 4) How does an espoused trauma informed care/cultural safety model shape women's experiences in women's refuges and crisis accommodation services?
- 5) What service gaps and contradictions are addressed or unaddressed by the implementation of trauma informed care?

Qualitative feminist methodology:

As there is no unified, singular qualitative 'feminist' methodology, it is necessary to outline the epistemological positions that give rise to this specific qualitative feminist methodology. This research design aimed to align with the following broad feminist research principles:

1. The use of women's experiences as a resource for research;
2. The improvement of women's lives through research; and
3. The reconceptualization of power, so the researcher is on the same plane as the subject (Duelli-Klein, 1983; Harding, 1987; Peplau & Conrad, 1989; Van Den Bergh & Cooper 1986 cited in Mason, 1997 p.12).

Research methods such as program evaluations and quantitative designs including the use of surveys were initially considered. However, both program evaluation and quantitative approaches were discarded in favour of an exploratory qualitative feminist design. While feminist research is not necessarily "bound to qualitative methodologies" (Mason, 1997 p. 11), qualitative research designs arguably best support the feminist principle of eliciting women's experiences (Gray, Agllias & Schubert, 2015). Feminist qualitative research and sociology, "privileges the lived and felt experiences of women' as the 'personal is an expression of the political" (Bell, 2015, p.21). Qualitative feminist research aims to facilitate the development of "counter discourses" which give rise to liberating "interpretations of women's identities, interests, and needs" and ultimately towards social change (Fraser, 1997, p. 81). While 'the

personal' can find expression in quantitative methodologies, qualitative in-depth interviews more readily capture subjective experiences.

The feminist principle of honouring the lived experiences of women encompasses not only women surviving housing injustice and homelessness, but also staff and key informants who are, based on the high prevalence of gender-based violence, also likely to be victims/survivors of gender-based violence. Women's refuge and crisis accommodation staff are also likely to have some lived experiences of systemic racism, poverty and housing injustice due to the under-paid, precarious and socially under-valued role of human service work within neoliberal settler colonial societies (Roschelle, 2008). Furthermore, some of the participants in this research project had lived experiences of housing injustice and homelessness prior to becoming refuge or crisis accommodation staff. While it is important not to collapse complex stratifications of gender, 'race' and class under the singular category of gender-based oppression, I agree with Audre Lorde's maxim, "I am not free while any woman is unfree, even when her shackles are very different from my own. And I am not free as long as one person of Colour remains chained. Nor is any one of you" (1984, pp.132-33). Yet it is also important to acknowledge the intersecting socio-political and economic privileges that construct women who are employed as human service workers in a relationship over power over women who are accessing women's refuges and crisis accommodation services.

A qualitative feminist methodology was also used in this study as this method aims to reduce the potential of causing harm to women who are victims/survivors of intersecting forms of structural and interpersonal violence through the research process (Gray, Agllias & Schubert, 2015). Qualitative feminist research methods also facilitate nuanced intersectional understandings of oppression, difference and of subjective experience (Trahan, 2011). This aim resonates with intersectional and materialist feminist theoretical framework guiding this

project. Furthermore, feminist research extends the analysis of power and inequality by supporting social movements and services aimed at improving women's lives:

Feminist knowledge production, when linked to methodological strategies should unravel issues of power and include interventions that help move toward social justice... Feminist qualitative research then, can and should take up the project of activism, either through a critique of complex issues and/or by intervening in ways that make sense for political movements (Davis, 2012, p.27).

Qualitative feminist research has been used in the identification of systemic barriers to effective gender-based violence and domestic and family violence service and policy responses (Skinner, Hester & Malo, 2005). While this research project has focused on the use of the trauma informed care practice model across three diverse service settings, this research project aims more broadly to inform and shape service delivery to better respond to the needs of victims/survivors of gender-based violence, systemic racism and housing injustice. These aims are arguably well supported by qualitative methodologies that are capable of exposing and identifying "unjust (not just inefficient) organisational processes and make them known and to ensure that subordinated voices are heard and heeded" (Humphries, 2008 p.31).

While it is not the aim of this research methodology to "map the totality of institutions", the use of qualitative interviews aims to uncover and indeed map, the "relations of ruling that shape local experiences" (DeVault & McCoy, 2006, p.20). This methodology facilitates exploration of these social relations across multiple institutional and geographical sites. This is not to deny the essential differences between countries and organisations but to facilitate a shared focus on trans-local experiences in multi-site contexts.

This international, qualitative feminist research project involved two services located in Sydney, Australia and one service in Vancouver, Canada. Across Sydney and Vancouver, a

total of three services participated in this research. These cities were selected in this design as they share many social, political, historic and economic similarities. For instance, Australia and Canada are both colonial settler societies. Australia and Canada participate in the OECD and have comparable political economies that can be described as neoliberal. These nation-states also share many similarities regarding the over-representation of First Nations women, refugee and new migrant women, single women and mothers and children in homelessness statistics. These nations-states also share similar patterns of concentrated housing injustice and homelessness in urbanized areas (Doherty, 2010).

Fairclough (2015) argues that a global analysis is necessary for researchers seeking to understand the intersections of “poverty and the increasing gap between rich and poor” and women’s oppression (Fairclough, 2015 p. 239). Fairclough (2015) argues that globalisation must be understood as an ‘economic process’, and more precisely, a neoliberal economic process. Alongside this material analysis, Fairclough (2015) suggests that globalised neoliberalism is represented through the ‘globalisation of discourse’. I have attempted to address these concerns by basing this research in two countries. In order to bridge the methodological gulf between micro-level field work and macro level structural analysis, multi-sited, international research can be engaged “to demonstrate the variety of ways in which globalization is grounded in the local” (Gille & O’Riaine, 2002 p.271). International “structures, processes and relations” (Fairclough 2015 p.239) profoundly influence and shape the ‘local or ‘micro’ experiences. International research facilitates a concern with the ways in which human and community ‘agency’ is constrained by global and local forces, such as neoliberalism, and captures “individual resistance, resilience, choices and complicities” (Erikson, 2011 p. 26). However, by internationalizing the research context, the aim was not to create a country-based comparison. Rather this research project focused on the enactment of

trauma informed care across three diverse service settings and the experiences of this practice model from the perspectives of staff, key informants and women.

Subject positionality of the researcher:

Feminist research demands a high degree of reflexivity among researchers and a clear acknowledgement of the unintentional biases stemming from the subject positionality or more specifically, the socio-political and economic privileges which influence the design, data collection, analysis and findings reported. I identify as (cis-gendered) 'white' woman with Irish, English, Scottish and German heritage. I was born on the stolen, unceded lands of the Darug First Nations peoples and my family history is implicated, as farmers, convicts and 'settlers', in the violence of the settler colonial state of Australia. I have Australian citizenship and an Australian passport. This privilege, in the context of global capitalism, white racism and settler colonisation 'entitles' me to freely cross borders, I am conscious that many people in the world are denied this right.

I am also a tertiary educated person with a social work qualification, which affords privileges within a neoliberal, capitalist political economy. I have no lived experience of being oppressed, harassed, incarcerated, violated or discriminated against on the basis of my skin colour in the context of interpersonal violence and/or systemic racism, slavery, settler colonisation, displacement or war. I am conscious, that while it is my intention to be an ally against all forms of racism, slavery and colonisation, that I cannot truly understand these experiences. I fundamentally agree with Hovane (2012) that "even though non-Aboriginal professionals may try to walk in our (First Nations peoples) shoes, it's still their own feet they are feeling" (p.31).

In my lifetime, I have directly experienced some forms of gendered violence including, sexual harassment, stalking, verbal abuse and hetero-patriarchal sexism. However, I do not identify as a victim/survivor of child sexual assault, or domestic and family violence. I have experienced

the effects of intergenerational oppression as my mother and father were both victims/survivors of family violence and alcoholism in the context of white, Australian, working-class families, who were living below the poverty line. However, I do not use the term ‘victim/survivor’ to name these experiences.

Similarly, while I have experienced poverty, employment precarity, housing stress and housing insecurity, I do not have a lived experience of being without a ‘home’, rough-sleeping or other forms of systemic housing injustice. I identify as a bisexual-queer, cis-gendered woman. As a cis-gendered woman I have not experienced discrimination based on my gender identity, gender presentation or any other forms of transphobic violence and discrimination. As a bisexual-queer person I have lived experiences of heterosexism and homophobia. However, I have also had experiences of heterosexual privilege. My personal experiences of socially and economically located privilege and disadvantage have deeply shaped this research project. The following section aims to present the ethical considerations involved in the attempt to decentre the power of my subject positionality and my role as a researcher within this project.

[Ethical considerations:](#)

As First Nations women are significantly over-represented in housing injustice and shelter use statistics and qualitative reports in Australia and Canada, it was anticipated that many First Nations women and staff would be involved in this research. As a white, non-First Nations researcher who has settler-colonial ancestry and who lives on stolen, occupied land, I have become conscious of ways in which my subject-positionality can reproduce racism and colonialism throughout the research process. I owe this learning to my involvement as an ally in First Nations activism. In settler-colonial societies such as Australia and Canada, the word ‘research’, “when mentioned in many Indigenous contexts, stirs up silence, it conjures up bad memories, it raises a smile that is knowing and distrustful” (Tuhiwai, 1999, p.1). Tuhiwai Smith (1999) and others have identified, that the involvement of First Nations people in

research has often resulted in the misrepresentation, misappropriation and commodification of First Nations peoples, histories, knowledges, and the outcomes of settler colonial research has also resulted further oppression and disenfranchisement (Castledon, Sloan, Morgan, Neimanis, 2010). Decolonizing and First Nations centred research methodologies is a burgeoning field. Tuhiwai Smith (1999) sets out a series of questions below designed to promote reflexivity in researchers and to promote the researcher's accountability to research participants and communities:

- 'Who defined the research questions?
- Who will benefit from the research and what are the community gains?
- What are the possible negative outcomes and how will the researchers eliminate these?
- To whom is the researcher accountable?
- What processes are in place to support the research, the researched and the researcher?'

(Tuhiwai Smith, 1999, pp. 175-176).

I attempted to respond to these reflexive decolonising questions and have aimed to maintain accountability to victims/survivors, I sought informal guidance from a range of activist and professional colleagues and groups.

During the research design, data collection and data analysis phases of this research, I worked closely with a Sydney based organisation which provided education and training to healthcare and human service professionals to prevent and respond to gendered violence, abuse and neglect. In my role as a researcher within this centre, I worked closely with the First Nations Advocacy Circle. One of the fundamental ways the First Nations Circle influenced this research design was in the development of a specific research question exploring cultural safety as a key principle of trauma informed care. This group identified, that while trauma informed

care was gaining traction in human services, the trauma informed principle of cultural safety was often disregarded or poorly implemented in practice. While the First Nations Circle felt there was value in exploring the emergence of trauma informed care, the Circle members expressed concerns that the trauma informed care practice framework did not translate into anti-racism monitoring and responses or into the recruitment, training and support of First Nations staff. I have honoured this recommendation in the research question, which explicitly aimed to explore cultural safety as a key principle of trauma informed care.

I was an active member of the Sydney based *No Shelter: A collective against gendered violence* which comprised social workers, women's refuge workers, activists, women victims/survivors of gendered violence and housing injustice. This activist group, inspired the intersectional and materialist feminist theoretical framework used in this study.

Informed and active consent:

This research study was conducted in accordance with the *Australian Social Work Code of Ethics* which states that; “social workers will ensure that consent is given voluntarily, without coercion or inferred disadvantage for refusal to cooperate” (AASW Code of Ethics, 2010, p.37). The principle of voluntary, active consent was rigorously applied to all participants including staff members and key informants. However, this principle was especially important for the women participants who were experiencing housing injustice. In this regard, I aimed to go beyond the standard research ethics protocols regarding informed consent and privacy. Throughout the research process I was conscious of the emotional and physical safety needs of women who have experienced multiple forms of racialized and gendered violence and housing injustice. This was a significant consideration as many women experiencing housing injustice and ‘homelessness’ are likely to be “accustomed to accommodating themselves to non-choice situations in order to survive” as such “researchers (must) take full responsibility for identifying and changing aspects of the research process that might be experienced as coercive” (Paradis,

2000, p.10). Women experiencing housing injustice may feel unable to refuse participation in research for many reasons including the perception that refusal to participate may endanger their access to service (Fontes, 2004). Similarly, I was aware that consent for staff members in organisational research can be coercive if staff members believe that their participation, non-participation and or answers given during the interview will negatively affect their employment. I cannot guarantee that the experience of violation and loss of power was not replicated in the research process, however I drew from my practice experience as a trained and qualified social worker and employed several approaches with the aim of giving staff, key informants and women multiple opportunities for active and informed consent (Fontes, 2004). I also ensured that participants were aware of the multiple opportunities to withdraw consent prior to and following the interview process.

Each participant signed two consent forms – one for their personal records (if safe) and one that I kept in a locked filing cabinet at Sydney University. I explained to each participant that I would de-identify all participants by assigning different names and removing or disguising other potentially identifying information. However, I also provided participants with the option to retain their true name and to be otherwise identifiable.

In the interest of promoting active and informed consent I was assisted by staff members who initiated conversations with women who have consented to the research to make sure they understand the consent process and withdrawal options (Fontes, 2004). I said that participating in the interview had no bearing on the service or future services provided to women participants. For staff participants, I made it clear that participating in the interview the personal views disclosed during the interview would not be shared with their employers, other staff or other organisations.

Additional consent measures were introduced throughout the interviews for women, staff and key informants. For instance, I asked women, staff and key informants the following questions

prior to the interview; “If you feel like you don’t want to answer a question, how will you let me know?” and “What will you do if tomorrow you decide that you wish you had not participated?” (Fontes, 2004, p. 148). During the interview, I introduced and described each set of questions and asked for consent before proceeding (Fontes, 2004). I prefaced each question with a description of the content of the question and asked the participant for full consent before answering each question. For example, I asked participants; ‘The next few questions are about your experience of staying in shelters/or working in a crisis accommodation service or refuge, would you like to stop the interview here or continue?’ None of the participants (women, staff or key informants) asked to terminate the interview early and no participants revoked consent to participating in this research project.

Participant Wellbeing:

Participant wellbeing for staff, key informants and women was a significant consideration during this research project. I am a qualified Social Worker and at the time of conducting field work for this project I had 5 years of previous experience as a professional human service researcher and at least 3 years as a ‘frontline’ social worker with experience in sexual assault, mental health, homelessness and community outreach services. During my professional experiences as a social worker and research I developed skills and further training in working with and sensitively interviewing women victims/survivors who were experiencing housing injustice and homelessness. My professional background has helped me to develop skills in asking sensitive questions and in perceiving the comfort or distress of participants. It was a significant personal and professional priority and intention to honour the strength, expertise and resistance of women experiencing housing injustice through this research project (Murray, 2011).

Both Human Research Ethics Committees at the University of Sydney and the University of British Columbia, raised specific concerns about the wellbeing of women who had experienced

housing injustice in this research project. I satisfied the concerns outlined by the HREC boards by ensuring that all women participants had ongoing access to supportive staff members based at the participating services. All interviews including interviews with staff participants and key informants were conducted in private rooms within the participating services. This was also designed to increase the safety of participants.

I had also planned to terminate an interview if a participant became distressed. Only one of the women participants became visibly distressed during an interview as she recounted her experience of surviving domestic violence perpetrated by her former husband. This woman had tears in her eyes, although was not crying. I asked this participant if she wanted to end the interview. However, this participant said that she wanted to proceed and to finish telling her story. At the end of each interview, I asked each participant about their experience of the research as a way of debriefing, reflecting and identifying if any further support was required (Gondolf, 2000). Almost all participants stated that sharing their stories and experiences was satisfying and for some, beneficial. For example, the woman who experienced distress while describing her husband's violent behaviours, stated that she hoped that sharing her story in the context of this research project may benefit other victims/survivors. While retelling aspects of her story was upsetting, participating in research was one aspect of her personal advocacy and activism of which she derived a great sense of pride.

Participant Privacy, Confidentiality and Storage of Data:

According to the AASW Code of Ethics "social workers will seek to ensure the anonymity and/or confidentiality of research participants and data and discuss them only in limited circumstances for professional purposes. Any identifying information obtained from or about participants during the research process will be treated as confidential" (AASW Code of Ethics, 2010, p.37).

The privacy and confidentiality of all subjects was a priority of this study. I, the researcher, was the only person who had access to information provided by participants. I did not identify women who participated in the research to service providers and I did not disclose their personal views in any communication with the participating service or any other service. The identities of women and staff participants and service names were changed so that no identifiable information was disclosed in the thesis, presentations or in any other publication. However, one key informant participant, Vikki Reynolds, asked to be identified in this thesis. A tension often exists within qualitative research between protecting the confidentiality of participants and honouring the intellectual contributions made by participants (Kaiser, 2009). As requested, I have used Vikki Reynolds' full name throughout the thesis findings. However, I have changed the names of services and workers that she named in this interview to protect their confidentiality.

All documents including interview transcripts and signed consent forms were only identified by code number and were and continue to be kept in a private locked filing cabinet at the University of Sydney. Electronic copies of interview transcripts were stored on a password protected university computer.

[Formal Ethical Approval:](#)

This research project received formal ethics approval from the Human Research Ethics Committee at the University of Sydney (see Appendix A) and the Behavioural Research Ethics Board at the University of British Columbia (see Appendix B). Local approval was also sought to conduct interviews with Australian First Nations peoples through the Aboriginal Communities Matter Advisory Group at the Education Centre Against Violence in Sydney. Research with Canadian First Nations, Inuit and or Metis peoples was guided by the social work faculty at the University of British Columbia, Vancouver.

Recruitment process for ‘trauma informed’ services:

Services were identified for inclusion in the study through online research and information through professional and academic networks including; academic supervisors, service staff and managers and community-based anti-gender-based violence activists. Services were approached to participate in the research study if they met the criteria of working with women experiencing housing injustice ‘homelessness’ or risk of homelessness and using a service philosophy and framework that responds to violence and trauma, for example: ‘trauma-informed service’, ‘trauma informed care’, ‘women sensitive’, ‘gender-specific’, ‘domestic violence service’ AND an explicit commitment to ‘cultural safety’, ‘cultural competency’ and or ‘anti-racism’. I approached five organisations in Sydney and four organisations based in Vancouver to participate in this research. Of those approached, two services in Sydney and one service in Vancouver agreed to participate. The organisations that declined participation offered a range of explanations. For instance, managers of a Sydney-based service stated that they were concerned about the political and funding climate at the time of invitation and declined any communication with staff. Managers from the remaining two Sydney-based services, provided some initial interest in participating in the research, however managers from both services eventually declined stating that they did not have the resourcing capacity to facilitate my request to conduct in-depth interviews with staff. In Vancouver, recruitment of services was challenging as I had limited professional and informal networks to recommend myself as an international researcher. The attempt to establish trust with individuals and organisations in the heavily researched area of the Downtown Eastside of Vancouver was especially challenging. Two organisations based in the Downtown Eastside declined participation based on service-research saturation. A manager of another service based in Vancouver agreed to participate during the final two weeks of my field work. Unfortunately, I

was not able to find interview times for staff, key informant or women participants at this final service before having to return to Sydney, Australia.

Recruitment and Data collection

The following data was gathered at each participating service site; service context and organisational profile involving desktop research 2) in-depth semi-structured interviews with 8 women who had accessed one of the participating services. 3) 22 in-depth interviews with staff participants 4) 2 in-depth interviews with key informants. The data collection period occurred over 7 months between October 2013 to May 2014.

I conducted site visits (approximately seven visits per site) at all three participating services and held interviews with participants on site.

Recruitment process for women participants:

This study involved the recruitment of women (including women-identifying and transgender women) who were aged at least 18 years and who had accessed crisis accommodation services for a minimum of three weeks within the previous 6 months. Women participants were recruited with the assistance of the participating case-managers and managers. I explained the research project in detail to case managers at each of the participating services who then communicated the following details to prospective participants:

- 1) The case-manager introduced the project to women they have worked with,
- 2) The case-manager emphasised that the voluntary nature of participation and conveyed that participation in the research would not compromise women's current access to the service or future access to the service,
- 3) The case-manager also described how the participant's confidentiality would be maintained throughout the research process and in any research outputs,

- 4) The case-manager introduced the women to the researcher,
- 5) The case-manager arranged appropriate interviewing times,
- 6) The case-manager provided post-interview follow-up and debriefing.

Case managers approached women they were in communication with, women they were continuing to support in the community, women in transitional housing or women who were staying in the women's refuge or crisis accommodation services and who were about to be placed into transitional housing. I did not interview any women who were experiencing acute distress including women who were severely mentally unwell and or who were intoxicated as this would affect their capacity to provide active consent.

I was not able to recruit women who accessed Coast Salish Place in Vancouver. Management staff did not believe that the women accessing the services would be able to provide full and active consent to participating in the research due to the wide-spread use of alcohol and other drugs. Management staff also argued that many staff members had lived experiences of Coast Salish house and other crisis accommodation services. It is possible that the Coast Salish Place management staff were acting as 'gatekeepers' in order to further protect the wellbeing of the women who had accessed the service. Gatekeeping has been acknowledged as a significant barrier to service research involving "vulnerable populations" such as women who have attended a crisis accommodation service (Umamaheswar, 2018). The possible gatekeeping at Coast Salish Place may have also been due to the recent intensive history of social science, medical and allied health and social work research focused on the populations who are residing in the Downtown Eastside area of Vancouver (Linden et al, 2013). Despite, the high volume of research, most of the Downtown Eastside research findings and recommendations have not been translated into social policies that would meaningfully improve the lives of people experiencing housing injustice (Linden et al, 2013).

Recruitment process for staff members:

Using a similar approach to the one outlined above, I initially approached the managers of each of the participating service sites to describe the following project details to staff. All staff who have worked at the participating agencies for three weeks or longer were approached to participate in the study. Most of the service managers (N=2 out of N=3), and staff members (N=11), who participated held social work qualifications although there were a few participants who held or were working towards an undergraduate arts degree (for instance in sociology) or who held or were working towards a diploma in welfare.

Managers explained to prospective staff participants:

- 1) The background and aims of the research project,
- 2) Emphasised that participation in the project was entirely voluntary and their participation or non-participation would not have any impact on their current or future employment,
- 3) Conveyed that the participation in the project would be confidential and that the identities of the participants would not be disclosed during the research process or in any research outputs,
- 4) Introduced the staff to the researcher and provided staff with the researcher's contact details.

I also explained to the managers and staff members at participating services that the research project was qualitative and exploratory and therefore, it was not an evaluation. Evaluations can create anxiety in human service research. Participants can feel that they are being judged or that researchers may publish information that may harm the reputation of a service and reduce funding to a service or service sector. To minimise this possibility, my interview questions focused entirely on staff experiences of delivering trauma informed care in the service.

[Descriptive summaries of participating services, women and staff members:](#)

The following service summaries are intended to provide some contextual information to assist the reader. All the names of services who participated in this research have been changed and identifiable information has been omitted. I negotiated the de-identified service summaries with each of the participating service managers to ensure that identifying material was not inadvertently divulged. Therefore, any similarities to existing services including service names, is coincidental.

Prior to each interview, I asked managers, staff and key informants, to describe their gender identity, age, status as a First Nations or non-First Nations identifying person, length of experience at the service or knowledge of the service sector, disciplinary background and practice philosophy. The subject positionality, ethics and beliefs of human service workers also influences the translation of practice frameworks. According to Zufferey (2015) “responses to homelessness are influenced by gendered, white, Western and middle-class discourses which are embodied and performed by social workers in their professional practice” (p.90). Therefore, it was anticipated that along with the divergent organizational philosophies, that the subject positionalities, ethics and beliefs held by women’s refuge and crisis accommodation staff, would influence the translation of ‘trauma informed’ concepts and principles into practice.

I also asked women who had accessed one of the participating services, to provide the same demographic information about their gender identity, age, status as a First Nations or non-First Nations identifying person, length of stay and reason for accessing the service. This demographic information was also used to assist the intersectional feminist analysis of women’s experiences of trauma informed services.

[Hamilton House \(Sydney, Australia\)](#)

“Hamilton House” was established over twenty years ago and is owned and run by a large Australian faith-based organisation. Hamilton House is located in the inner city of Sydney and is a 24-hour, service. Over the past five years, Hamilton House has implemented a model of trauma informed care. Prior to the implementation of trauma informed care, the service did not use any trauma or violence response and prevention frameworks or screening tools.

I interviewed the following women and members of staff at Hamilton House:

Staff:

Angela: Identified as a non-First Nations woman. Angela was a social worker and had been the service manager for 3.5 years at the time of interview.

Mark: Identified as a non-First Nations man. Mark was a social worker and worked as the team leader at Hamilton House for 5 years and overseeing the implementation of trauma informed care.

Julian: Identified as a non-First Nations man. Julian had a degree in social science and worked as a case-manager at Hamilton House for 18months.

Megan: Identified as a non-First Nations woman. Megan was a qualified social worker and had worked as a case-worker with Hamilton House for three years.

Belinda: Identified as a non-First Nations woman. Belinda had a background in adult education and had worked as a team leader and caseworker at Hamilton House for 12months.

Terry: Identified as a non-First Nations woman. Terry had worked at Hamilton House for two years.

Sandra: Identified as a non-First Nations woman. Sandra was a social worker and was employed as a specialist trauma informed case-worker. Sandra had 15 months experience in this role at the time of interview.

Danielle: Identified as a non-First Nations woman. At the time of the interview, Danielle had been employed as a case-worker for 10 months.

Women residents at Hamilton House

Marlene: Identified as a non-First Nations woman. Marlene was in her early forties. She said that she had become homeless after leaving a violent partner. Marlene had stayed a Hamilton House for 9 months.

Cindy: Identified as a non-First Nations woman. Cindy was a teenager, aged over 18 years, who came to Hamilton House after she was forced to leave her home due to violence perpetrated by her father and brother. Cindy stayed in Hamilton House for 12 months.

Anita: Identified as a non-First Nations woman. Anita was in her 30s. She first came to Hamilton House after leaving her violent and abusive husband.

Paula: Identified as a Greek migrant woman. Paula was in her early fifties. She came to Hamilton House after leaving her violent partner. She stayed at Hamilton House for 15 months and now lives in a public housing property in the Western suburbs of Sydney.

Claire: Identified as a non-First Nations woman. Claire was in her late 60s and had become homeless for the first time after losing her job and being unable to continue paying rent and had no friends or family members. Claire had stayed with Hamilton House for 6 months.

[Amelia's Place Refuge \(Sydney, Australia\)](#)

Amelia's Place is a women's refuge based in Western Sydney. Established in 1987, the service identified as a feminist domestic and family violence refuge. The service only works with women and their children. In the last five years this service has expanded to include referrals from women experiencing 'homelessness'.

Amelia's Place has a First Nations women's specific accommodation service which can accommodate 6 women and 12 children.

Staff:

Margaret: Identified as a non-First Nations woman. Margaret was a social worker and had worked at Amelia's Place for 4 years.

Rosalyn: Identified as a non-First Nations woman. Rosalyn held a TAFE qualification in welfare and had worked as a case worker for 3 months. Rosalyn also had accessed the service 7 years ago after leaving a violent partner.

Renée: Identified as a non-First Nations woman. Renée had a degree in nursing and has worked in domestic and family violence refuges for 10 years and had worked as a case worker at Amelia's Place for 2 years.

Kayleen: Identified as a First Nations woman. She was a social worker and had worked at Amelia's Place for 2.5 years.

Justine: Identified as a First Nations woman. Justine was a social worker and had worked at Amelia's Place for 18 months.

Shannon: Identified as a non-First Nations woman. Shannon was a social worker and had worked as a case manager at Amelia's Place for 12 months.

Women at Amelia's Place

Julie: Identified as a First Nations woman. Julie was in her 30s. Julie had been staying at Amelia's place for the past twelve months with her three children, aged 6 months, 2 years and 7 years. Julie came to the refuge after leaving a violent partner.

Daiyu: Identified as a Chinese new migrant woman. She was in her late 20s. Daiyu was staying at Amelia's Place with her 1-year old child at the time of interview and had previously

stayed at Amelia's Place on a separate occasion. The total length of time Daiyu spent at Amelia's Place was 8 months. Daiyu, came to the refuge on both occasions due to domestic violence perpetrated by her partner and father of her child.

Changying: Identified as a Chinese new migrant woman. She was in her mid-30s. Changying was also at Amelia's Place with her two children aged 4 and 6 years of age. Changying had been staying at Amelia's Place for 9 weeks at the time of the interview. She had come to the service due to domestic violence perpetrated by her husband.

Coast Salish Place (Vancouver)

Coast Salish Place is a not-for-profit crisis accommodation and transitional housing service which has provided accommodation to women experiencing housing injustice in Vancouver in the early 1980s. Coast Salish Place's primary organisational aim is to end violence against women through direct service work and to prevent gendered violence through community education and development.

Coast Salish Place states that all accommodation and programs are accessible to anyone who identifies and lives full time as a woman and who experiences gendered violence and misogyny, including transgender women, two spirit and intersex women and non-binary identifying people.

I interviewed the following staff members at Coast Salish Place:

Joan: Identified as a Métis woman. Joan was the service manager with over twenty years of experience at Coast Salish Place as a housing support worker and as a manager.

Brandy: Identified as a First Nations woman and had been a housing support worker at Coast Salish Place for five years.

Mahala: Identified as a First Nations woman. Mahala was a social worker and had been a housing support worker at Coast Salish Place for eight years.

Robin: Identified as a Metis woman. Robin had been involved in Coast Salish Place as both a woman who accessed the service (12 months) and as a housing support worker (3 years). At the time of the interview, Robin was enrolled and completing a social work degree part-time.

Dan: identified as a non-First Nations, Transgender male. Dan was a social worker and he had worked as a housing support worker at Coast Salish Place for 18 months at the time of the interview.

Key Informants:

Vikki Reynolds: Identified as a non-First Nations, activist, counsellor and academic and has been a clinical advisor to Coast Salish Place. Vikki Reynolds participated in this research project as a key informant and it was her preference to be identified in the reporting of the findings. Vikki Reynolds was also a clinical advisor and supervisor to the Coast Salish Place service.

Stella: Identified as a First Nations woman. Stella also identified as an anti-institutional abuse and housing justice activist. Stella was also a long-term Sydney-based rough sleeper who stayed in Hamilton House before the service implemented trauma informed care.

The Interview questions and Process:

I conducted semi-structured, in-depth interviews with 32 actively consenting participants. All interviews were recorded on a digital recording device which were subsequently transcribed. At the time of developing the interview schedules for this research project, there was limited research exploring trauma informed care in human services settings. However, the Trauma Informed Program Self-Assessment Scale (Fallot and Harris, 2006) and the Trauma-Informed Organizational Toolkit (Guarino et al., 2009) contained key domains out of which, I formulated

interview questions for staff, key informants and women who participated. The following key domains were incorporated into the interview schedules for this project: trauma informed training and education, staff supervision, support and self-care, physical safety, cultural safety and involving women accessing the service in decision making processes. Questions were also modelled from the interview schedule used in the *Bridging the Gap* research project (Laing & Toivonen, 2010). The modified *Bridging the Gap* (Laing & Toivonen, 2010) interview questions were included as they reflect best practice guidelines for interviewing victims/survivors of gender-based violence including domestic and family violence. It was anticipated that many of the women (including staff) would be victims/survivors of gendered violence, domestic and family violence. Therefore, staff members and key informants were asked a similar set of semi-structured interview questions based on these key domains (see appendix H).

Women were specifically asked to describe their experiences of the service in relation to their feelings of; safety, trustworthiness, choice, collaboration and empowerment (see Appendix I). For example, the researcher asked women ‘Did you feel cared for, respected, listened to, and supported while staying here? Do you feel physically safe staying at this service? Do you feel that the staff worked with your strengths? The researcher also asked women questions related to the key trauma informed domains identified by Laing and Toivonen (2010), including women’s experience of 1) a trusting relationship with workers 2) feeling listened to and validated, 3) holistic service provision, 4) flexibility and availability of workers, and experiences of 5) cultural safety. Women accessing the service were asked questions about how the staff worked with them and about any resources the staff helped them to access for instance, if the staff helped them to understand perpetrator tactics and worked with them to develop safety plans. Finally, women were asked about their ideas for ending violence broadly and how services might better help them (see Appendix I).

Data Analysis:

I transcribed verbatim all 32 interviews from a digital voice recorder. The interview data was analysed using thematic analysis in two stages. Following Braun and Clark (2008), the themes that were identified “captured something important about the data in relation to the research question(s) and represents some level of patterned response or meaning within the data set” (p.82). In practice, the thematic analysis of 1) staff and key informant interview and 2) women’s interview transcript data followed the procedure described by Braun and Clark (2008):

1. Transcribing interview data: reading and re-reading the data.
2. Generating initial codes
3. Collating codes into potential themes
4. Reviewing and testing key themes: Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.
5. Defining and naming themes.
6. Producing the report: final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis (p.87).

The approach employed in the thematic analysis of women’s interview transcript data was different to the processes employed in the thematic analysis for staff and key informant’s interview transcript data. These key approaches are outlined in detail in the following sections.

Stage 1: Interactional and Discursive view of Violence and Resistance Heuristic

The *Interactional and Discursive view of Violence and Resistance* framework was used as a heuristic to code the data of staff and key informant interview transcripts in the initial stage of analysis (Coates & Wade, 2007). It is important to mention that the *Interactional and Discursive view of Violence and Resistance* heuristic was not used in the analysis of women’s interview transcript data. Please see the following section for an outline of how women’s interview transcript data were analysed.

Following (Sampson, 2012), I adapted the *Interactional and Discursive view of Violence and Resistance* as an initial coding framework. Sampson (2012), argues that using the *Interactional and Discursive view of Violence and Resistance* as a heuristic, can be used as an entry point into the data (Sampson, 2012 pp.73-74). This heuristic was used in the analysis of staff and key informant data for several reasons. As identified by Sampson (2012), the original *Interactive and Discursive view of Violence and Resistance* framework was relevant to the research questions and methodology for this study and this was easily adapted into a heuristic. As discussed in the previous chapters, the ways in which trauma is conceptualised has multiple political implications. In order to respond to the research questions which centred on how services and social workers/human service workers defined and enacted trauma informed care (cultural safety), it was necessary to incorporate a method for delineating the discursive and political constructions of trauma.

The framework was devised by Coates and Wade (2007), as a tool to identify the ways in which language and discourse can misrepresent victims/survivors and to misrepresent perpetrators of violence. Coates and Wade (2007), argue that the use of language is central to the maintenance of power and they identify that “the problem of violence is inextricably linked to representation” (Coates & Wade, 2007 p. 511). As such, it is possible for social workers, social policy writers, human services, advocates, researchers etcetera, to misrepresent violence. For instance, misrepresentation in language and discourse can be used intentionally and unintentionally to blame victims and minimise perpetrator responsibility (Coates & Wade, 2007). Ultimately, misrepresentation can be considered to dangerously “impede effective interventions through education, victim advocacy, reportage, law enforcement, criminal justice, child protection, and counselling with perpetrators and victims” (Coates & Wade, 2007, p. 521).

Coates and Wade (2007) argue that violence has a number of defining features such that ‘violent actions’ and ‘violent language’ can be distinguished from all other acts. The key concept they introduce is that violence is always deliberate. For instance, perpetrators use specific tactics to stifle resistance of the people they have targeting anticipating that their victim will attempt to resist (Coates & Wade, 2007). Women’s rights activists and theorists have conceptualised the specific tactics commonly used by perpetrators to gain power over people they have targeted and suppress resistance through fear and threats. For instance, Laing and Humphreys (2013) argue that perpetrators isolate victims and that the abuse is kept secretive “because secrecy enables ongoing abuse of power and evades accountability” (Laing & Humphries, 2013, p. 140). Perpetrators also “deny, minimize and excuse their violence, blame their victims and make victims responsible for their violence” (Laing & Humphries, 2013, p.141). Furthermore, Laing and Humphreys (2013), argue that ‘victims often are made to feel loyal to the perpetrator and to feel responsible for others often risking their own safety and wellbeing to do so’ (p. 142). Therefore, language is a key site of power and manipulation. However, violence is not confined to discourse and representation, and the exploration of language and discourse, must be balanced with the understanding that violence has material consequences.

Drawing from the above definitions of violence, Coates and Wade (2007) identify four ‘operations of language’ which can be used to:

- 1) Conceal violence,
- 2) Obfuscate perpetrator’s/institutional responsibility,
- 3) Blame victims and,
- 4) Minimise the resistance of victims/survivors (Coates & Wade, 2007).

For these authors for every history of violence, there is a parallel history of resistance (Coates & Wade, 2007). Just as language can be used to facilitate violence, Coates and Wade (2007) argue that language can be used to resist and name violence. Coates and Wade (2007) constructed the following language categories:

- 1) Expose Violence,
- 2) Clarify perpetrator's responsibility,
- 3) Honour Victims Resistance and Voice,
- 4) Contest language and concepts that are pathologising (Coates & Wade, 2007).

Heuristic:

I developed a heuristic based on Coates and Wade's (2004; 2007) *Interactional and Discursive view of Violence and Resistance* tool, which consisted of seven questions. The purpose of using the *Interactional and Discursive view of Violence and Resistance* heuristic was to guide the initial phase of coding. However, it is important to emphasise that this framework was only used in the initial stage of coding.

The following list of questions were adapted from the original *Interactional and Discursive view of Violence and Resistance* tool developed by Coates and Wade (2007). Where the original *Interactional and Discursive view of Violence and Resistance* describes the misrepresentation of 'perpetrators', these questions have been changed to better reflect the organisational focus of this research process.

- 1) How does the language used by staff conceal gendered violence and racism?
- 2) How does the language used by staff obfuscate institutional responsibility?
- 3) How does the language used by staff blame victims and/or minimise the resistance of victims/survivors?

- 4) How does the language used by staff expose gendered violence and racism?
- 5) How does the language used by staff clarify institutional responsibility?
- 6) How does the language used by staff challenge pathologising and victim blaming language?

Heuristic procedure:

I analysed each interview transcript (from staff and key informants) to code each instance of the operations of language identified by Coates and Wade (2007). I read each transcript a minimum of ten times. I used an excel spreadsheet to organise these preliminary codes.

[Thematic analysis of interview transcript data from women who participated in the study:](#)

In contrast to the analysis approach taken with staff and key informant interview transcript data, the interview data from women who had accessed participating services were initially coded inductively. In other words, the coding and the development of key themes were shaped by the raw data as opposed to using a deductive approach. Interview transcripts were each read a minimum of ten times to identify common themes, patterns and key differences between women's experiences. This approach aimed to remain closely aligned to women's narratives and aimed to minimise the imposition of guiding theories or philosophies. As Spivak (1988), identifies, extremely disfranchised women (the subaltern) in the context of settler colonial societies, are often spoken for and their narratives and experiences are redefined by settler colonisers. Thus, Spivak (1988) claims, the 'subaltern' is often denied the right to 'speak' and the right to her own history and experiences. To minimise replicating this form of violence and denial through the research process, after the key themes were developed from the initial coding process these key themes were shared with three women and two staff participants with lived experiences of housing injustice and gendered violence. These participants confirmed that the key themes that were identified closely reflected their experience.

Stage 2 Data Analysis:

Following the initial coding using the discursive functions of language heuristic, I then organised the data into descriptive, lower order themes. These lower order themes were then analysed using a dialectical process which identified common and uncommon statements, language, discourses and experiences. The dialectical process involved a further comparison of lower order, descriptive themes with critical literature. For example, as discussed in chapter 2, my study is grounded in intersectional, and materialist feminisms. These theoretical frameworks were used to assess the transcribed data (for staff and key informants) for thematic and discursive patterns, such as the appearance of biomedical and psychiatric discourses, the neoliberal discourse of individual responsibility, and the use (and co-option) of feminist language without politicised, feminist, conceptual and political meanings. Following this process, I then organised the lower order themes into clusters. Again, using a dialectical analysis, I began to describe the higher order themes from the lower order thematic clusters. In order to minimise the methodological problem of producing descriptive rather than analytical higher order codes (Bazeley, 2009), I examined higher order themes in relation to the following categories: service type, male and female identifying staff members and between, First Nations, Metis and Non-First Nations identifying staff members, women accessing the service, staff with lived experiences of gender-based violence and housing injustice, and staff who stated that they had lived experiences of gender-based violence and housing injustice. This process helped reveal meaningful associations between the aforementioned categories and the construction of higher order themes. This also clarified higher order themes that were shared across categories, such as service types (Attride-Stirling, 2001). I also interrogated both high and lower order themes by exploring both the internal and external factors that likely influenced the patterns in the data (Bazeley, 2009). Finally, I examined the data for ‘outliers’,

or participants who had very divergent views in comparison with other participants. This also helped to ‘test’ both lower order and higher order themes (Bazeley, 2009).

The following table provides an overview of the thematic analysis strategy used in this study.

Thematic analysis:

Research Questions:

	Heuristic	STAGE 1	STAGE 2	STAGE 3
1) How do staff understand and experience ‘trauma informed care’ in women’s refuges and crisis accommodation services?	How does the language used by staff conceal violence* (gendered Violence/Institutionalised/Systemic violence?) *Violence includes racism.	} Use of punitive strategies masked by language of trauma informed care.		} A continuum of trauma informed service models shaped and constrained by neoliberalism.
2) How do these understandings shape their work with women who are victims/survivors of gendered violence, systemic racism and housing injustice?	How does the language used by staff obscure institutional responsibility?	} Co-option of feminist discourses and anti-violence work by trauma informed discourses.	What internal and external factors facilitate this?	} 1) Behavioural Management Trauma Informed Care, Limited Cultural Safety
		} Use of the discourse of individual responsibility.		
		} Use of trauma informed care language in place of ‘violence against women’ language.		

<p>3) How do staff understand ‘cultural safety’ (a key principle of trauma informed care) in women’s refuges and crisis accommodation services and how do these understandings influence their work with women?</p>	<p>How does the language used by staff blame victims and/or minimise the resistance of victims/survivors?</p>	<p>} Use of psychological, biomedical and punitive welfare discourses</p>	<p>} What internal and external factors facilitate this?</p>	<p>} 2) Politicised, Social Change Trauma Informed Care, Integrated Cultural Safety</p>
<p>4) How does an espoused trauma informed care/cultural safety model shape women’s experiences in women’s refuges and crisis accommodation services?</p>	<p>How does the language used by staff expose violence? (gendered Violence/Institutionalised/Systemic violence?) *Violence includes racism.</p>	<p>} Discourse of harm reduction.</p>		

How does the language used by staff clarify institutional responsibility? } **Focus on the social context of housing injustice: gendered violence, settler-colonisation, systemic racism, homophobia and transphobia**

How does the language used by staff challenge pathologising and victim blaming language? } **Peer led service provision**
Women viewed as experts in their own lives – women’s decisions are valued and respected.
Discourse and praxis building women’s ‘influence, purpose and belonging’.

Conclusion to the chapter:

This chapter has provided an overview of the research questions, ethical considerations and a rationale for the qualitative feminist research methodology utilised in the research project. This chapter also provided an outline of the research process and the thematic analysis strategy used in the analysis of the interview transcript data from 32 in-depth interviews with staff, key informants and women who had accessed least one of the three participating women's refuge or crisis accommodation services located in either Sydney or Vancouver. The findings from this research will be discussed in chapters 5 to 7. The next chapter, chapter 5, introduces the findings section of this thesis and explores one of the key findings arising from this research; that there was a wide interpretation of trauma informed care across the three participating services. The trauma informed care models were presented as a continuum of practice.

CHAPTER 5

A continuum of Trauma Informed Care Models:

Introduction:

This chapter is the first of three to present the key findings from this qualitative feminist study. The translation of trauma informed care into practice and the experiences of trauma informed services from staff members and women's perspectives were central to this research project. However, as argued in Chapter 3, human services cannot be understood in isolation from the dominant social, political, economic, geographical and historical contexts which they are embedded within. From a materialist feminist perspective, any human service research, demands an analysis of service provision within the neoliberal political economy. Similarly, intersectional feminism calls for an analysis of human service provision within the context of systemic and institutionalised racism, settler colonisation and heteropatriarchal oppression. These staff and key informant interview transcript data were initially analysed using a heuristic based on the *Interactional and Discursive View of Violence and Resistance* (Coates & Wade, 2007) and this was followed by two stages of thematic analysis grounded in materialist and intersectional feminisms.

This chapter responds to the following research questions:

- How do staff understand and experience 'trauma informed care' in women's refuges and crisis accommodation services? and,
- How do these understandings shape their work with women who are victims/survivors of gendered violence, systemic racism and housing injustice?

This chapter attends to these research questions by exploring one of the main findings identified in the research analysis; that each of the participating service sites in Sydney and Vancouver, had implemented a unique model of trauma informed care and practice. While all the

participating services and staff used a shared language of ‘trauma’ and ‘trauma informed care’, it was clear that there were multiple and contradictory interpretations operating across the three service sites. This raises questions about how meaning is shared between services and policy makers. It also raises questions about how different interpretations of ‘trauma informed care’ result in different priorities and responses in practice.

This chapter describes two dominant models of trauma informed care practice: 1) Behaviour management trauma informed care and 2) politicised trauma informed care. These dominant models of trauma informed care can be understood as a continuum of practice with behaviour management trauma informed care and politicised trauma informed care representing opposite ends of the continuum. In broad terms, the Sydney based crisis accommodation service, Hamilton House, predominantly utilised a behaviour management model of trauma informed care. Conversely, both the Vancouver-based crisis accommodation service, Coast Salish Place, and the Sydney based feminist women’s refuge service, Amelia’s Place, used models of trauma informed care that could be described as politicised.

It is important to emphasise that in reporting on the differences between the dominant models of trauma informed care that any criticism does not lie with individual workers or service managers. Furthermore, by defining a continuum of trauma informed care, the aim is not to produce a binary of ‘good’ or ‘bad’ service provision or ‘good’ and ‘bad’ workers. Rather, following an intersectional and materialist feminist analysis, criticisms are attributed to the diffuse power of the neoliberal political economy. Yet, it is not argued that workers and services have no agency, as Foucault (1984), asserted, power is (re)produced, resisted, embodied and enacted through social relations and institutional processes rather than through the ‘top-down’ application of power-over passive subjects. Services and workers have agency; however, their expressions, knowledges and experiences are only intelligible through an analysis of the social, political and economic context, in this case, settler-colonisation and

neoliberalism. The continuum model of trauma informed care also intends to be viewed as dynamic, rather than static, with services and workers at times moving towards or away from either behaviour management or politicised models of trauma informed care.

The representation of qualitative interview data can be unclear especially in the representation of shared perspectives or experiences. In the attempt to be transparent, this chapter and the subsequent findings chapters adopt the following guide developed by Rawsthorne (2009, p.49) and Tseris (2015, p.92). The terms ‘most’ or ‘the majority’ were used to refer to at least three quarters of participants; the terms ‘many’ or ‘several’ or ‘a number of’ were used to refer to at least half of the participants; the term ‘some’ was applied to refer to more than three participants but less than half of the participants; and the terms ‘a couple’, ‘a minority’ or ‘a small number’ were used to refer to less than three participants.

This chapter begins by introducing each of the dominant trauma informed care models that were identified through analysis of the data. With the aim of presenting consistent findings this chapter looks explicitly at the 1) discourses 2) training and supervision models, and 3) key practices which defined each of the dominant models of trauma informed practice 4) possible sites of resistance to and compliance with settler-colonial, ideologies, discourses and policies.

Behavioural Management trauma informed care:

Hamilton House provides a useful case-study for the implementation of trauma informed care in a service with no prior organisational history of responding to gendered violence or trauma. Prior to the implementation of trauma informed care, Hamilton House had operated exclusively as a crisis accommodation service providing shelter (crisis and transitional housing), basic alms, welfare and social housing support. Most staff participants from Hamilton House said that the trauma informed care training and supervision was their first introduction to the high prevalence of ‘trauma’ experienced by the women accessing their services. While Hamilton

House staff had always worked with women who had lived experiences of ‘trauma’ and gendered violence, staff had not been trained to understand the centrality of violence in the lives of women experiencing housing injustice.

The influence of psy constructions of trauma:

The type of trauma informed care training and supervision received by staff at Hamilton House fundamentally influenced the model of practice that was implemented and enacted by staff. At the time Hamilton House sought to implement a model of trauma informed care, there were limited options in terms of training and supervision support. As such Hamilton House Staff received training developed and delivered by psychologists and counsellors who had been local advocates for the implementation of trauma informed care in homelessness services. As such, the dominant trauma discourse used by Hamilton House staff participants could be described as a psy trauma discourse informed by a range of psy disciplines including psychiatry, psychology and psychotherapy. At the time of conducting fieldwork for this research project, trauma informed care in Australia was a new and burgeoning field and as such it had received minimal critical appraisal. However, the organisation’s choice to accept trauma informed care training and supervision by psychologists who utilised an uncritical psy discourse (as opposed to a feminist or anti-racist discourse), had far reaching implications.

The use of the psy trauma discourse created several tensions and contradictions during the implementation of trauma informed care. For instance, many Hamilton House staff participants reported that a key benefit of the trauma informed care training was gaining a new or increased understanding that mental health labels, particularly Borderline Personality Disorder, can be experienced by victims/survivors as oppressive and stigmatising. Along-side this understanding, staff continued to use some psychiatric concepts and language to describe the women that they worked with. While staff participants refrained from using explicit diagnostic

psychiatric ‘labels’ to refer to women, staff participants instead labelled women as ‘traumatised’. The psy ‘trauma’ label was applied in a range of contexts which had emancipatory, neutral and oppressive consequences for the women accessing Hamilton House.

As discussed in the literature review in Chapter 2, the psy trauma discourse has been criticised for producing overt and covert victim-blaming, responsabilising and pathologising representations of victims/survivors. Similarly, Hamilton House staff participants responded to the question, ‘how do you understand trauma in the lives of the women you are working with?’ with descriptions of ‘trauma’ that could be interpreted as pathologising and responsabilising. For instance, Julian, a case-manager at Hamilton House, described the influence of the trauma informed care training on the way he came to perceive women who displayed challenging behaviours at the service:

Julian: Often, we will be talking with the child, the child-mind of the client. Where I feel like I am dealing with an adult and it’s hard to come to terms with decisions clients are making and the way that they are behaving and often what (the trauma informed care trainer) has said to us, is that they are showing us their inner child.

The ‘inner child’ concept originated from the field of psychotherapy and has been used in multiple psychotherapeutic modalities such as art therapy, transactional analysis and has been used extensively in ‘Self Help’ literature. Without exploring the debates concerning the history and applications of inner child work and associated criticisms, it is possible to discuss the way the ‘inner child’ concept is used in the context of this interview. It is also important to mention that Hamilton House staff did not receive inner child therapy training, nor were case-work staff using this psychotherapeutic approach in their work with women. Thus, the concept of the inner child used in this example was only used as a lens through which to understand the behaviours and needs of ‘traumatised’ women.

The word 'child' has many negative connotations and is synonymous with immaturity, naivety and possibly incompetence. Conversely, the word 'adult' is synonymous with rationality, responsibility and competency. If the women accessing the service were perceived as having a 'child-mind', this in turn implies that the staff believed the only 'adults' were other staff members and or women who were perceived as being compliant. This perception creates a context for a paternalistic service culture which contradicts the trauma informed principle of sharing power with women accessing the service. The idea that women's 'challenging behaviours' stems from a regression to their wounded, 'child mind' misrepresents women and precludes the possibility that the women accessing the service may in fact be making very 'adult', sophisticated decisions based on their lived experiences and knowledge. This view also contradicts trauma informed care literature which emphasizes respecting victims/survivors as the experts in their own lives and honouring their resistance.

The psy trauma discourse used by Hamilton House staff participants was often used as a euphemism which eluded to but ultimately obscured forms of interpersonal/gendered violence and structural violence. The psy construction of trauma rendered 'trauma' as a purely psychological *impact* or *reaction* to a *past* event.

In many Hamilton House staff participant interviews, the psy trauma discourse concealed an analysis of gender-based violence and domestic and family violence in the context of homelessness/housing injustice. For instance, Mark a social worker and team leader, struggled to both define trauma and to relate this concept to the experiences of women accessing the service:

Researcher: How do you understand trauma - what does that mean to you?

Mark: Really the measure of the trauma is, well it is all about its impact. Well if this person's in a car accident... We've had some people go through some horrific things and

really have for whatever multiple reasons are pretty, are okay... so it's kind of getting people past that trauma. I guess my concept of trauma is just around those life events or things that happen to people that have that impact on us as people. Both physiological and psychological.

While Mark uses the example of a 'motor vehicle accident' as an example of a traumatic event, he did not at this moment, nor at any other moment, discuss trauma in relation to for example; gendered violence, domestic and family violence, sexual assault, racism or housing injustice. In this example, the cause(s) of the original trauma/injustice are not constructed as a relevant concern or priority of the service. In other words, social justice concerns including ending housing injustice and ending violence against women were clearly omitted from the psy construction of trauma in this model of trauma informed care. As Mark, and the wider Hamilton House service, side-stepped the correlation between gendered violence and trauma, staff members avoided any responsibility for responding to or preventing the ongoing risk of violence experienced by women at an individual level and at the level of systemic advocacy. Instead, Mark, like many staff participants at this service, believed that trauma informed care is a form of psychotherapeutic work. This was imagined as the provision of temporary accommodation staffed by workers who were demonstrably understanding, kind and flexible in the attempt to create emotional safety for women. In the following example, Sandra, a trauma informed care specialist worker, acknowledged that while many of the women accessing the service are victims/survivors of past violence, she reiterated that the primary aim of the trauma informed response was therapeutic:

Sandra: That experience of trauma can lead to them continuing to be vulnerable to further trauma. Trauma informed care is about trying to break that cycle or break the potential for trauma to occur... A lot of them are single mothers, having survived and coped for a very long time and battled with injury. Just getting to a place where they

can stop breath and feel supported. Feeling safe and feeling like someone is there to help them is probably the over-arching factor.

In the above example and in other interviews with staff participants from Hamilton House, the language of trauma was often used as a euphemism encompassing many diverse forms of injustice such as: gendered violence, child sexual assault, sleeping rough for long periods of time, mental health concerns and challenging or distressing behaviours. The broad use of the language of 'trauma' obscured the details and the experiences of women. In this instance, it was unclear how trauma informed care could be mobilised to 'break the cycle of trauma'. If trauma is principally understood as a complex psychiatric and psychological reaction to past trauma, does this then recast the work of trauma informed care into psychiatric rehabilitation? Although subtle, the psychotherapeutic discourse implied responsabilisation by constructing traumatised women as responsible for their traumatised mental states which have led to their ongoing 'homelessness' as well as their 'challenging behaviours'.

The majority of staff participants from Hamilton House believed that the physical and emotional respite provided by the service would initiate women's emotional and psychological recovery from the symptoms of 'trauma'. Once rehabilitated from the physiological and psychological symptoms of trauma, women were thought to be better positioned to maintain housing tenancies. As Willse (2010a) argues, in the context of neoliberalism, "shelters often institute social work strategies that are designed to discipline the individual such that they learn to overcome the individual, personality-based obstacles to finding and maintaining housing" (Willse, 2010a pp. 157-158). Drawing from this analysis, it is possible to view trauma informed care as a disciplining strategy aimed at rehabilitating women such that they become compliant and therefore housing and job-ready. If this is understood to be a core rationale of the implementation of trauma informed care at Hamilton House, it is not surprising that

systemic advocacy was not featured in the implementation of this model of trauma informed care.

As a caring yet possibly disciplining approach, this model of trauma informed care can be described as a type of behavioural management. Examples of the application of trauma informed concepts in service of behaviour management will be further explored in the following section. However, it is important to return the discussion to the psy trauma discourse and staff perspectives on responding to gendered violence.

In the following example, Angela, the service manager at Hamilton House, utilised a psychiatric and psychological trauma discourse to describe the service priorities in responding to the women who were viewed as ‘traumatised’:

Angela (Manager): Trauma informed care is very much recognising that people have experienced trauma in the past.

Researcher: Do you often see people coming in who are on the run?

Angela: Yeah and on the run, can be that can be they are literally running from something or someone or it could be in that state of avoidance. That’s a trauma response so (women often say) “I don’t want to talk to the world, I don’t want to fill this form out”. So, it can literally mean “I am fleeing for my life” or it can be “I don’t want to interact with the world”.

The language of ‘avoidance’ strongly draws from the psy trauma discourse and constructs trauma informed care as a predominately therapeutic intervention. Angela acknowledged that women were often at risk of violence however this was balanced with a strong concern for the psychological impacts of trauma. As trauma was viewed by most Hamilton House staff participants as an event confined to women’s *past*, the women staying at Hamilton House were perceived as no longer being at risk of harm or gendered violence. Therefore, the therapeutic

psy trauma discourse limited the possible range of service supports and referrals for women who may have experienced trauma in the *past* and who continued to be subjected to ongoing threats of stalking, harassment and violent assaults including lethal assaults. As discussed in Chapter 2, all women experiencing housing injustice are at an elevated risk of sexual domestic and family violence. Perpetrators of domestic and family violence often escalate and intensify violence against women in the immediate aftermath of their escape (Laing & Humphreys, 2013). Given this evidence, the managerial and staff participant's emphasis on therapeutic responses to past trauma or psychological trauma over responses to women in immediate risk of harm was a surprising finding.

Most Hamilton House staff participants, utilised the psy trauma discourse to create a conceptual distinction between 'trauma' and 'violence/gendered violence', and this distinction was replicated in practice. Most staff participants asserted that as Hamilton House was a crisis accommodation service and not a domestic violence service or women's refuge, assessing women's risk of ongoing harm (including the risk of lethality) was beyond the roles and responsibilities of staff.

As previously mentioned, the psy trauma discourse extended rather than challenged the disciplinary and coercive practices of the Hamilton House. Hamilton House staff participants also exercised discretionary power in determining which challenging behaviours were to be tolerated by the trauma informed service. While some women's behaviours were tolerated as coping mechanisms or 'symptoms' in the context of psychological trauma, other women's challenging behaviours were viewed as unacceptable and these women were responded to with harsh disciplinary and punitive measures i.e. the withdrawal of accommodation and service supports.

[From punitive practice to 'caring':](#)

All staff participants from Hamilton House believed that the implementation of trauma informed care introduced significant changes to the service culture. Hamilton House management invested in extensive trauma informed care training and supervision for all staff members, prolonged service supports to many women and their children, mediated and supported safe relationships between women sharing accommodation facilities, and absorbed the financial burden of damages and the ongoing maintenance costs for the property. Hamilton House staff participants identified that the implementation of trauma informed care resulted in the following key understandings and practice approaches: 1) Many staff participants reconceptualised women's 'challenging behaviours' as coping mechanisms in the aftermath of traumatic experiences 2) Staff participants reported responding to women's 'challenging behaviours' by relaxing previously strict and punitive organisational rules.

As described in the previous section, the implementation of trauma informed care introduced a series of therapeutic-oriented questions and curiosities. For instance, Mark, a practice manager, stated that following the trauma informed care training he began to initiate conversations with women to 'explore their aggressive behaviours' and to find out 'how we can make them feel safe' while staying at the service. This was a new area of practice and staff participants suggested that this increased communication between staff and women at Hamilton House. The following 'case' example provided by Megan, a case-manager at Hamilton House, illustrates the how trauma informed care was interpreted and implemented at Hamilton House:

Megan: Honestly for me it's the bigger picture stuff, it's how we have got everyone from our cleaners to our facilities team and how we have got everyone to understand what is going on. We have an old lady at the moment who is also in one of our studio rooms. She is quite unwell she's been here for a year. She has completely damaged the room. I've had to speak to the facilities people and said 'yep, she has damaged the room, it is going to cost us a lot of money when she moves out. However, she's had a lot of

childhood trauma and people used to go into her room and abuse her. And so, she is taping up all the wall, doors, all the windows and all the wardrobes and the man holes because of her fear of people coming in and her paranoia around that. And I've been having conversations with staff that this is not her 'damaging' the property this is her making herself feel safe and this is what she does to feel safe.

This example represents a clear departure from the service's former punitive organisational culture and practice. In this example, the trauma informed care training prompted staff to understand the connection between the woman's distressing behaviour (taping up the doors and windows) and the woman's history of child sexual assault. Staff reframed the 'bad' behaviour and 'damaging the property' as the woman's self-protective strategies. Prior to the implementation of trauma informed care, the woman in this example would have likely been exited and possibly banned from the service for breaking service rules and for 'damaging the property'. The trauma informed care framework enabled staff to instead, act leniently and to increase service supports. Despite the woman's challenging behaviours, she was understood to be deserving of care and support. However, the behavioural management of women remained an ongoing concern after the implementation of trauma informed care.

It is important to mention here that while the dominant model of trauma informed care implemented at Hamilton House has been described as a form of 'behaviour management' which involves some criticism, the dedicated increase in service supports for women and the significant efforts to change a punitive organisational culture should be regarded as honourable. However neoliberal processes, ideologies, discourses and policies constrained and undermined the good intentions of staff ultimately giving rise to a behaviour management model of trauma informed care. Behaviour management trauma informed care was mainly associated with institutional processes and staff practices which aimed to pacify the distressing and challenging behaviours used by the women who were accessing the service.

Risk management vs trauma informed care:

Most staff participants stated that prior to the implementation of trauma informed care, the service typically withdrew supports from women who had ‘challenging’ behaviours such as; aggressive or threatening behaviours towards staff and other women, alcohol and other drug use, staying with friends and partners while occupying a ‘bed’ at the service and the failure to attend appointments. The withdrawal of service supports mostly referred to the practice of exiting women at an earlier than planned date and or referring women onto other residential and housing services. Mark, a staff participant explained, that formerly, the service focused on the woman’s “bad” behaviours and “what she is doing is wrong” rather than how the service could better accommodate and respond to the woman’s needs. Terry, a case manager at Hamilton House said that since the implementation of trauma informed care “we don’t just write them (women accessing the service) off anymore or move them on because it’s too difficult...we have taken on everything that we have learnt”. This reflection provides an important insight into the prevailing staff attitudes prior to the implementation of trauma informed care. Some staff participants from Hamilton House also explained that the previous organisational culture was oriented to the belief that ‘bad behaviours’ should not be ‘rewarded’ by ongoing service supports. In other words, the punitive organisational culture was intended to have a positive disciplinary effect on ‘difficult’ women. By encouraging women to understand that the consequences of their aggressive and distressing behaviours would be the termination of service supports, the punitive approach was thought to help women to modify their behaviours to be more cooperative and compliant with service rules. This punitive and disciplining organisational culture is prevalent across many crisis accommodation and human services and it is endorsed through overarching neoliberal welfarism and neoliberal social policies in Australia and in Canada.

Neoliberal governments have instituted numerous changes to the welfare state. While welfare is still administered by neoliberal states it has been reconfigured. Neoliberal welfarism has made access to financial and housing supports highly conditional (Cooper, 2017). As discussed in Chapter 3, welfare recipients are required to comply with increasingly bureaucratic tasks (e.g. reporting) and mutual obligations (e.g. working-for-the-dole, attending compulsory meetings and programs) in order to receive assistance and those who ‘fail’ to comply with these rigid requirements come to be penalised and denied access to life sustaining service supports. Rendo (2014) argues, neoliberal welfarism directly effects ‘homelessness’ service staff who are caught between paradoxical demands of providing care to highly victimised and disenfranchised people and ensuring compliance from victims/survivors to service and statutory rules and obligations:

One the one hand, the complexities and emotionally challenging nature of caring relationships, which they are ethically committed to and are the cornerstone their role. On the other, the pressures of depending on statutory resources and the requirements and controls this involves, which detach them from the human and intimate encounter with clients (Rendo, 2014, p.231).

However, the potential for trauma informed care to disrupt the previous organisational culture steeped in conditional and punitive practices was additionally constrained by the pressures imposed by neoliberal welfarism. This was suggested in some staff participant interviews who used trauma informed care language to describe conditional and punitive practices. In the following example, Julian a case manager at Hamilton House stated that despite the implementation of trauma informed care, the expectation remained that women at the service would largely comply with service rules or risk the withdrawal of accommodation supports.

Julian: We can accept women but on the proviso, that, you need to do a, b, c. You agree to unit inspections. Like their living skills may not be up to scratch, so we are

going to perform unit inspections on a daily basis. Or you need to need to participate in x amount of day services here to qualify to stay here... We document each time there is a breach of service rules. So, we set up an individual agreement with a client based on their scenario. If that agreement is breached a certain amount of times, that will put their accommodation at risk... I guess it is in line with Trauma Informed Care because if there is someone acting out or not complying with service rules or putting the safety of other people at risk. Those other people may have a trauma background. It could set other people off. Unfortunately, there are certain rules. It's like a strict society in here.

In the above example, the language of trauma and trauma informed care was steeped in the dominant neoliberal risk management and mutual obligation discourses. As discussed in Chapter 3, risk management institutes highly defensive and reactive case-management approaches that are particularly intolerant of people who, in Julian's words, are "acting out or not complying with service rules or putting the safety of other people at risk". Risk management introduces heightened surveillance and behaviour regulation of human service "clients". According to Webb (2006) "within a blame culture, risk avoidance becomes a key priority...this in turn hardens the defensive tactics of front-line workers resulting in secrecy, distrust and fear" (p.70). The neoliberal risk management/risk averse culture also dissuades managers and staff of human services from accommodating women with challenging behaviours. Challenging, aggressive and or 'non-compliant' behaviours (by 'clients' or staff) is often dealt with, with non-negotiable, highly bureaucratized withdrawal of services (or termination of employment). Therefore, risk management decision making forecloses any question that women may legitimately break service rules that are oppressive or discriminatory and denies the resistance and voice of women. In this context, risk aversion outweighs the trauma informed concern for honouring and working with women's resistance.

In the context of risk management, trauma informed care was used by staff as a disciplinary tool, rather than as a lens through which to understand women's challenging behaviours as signifiers of human distress. As a service tool, the discourse of trauma informed care can be used to justify the early exiting of women from the service. However, it is also possible that the trauma discourse had in some circumstances, potential to challenge organisation risk management. The idea that some challenging behaviours may be legitimate (as a response to 'trauma') possibly disrupts the zero-tolerance logic of risk management.

Risk management was instituted in staff practices and in the physical structure of the building. For instance, Hamilton House also used 24 hour Closed Circuit Television (CCTV) extensively both internally and on the external entrances to the crisis accommodation site. Hamilton House also used a number of other electronic security devices such as swipe cards and portable staff alarms. Most staff participants at Hamilton House felt that the use of surveillance technologies and staff alarm systems helped to create physical and emotional safety both for staff and women accessing the service and therefore complimented the aims of trauma informed care. However, a couple of staff participants at Hamilton House suggested that the use of surveillance technologies represented a significant disjuncture between the aims of trauma informed care and the institutional risk management culture at Hamilton House. For instance, Danielle argued that these measures were 'authoritarian' and felt that this created an unequal power dynamic between workers and women. Danielle identified the possibility that institutional surveillance may 'retraumatise' women with incarceration experiences as the institutional use of surveillance in prisons is especially heightened. Danielle observed women 'behaving themselves' once they became aware of the surveillance used by staff and the CCTV cameras. This suggests that the surveillance technologies used in Hamilton House are used in part, to manage the behaviours of women accessing the service as well as for their 'protection'.

Danielle suggested that some women have resisted the use of surveillance cameras and the practice of note taking and recording of their movements.

Furthermore, some staff participants used trauma informed care as a gently coercive strategy to ensure women's compliance with institutional bureaucracy, rules and processes – or what could be described as service needs. For example, Terry drew on the trauma informed principle of ensuring women have choice and control in making decisions that affect their lives:

Terry: A lady who was quite resistant to giving us information, because in the past, she had quite paranoid ideas I suppose about what was going to happen to her information. So, she didn't want to sign any information. So, instead of me saying, 'well you have to sign these forms', so, it was me handing the documents to her saying 'here are the documents, you don't have to sign them, but if you don't sign them, I am not able to...', like I wouldn't be able to advocate on behalf of *Housing NSW* to start the process and then she would have to do that to herself. In some ways, yes, I still felt like I was manipulating that person to 'you have to do this', but I was also giving her a choice that 'if you don't sign them then I can't do certain things'. She signed the forms in the end and she was really thankful that she wasn't actually pressured into doing that. Just having that control.

Before exploring the above example in some detail, it is important to emphasise that much of the work undertaken by social workers and human service workers is to assist people to meet mutual obligation or welfare obligations to State based agencies such as Centrelink and Family and Community Services (formerly Housing NSW). In an Australian context, the State provision of public housing and financial assistance is highly conditional and regulated by mutual obligation contracts. Contrary to universal welfarism, which granted access to human and financial services with few conditions, neoliberal welfarism is characterised by working

for welfare or attending employment programs to receive ‘entitlements’ (Cooper, 2012). If an individual ‘fails’ to meet their mutual obligation requirements services can be abruptly terminated, penalties can be applied and applications for future welfare assistance do not guarantee access. In this context women, including those understood to be ‘traumatised’, are still required to adhere to administrative procedures, agree to unit inspections and agree to perform mandatory activities in order to receive housing support and other services. In the above example, Terry was constrained by the bureaucracy of the State Housing system. Housing applicants must sign consent forms to permit a case-worker or other support person to act as an advocate. Therefore, the suggestion that the woman in this example had any meaningful ‘choice’ in signing or not signing the consent form was deceptive. Terry was also constrained and understood that the woman’s refusal to sign the document would likely have had many negative implications which may have compromised her access to long term public housing. In this example, the trauma informed care (and feminist) principle of supporting a woman’s choice is reconstituted into a form of manipulation and coercion, albeit gentle and caring. While Terry was ultimately acting in the best interests of the woman in this example, this example does provide evidence that trauma informed care in this service was utilised to facilitate greater adherence to service rules, conditions and compliance with the mutual obligation requirements of neoliberal state welfare. Another interpretation is also possible: That the principles of trauma informed care, were not only modified to increase the service capacity to manage women’s difficult behaviours, but they were in many circumstances only partially applied.

In another salient example, Megan, a caseworker from Hamilton House, stated that a trauma informed care approach was used to exit a woman from the service at a slow pace as opposed to initiating the woman’s eviction at short notice – as was the service culture prior to the implementation of trauma informed care:

Megan: We have a particular client at the moment, she went into one of our outreach properties. She had an alcohol addiction she had drunk a couple of times in the outreach houses which is a group living situation. We had tried to continue working with her but she had to come back here in one of our crisis rooms and we had to continue to look for somewhere else for her to stay because her drinking in front of the other women was confronting and quite triggering for them. So, back in the day we would have existed her very quickly. We would have said ‘no these are our rules’, but we are working a lot more closely with her and making sure she has got the support she needs and she is still here at the moment, even though she found to be drinking onsite here as well. I have tried to find her somewhere, but there actually is nowhere for her to go, currently. We have to continue to work with her, so we have been a little bit more understanding, whereas previously we might have been like ‘nup, (SIC) you just go to a detox bed’. But in saying that she has broken our rules, and we will be moving her on, but we are just doing it in a more, in a way that is suited to her I think.

Before delving into this discussion, it is important to reiterate that many staff participants from this service strongly believed that the trauma informed care training resulted in many positives changes to the organisational culture, and that trauma informed care benefited women who received greater support, understanding and latitude. It is also important to acknowledge the challenges of crisis accommodation and transitional housing arrangements where people who are recovering from alcohol and other drug use and addictions are often placed with people who are actively using alcohol and other drugs despite service rules which prohibit substance use. The over-burdened and critically under resourced human service system leaves women who have substance use challenges and who are experiencing housing injustice with few options beyond cycling between crisis accommodation services, hospitals, detox beds, periods of incarceration and ongoing housing injustice (Robinson, 2010). Crisis accommodation

services are generally not resourced to support women who use alcohol and other drugs, and consequently are also frustrated by limited referral pathways, leaving staff with seemingly impossible competing demands of managing both the wellbeing of all women in the crisis accommodation service and the wellbeing of women who use alcohol and other drugs. It is likely that these service system and organisational limitations prevented the principles of trauma informed care from being fully realised within the service.

There are many other possible ways of interpreting Megan's example, and specifically why some challenging behaviours were tolerated by staff at Hamilton House while others were not. A materialist feminist analysis suggests that alongside resourcing constraints, the decision to exit some women and not others, may have been mediated by moralising judgements about the 'deserving and undeserving poor'. In some circumstances, the concept of psychological trauma was viewed as mitigating. The trauma informed care training helped some staff participants to understand that trauma survivors are 'deserving of care' because their original injury (childhood trauma) led to the development of behavioural and psychological problems which eventually caused their 'poverty' and 'homelessness'. As a 'deserving poor' discourse, the trauma survivor, much like the person with a serious mental illness, is deemed by human service workers to be 'not guilty' and thus, judgement is suspended for the perceived failure of the individual who is *unable*, not *unwilling*, to participate in the labour market or in private property market. Conversely, women experiencing housing injustice and who use alcohol and other drugs have historically been constructed within the 'underserving poor' discourse, and thus held responsible for their 'bad life choices' culminating in homelessness. Alcohol and other drug use is strongly, positively correlated with early and repeated psychological trauma (Ferlitti, 2004) and with victims/survivors of domestic and family violence (Gutierrez & Van Puymbroeck, 2006), and with experiences of homelessness and housing injustice (Doran et al,

2018). Given this, it was surprising that the trauma informed care framework did not introduce any specific service changes or training for staff at Hamilton House to better respond to women using alcohol and other drugs and women who were in the process of recovering from alcohol and other drug use.

In summary, neoliberal constraints defined the decision making within crisis accommodation services such as Hamilton House. The risk averse organisational culture at Hamilton House likely biased staff attitudes and responses towards conditional and punitive decision making. Subsequently, the risk averse culture undermined the capacity for the service to enact trauma informed practice principles. Given these pressures it is perhaps not surprising that in most of the previous examples, trauma informed care was used to both manage risk and to manage the behaviour of women. While the trauma informed care training helped staff to be more understanding and in some instances, to extend service supports to women with challenging behaviours, ultimately the trauma informed model at Hamilton House was only partially effective in disrupting the services previous organisational culture. Furthermore, as a behaviour management approach, trauma informed care was limited in counteracting other oppressive and coercive neoliberal discourses, such as mutual obligation and risk management. The next section introduces the politicised models of trauma informed care.

[Politicised models of trauma informed care:](#)

In contrast to Hamilton House, Amelia's Place women's refuge in Sydney and Coast Salish Place in Vancouver both had extensive organisational histories of responding to trauma in the context of gendered violence, systemic racism and housing injustice, prior to the implementation of trauma informed care. Amelia's Place was established during the women's refuge movement in Sydney during the 1980s and has since operated primarily as a refuge for women victims/survivors of domestic and family violence. Over the last five years, Amelia's Place has expanded the service model to accommodate all women experiencing housing

injustice including ‘long term homeless’ women and women who have become homeless due domestic and family violence. Similarly, Coast Salish Place was established during the 1980s to provide crisis and transitional housing to women, transgender women, intersex and non-binary identifying people in Vancouver city. Both services utilised a feminist analysis of violence against women and incorporated First Nations designed and led models of cultural safety. Trauma Informed Cultural Safety will be explored in further detail in the following chapter, Chapter 6.

Amelia’s Place and Coast Salish Place offered a model of trauma informed care that was considerably different to the behavioural management model described above. In both services the implementation of trauma informed care extended and reinforced the pre-existing politicised organisational cultures. Just as psy trauma discourses shaped the behavioural management model of trauma informed care, political discourses about gendered and racialized violence shaped the implementation of politicised trauma informed care. The following list of approaches defined the politicised model used in both services:

- 1) Conceptualised trauma within a structural context including settler colonisation;
- 2) Staff were critical of psy trauma discourses and the influence of psychiatric, psychological and psychotherapeutic disciplines on trauma informed care;
- 3) Criticised and resisted conditional and punitive practices within services;
- 4) Aimed to create emotional, cultural and physical safety for women accessing services. This included gendered violence response and prevention strategies such as co-creating safety plans with women;
- 5) Facilitated groups with women about gendered violence and First Nations-led reclaiming culture and healing circles;

6) Were frequently engaged in advocacy and activism campaigns to end systemic gendered and racialized violence and housing injustice.

The influence of political constructions of trauma:

Management and staff participants at Amelia's Place and Coast Salish Place rarely used the language of 'trauma' to describe the women accessing their services. Instead, staff participants tended to describe; sexual assault and domestic and family violence. In other words, staff specified the form of violence rather than the psychological impacts of violence (and or injustice). This was related to the feminist principle of clarifying perpetrator's responsibility and resisting victim-blaming and pathologising discourses. Furthermore, as will be described in the subsequent sections, while women were understood to be 'traumatised' service responses were tailored specifically to sexual assault, domestic and family violence.

Many staff participants from Coast Salish Place and Amelia's Place and one key informant, expressed criticisms of the psy trauma discourse and its applications, across health, housing, criminal justice and violence, abuse and neglect sectors. For instance, Vikki Reynolds, who was interviewed as a key informant, argued that the psy conceptualisation of trauma is dangerous because it subtly pathologises and confers blame on the victim/survivor of gendered violence. Speaking in the 'voice' of the psy trauma discourse Vikki Reynolds argued:

Vikki Reynolds: She's traumatised and trauma is located inside the brain and body of the victim of violence - okay? So, we're using all these medicalised terms that take things out of the social context, right, and locates them inside the body of this individual women and then the worker...So, a man is violent to a woman - rapes her or beats her - she gets "Post Traumatic Stress Disorder" and her worker gets "burn out". So, those two workers probably both women are now, you know, mentally ill, and he's fine even though he's beaten and raped women.

This powerful reflection, exposed the uncritical use of the psy trauma discourse in human services which simultaneously pathologises victims/survivors and sanctions, or more moderately, does not hold the violence of perpetrators to account. The danger for women who are victims/survivors, extends beyond being misrepresented and labelled as mentally ill. Human services are often manipulated by perpetrators and can collude with the perpetrator's narratives and demands (Laing & Humphreys, 2013). The construction of women (victims/survivors or otherwise), as 'mad, bad or sad' (Appignanesi, 2008), through the discourse of trauma can introduce doubts about the rationality of women as victims/survivors. The suspicion that women who are victims/survivors may be 'delusional' or may exaggerate claims of being assaulted, can result in human service staff who routinely minimise or disbelieve women's accounts of violation (Laing et al, 2010). Therefore, the refusal to use the term 'trauma' in politicised services is potentially an example of resistance to victim blaming and pathologising discourses. Applying Coates and Wades' (2007) ideas about the functions of language, it is also possible to interpret the refusal to use the term 'trauma' as a political act of naming the perpetrator and their harmful actions.

Some staff participants including the manager Coast Salish Place, raised concerns about the model of trauma informed care. Joan, the manager of Coast Salish Place, explained that in recent years the model and language of trauma informed care has gained traction across agencies in British Columbia. The broad implementation of trauma informed care across these sectors was initially welcomed, yet as Joan and other staff participants argued, the new psychological/psychotherapeutic trauma discourse undermined feminist anti-violence against women work. Joan described how the service strategically used the language of trauma informed care in the Operation Management Plan primarily to maintain funding for the service. However, Coast Salish Place introduced a politicised and anti-oppressive lens to trauma informed care:

Joan: Trauma informed care, needed to be amended or adapted or something to make sense in the work that we do... We've had to take (Trauma informed care) and kind of apply a bit of it, not a bit of it, but add a feminist anti-oppression, gender lens to it, because they would argue they are feminist, but definitely an anti-oppression lens to the trauma informed care treatment stuff.

Joan highlighted the struggle and advocacy that is often involved in creating and sharing meaning and therefore praxis across human service sectors funded by neoliberal governments. As Ready (2012), argues, feminist anti-violence against women services in the context of neoliberalism, are often coerced into 'uneasy alliances' with neoliberal funding streams and neoliberal discourses which fundamentally challenge and sometimes compromise the values of feminist praxis. As discussed in Chapter 3, the neoliberal discourse of individual responsibility manifests in the proliferation of gender-neutral language (such as intimate partner violence) which can obscure the gendered pattern of male violence against women and children. However, in order to retain funding sources from neoliberal governments, Ready (2012), argues anti-violence against women services are coerced into relinquishing feminist language and agendas in funding applications and agreements and public documents. However, many anti-violence against women services continue to subversively and covertly pursue a feminist agenda in activism and in practice. As Joan identified, the difficulty faced by politicised, First Nations-led and feminist services in resisting the challenges posed by neoliberal governments, is that many neoliberal policies and programs have adopted the same language of feminist or anti-racist organisations, without the social justice content. For instance, the use of feminist language may satisfy governments and services that they have responded to the demands outlined by victims/survivors and feminist organisations. However, the use of feminist or feminist sounding language does not guarantee that anti-violence against women approaches and understandings are implemented.

Neoliberal governments co-opt the language of feminist and First Nations services (and activist groups), while depoliticising the concepts and socio-political change agenda that underlies the language. In a co-opted form, politicised language is rendered compatible with, rather than antagonistic to, the neoliberal settler-colonial state (Roy, 2014). For instance, Ready (2012) found that just as neoliberal Canadian governments claimed to endorse domestic and family violence response and prevention as a key priority, funding was redirected away from women's refuges to the criminal justice sector. Similarly, at the time of conducting this research (2013-2014), the New South Wales state government of Australia implemented a state-wide policy known as *Going Home Staying Home* (GHSB). Under the guise of responding to housing injustice experienced by women, the NSW state government cut 221 contracts for housing services and closed approximately 70 women's refuges (Bamford, Gaps, Gurr, Howard, Onyx & Rawsthorne, 2016). However, the post implementation review of the GHSB, reported that "the number of women's services overall had increased with GHSB" and that "no Government owned women's refuge ceased operating as a result of the reforms" (KPMG 2015, p.87). This review did however, disclose that some "refuges are now operated by services which are not women-only services" (KPMG 2015, p.87). The KPMG (2015) final report did not provide any elaboration on how the "not women-only services" that accommodated men due to GHSB, continued to function as "women's services" (p.87). Furthermore, no analysis was provided regarding how GHSB responded to or failed to respond to women's safety concerns (KPMG, 2015). Rather, the KPMG (2015) report provided a brief recommendation for future monitoring and evaluation activities to examine the impact of sector-wide reforms on "women leaving domestic and family violence" (p.87).

The NSW government also claimed that GHSB did not result in changes to the provision of women's refuges (KPMG, 2015). However, the KPMG (2015) review does indicate that the GHSB funding and governance structure have led to previously independent women's services

seeking partnerships with larger providers. The ‘partnerships’ eluded to in the KPMG (2015) review, included large, well-funded faith-based charity organisations. This led the advocacy group, such as *SOS Women’s Services* (2015), to argue that most of the remaining women’s refuges were transferred to the control of faith-based charities which do not utilise a gendered analysis of violence or of ‘homelessness’. Therefore, it is possible to view the GSHS ‘reform’ as an example of neoliberal government co-option, which retains the feminist language of ‘women’s services’ and ‘women’s refuges’, whilst recalibrating issues such as violence against women and housing injustice into a management or governance issue (Willse, 2015).

The widespread adoption of co-opted anti-violence against women language and concepts complicates advocacy and shared, cross sector communication. It fosters an impression that governments and human services are proactively responding to gendered violence and housing injustice while, crisis response and violence prevention work remain desperately under resourced and the service system fragmented. Echoing these concerns, Helen, a trainer and worker at Coast Salish Place argued that “trauma informed care is still a cookie cutter. That’s what I experienced going into the three trial sites using it, they are used to doing other training but in general they want a booklet, a toolkit, a check list”. Helen’s comment suggests the blunt application of standardised trauma informed care in human services in Vancouver neglects any focus on First Nations intergenerational trauma or gender-based violence. As such Helen also believed that the framework was deskilling and did not adequately equip staff to respond to the complexity of supporting women victims/survivors who are experiencing housing injustice. Joan also felt strongly that the psy trauma discourse lacked a class analysis and inherently reflected the values and worldviews of ‘white and middle class’ professionals.

The broad implementation of depoliticised and co-opted feminist language and concepts can also delegitimise the work of organisations that resists neoliberal governments.

Resisting conditional and punitive practices:

Staff participants from Amelia's Place and Coast Salish Place tended to be very conscious of the potential for services to retraumatise and victimise women accessing crisis accommodation. For instance, Joan described how Coast Salish Place service actively avoids using conditional and discipling practices as this was regarded as a form of institutional oppression:

Joan: I think a lot of services base things on privilege and consequence and a lot of women that come to us are very institutionalised. A lot of the young women grew up in care and um, maybe foster care settings or even a group home where there is a lot of rules and um, and even in the structures of other organisations that I see out there, there's a lot of kind of, there's always kind of a privilege and consequence model. So, if you make all your appointments then you have housing but if you can't make those appointments then you're going to miss out. You're not going have housing. To some extent that's good to have a little bit of pressure and a little bit of goal setting and you know...But, to tie that in with your basic needs you know. To say, we're not going to give you a meal if you don't make it to your appointment... Or not even offering them the housing because they're not stable enough.

Given the over-representation of First Nations people who are victims/survivors of Residential Schools and orphanages conditional and discipling service provision is likely to be especially retraumatising. For the same reasons this form of service provision may also retraumatise women who have incarceration experiences including prisons, refugee detention centres and prisoner of war camps. Along with the understanding that women can be psychologically 'retraumatised' by conditional practices, politicised trauma informed care services understood that conditional practices contribute to further housing injustice and gendered violence. Some Coast Salish staff participants discussed the risk management practices that were prevalent

across the wider crisis accommodation service sector in Vancouver. Robin, a case manager at Coast Salish Place said that the practice of refusing people using alcohol and other drugs from accessing crisis accommodation services resulted in several deaths. In reaction to these deaths, Robin explained that more human services in Vancouver began to offer ‘low barrier’ supports. However, despite the move towards low barrier and trauma informed care the risk management culture still exerts pressure on staff to refuse people who use alcohol and other drugs and who have other ‘challenging’ behaviours. Arguably, the emphasis and awareness of the material consequences of conditional service provision from the politicised trauma informed care services, distinguished this model of practice from the risk and behavioural management practices at Hamilton House.

Coast Salish Place staff participants described their non-conditional practices as ‘harm reduction’ and ‘low barrier support’. These principles have encouraged extremely disenfranchised women who are victim/survivors of multiple intersecting forms of social injustices to access Coast Salish Place service. Robin and Joan from Coast Salish Place and Vikki Reynolds indicated that this service provides housing to women that most other services would exclude based on their challenging behaviours and high level of need. Therefore, it is possible to view the principle of low barrier service provision as a form of resistance to neoliberal risk management.

It should be reiterated that there are significant difficulties and risks for organisation in the provision of accommodation to women who are using alcohol and other drugs, who have challenging behaviours, who are ‘traumatised’ and surviving housing injustice and gendered violence. Amelia’s Place also aimed to accommodate women with extremely challenging behaviours including alcohol and other drug use. Kayleen, a First Nations woman and a social worker was positive about the service’s capacity to accommodate women with challenging behaviours:

Kayleen: Since the changes with the government we have become helping women who are homeless. But previously our main issue was domestic violence, but since the changes we do take homeless women and children. Our resource centre is open to all women in our community and it's going really well.

However, not all staff participants from this service agreed with the 'low barrier' principle. Furthermore, some workers were angry and frustrated that the service that was 'forced' to accept 'homeless' women and expressed concerns that the domestic and family violence service was being diluted and stretched to accommodate homeless women. For instance, Margaret, a social worker at Amelia's Place argued that the needs of 'homeless' women and women experiencing domestic violence are fundamentally different leading to tensions between these two groups of women within the refuges:

Margaret: Now we are required to take homeless people in as well. We have always been DV specific, so the beds are women and children escaping domestic violence. Where homelessness can be from anything... it could be because they are criminals, or you know there could be mental health, drugs and alcohol issues, (perpetrating) violence and they can't easily stay with other people. The one's used to a home and she just needs to find a safer home where the other one, a lot of them aren't used to a home environment.

The view that women who are 'homeless' and who have challenging behaviours/high needs should not be accommodated alongside women and children who are victims/survivors of domestic and family violence has been criticised as an exclusionary practice (Robinson & Searby, 2006). Similarly, the introduction of government policies (e.g. Going Home Staying Home, in an Australian context) which effectively subsumed domestic and family violence refuges under the brand of 'homelessness' services, has also been criticised for erasing the

issue of gendered violence and for undermining the critical work of women's refuges (Bamford et al, 2016). Through an intersectional and materialist feminist perspective, this debate highlights yet another dimension of settler-colonial and neoliberal structural violence namely; pitting 'homeless women' and 'victims/survivors of domestic and family violence' against each other in the struggle for safe, accessible emergency housing.

The neoliberal state arguably contributes to this bitter struggle for accommodation through the chronic under-resourcing of this service sector. Under-funded services are largely unable to adequately and safely accommodate women who use alcohol and other drugs, have complex mental health concerns and who have challenging behaviours. As women's refuges and crisis accommodation services in Sydney and Vancouver struggle to cope with the overwhelming demand for beds, women who are arguably 'less traumatised' due to being domiciled and only recently 'homeless' may be easier to accommodate than women who have been sleeping rough, without shelter for many years. To resolve this gap in service provision, it has been suggested that specialist crisis accommodation services, like Coast Salish Place, be established, well-funded and expanded for women who are experiencing housing injustice in Australia (Robinson & Searby, 2006). However, given the high rate of gendered violence experienced by women who have experienced housing injustice for extended periods, if such a model were implemented in Australia, this would need to incorporate many of the gendered violence response and prevention strategies used by women's refuges.

[Responding to gendered violence and co-creating safety with women:](#)

Staff participants in Amelia's Place refuge and Coast Salish Place both conveyed the importance of providing emotional safety coupled with the understanding of the ongoing risk of violence (e.g. physical and sexual assault, domestic and family violence, stalking and lethality risk), against women and their children. As such staff participants from these services

used a range of strategies to anticipate, record and respond to violence against women. Staff participants from politicised trauma informed services, emphasised that a critical part of providing long term safety for women and children was keeping professional records of gendered violence. Staff participants explained that these notes provided evidence which could be subpoenaed and used in cases to prosecute perpetrators of gendered violence. It is important to note that the behaviour management model of trauma informed care, which understood women to be psychologically traumatised but no longer at risk of harm, did not prioritise these strategies. Safety from physical violence has been identified as foundational to providing an effective response to survivors of violence and trauma (Herman, 1992). Herman (1992), argues, the safety of the survivor must be prioritized and ensured before any therapeutic work is attempted. Therapeutic healing and recovery from ‘trauma’ are only possible, once a victim/survivor is physically safe from harm and the threat of ongoing harm (Herman, 1992).

Staff participants from politicised services indicated that it is not safe to assume that women are no longer at risk of violence as women at these services were routinely stalked, threatened and harassed by current or former partners and family members. Most staff participants from politicised services argued that it is necessary to ask women about domestic and family violence and to create safety plans with women given the ongoing risks to women’s safety and wellbeing. Joan, Robin, Mahala and Brandy from Coast Salish Place also described regularly filing missing persons reports whenever a woman from the service had not been seen for 48 hours or longer. This practice came in response to the issue of the ‘missing and murdered women’; the high frequency of assaults and abductions of women, especially First Nations women from the urban area of Vancouver. Both services also regularly involved police and child protection services, although as will be discussed in the following chapter, Chapter 6, the alliances between politicised trauma informed services and statutory bodies was experienced by staff participants as highly contentious.

Creating safety in politicised services also involved anticipating that women and their children accessing the services had sustained physical injuries from assaults perpetrated by a current or former partner and or family member(s). Therefore, women and their children were routinely offered medical assessments and treatment. Shannon, a case-worker from Amelia's Place, described the critical importance of understanding the ongoing risks of harm (physical, sexual and lethal assault) to women and children who are seeking crisis accommodation and women's refuge services:

Shannon: Everything we put in place for women if they come in crisis feeling scared, it's very real that partners could go out there looking for them... although we don't need to get the whole details...we definitely have to ask questions around safety – “Do you think he knows where you are?” and “will he go looking for you?”

Similarly, Justine another case-worker from Amelia's Place, explained that while the service asks women about current experiences of violence and their perceived risk of further violent victimisation, staff do not ask women to share their whole story:

Justine: So, getting that information is critical but we don't push. We're not going to ask her a million questions when she's in crisis. We have to just let her give us what she needs to give us. Sometimes she might tell us everything, sometimes they just tell you a tiny bit and then as they get to know you, trust you, they could give just a tiny bit more.

The approach described by Justine and Shannon was both attentive to the emotional and physical safety of women. Justine's description also indicated that staff at Amelia's Place prioritised building trust with women. These practices also reflect contemporary recommendations for working with women who are victims/survivors of gendered violence. Laing and Humphreys (2013) argue that the following practices are essential for working with women

who are victims/survivors of gendered violence, in particular domestic and family violence: 1) risk assessment and safety planning: This is understood to be a “woman-centred, collaborative and dynamic process between a woman and an advocate”, that takes into account women’s diversity and intersectional positionality as well as any possible risks posed by the involvement of “statutory bodies, legislation and the involvement of human services” (p.65). 2) partnering with women: Which may be summarised as “respecting women as the experts in their own life” (p.66). 3) working collaboratively across agencies: Counselling and case-work by individual workers does not adequately or effectively increase the safety of women, therefore a ‘network’ of coordinated services is required which may include; “police, courts, housing, child protection, family support, immigration, drug and alcohol and income support services” (p.67). Laing and Humphreys (2013) also argue that systemic advocacy is a core component in the work to end gendered violence. The systemic advocacy work undertaken by staff participants from politicised trauma informed care services will be discussed below. However, before moving to the next section, it is important to emphasise the depth, ‘risk’ and complexity of working with women in response to and in the prevention of gendered violence. The emotional safety of women was also a key priority in politicised trauma informed services. However, these services also worked to promote the immediate and long-term physical safety and wellbeing of women (and their children) and to seek justice for the crimes committed against them. In contrast, the model of behaviour management trauma informed care sought to increase the emotional safety of women during their stay in crisis and transitional accommodation, however, women’s safety beyond the duration of stay at the service was not taken into consideration.

[More than just a job:](#)

Most staff participants from Coast Salish Place and Amelia’s Place and both key informants for this study were actively involved in activist and advocacy campaigns that extended beyond

their paid employment. For instance, all the staff participants from Coast Salish Place were actively involved in activist campaigns including the annual Missing and Murdered Women's Memorial March. Staff participants viewed this protest as an important extension of their advocacy work. Staff participants invited and involved women who were attending support groups at the service to participate in organising and participating in the Memorial March.

Similarly, at Amelia's Place, many staff participants discussed actively involving women from the service in activist campaigns against gendered violence. For example, Renée from Amelia's place spoke of the importance of involving women in activist campaigns to end gendered violence:

Renée: Part of our job role is to advocate for, against violence against women so if we get the chance to go to a protest or anything like that we get in on it...For example there was *One Billion Rising*, a protest against violence toward women around the world. We empowered women from our service to get involved in that as well. So, they're a part of their healing and we're sort of in on the same platform. We're both women fighting for the same thing so any chance we get we do that.

By taking a politicised approach to working in the intersections between gendered violence, systemic racism and housing injustice, staff participants from politicised services decentred the power relationships between staff and women. The involvement in advocacy and activism, within and beyond the service, reoriented relationships between staff and women towards a relationship of solidarity as opposed to a relationship between 'professionals' and 'clients'.

Conclusion to the Chapter:

This chapter discussed the wide interpretation of trauma informed care between participating services as a continuum of practice ranging from; behavioural management to politicised models. The differences in interpreting, implementing and enacting trauma informed care

could be largely attributed to the pre-existing differences between organisational philosophies, service identities, geographical localities and the ideological perspectives of trainers, supervisors and service managers. These ideological and organisational orientations greatly influenced staff participants' views regarding what 'trauma' is and how 'trauma' should be responded to in the context of working with women who are living through housing injustice.

Furthermore, the differences between behavioural and politicised models of trauma informed care used by services participating in this research project in many ways reflected the core conceptual tensions identified in the second part of literature review in Chapter two. The literature review identified three distinct categories of 'trauma' discourse within the available literature: 1) a psychiatric/psychotherapeutic trauma discourse; 2) a feminist violence against women discourse and finally; 3) a First Nations/intersectional feminist discourse. The feminist and First Nations trauma discourses can also be viewed within a broader category of the politicised 'trauma' discourse. This discourse(s) conceptualises 'trauma' and responses to 'trauma' as contingent upon specific social, political, historical, geographic and economic contexts. This discourse was associated with politicised and feminist models of trauma informed care. Conversely, the first category of literature, psychiatric/psychotherapeutic (psy) trauma discourses, conceptualises 'trauma' within a paradigm of bio-psycho-social and neurological/neuropathological symptomatology. The psychiatric/psychological trauma discourse in conjunction with neoliberal trauma discourses of individual responsibility were more strongly associated with the behavioural management model(s) of trauma informed care.

An intersectional and materialist feminist analysis highlights the numerous pressures exerted by settler-colonialism and neoliberalism in Sydney and Vancouver. This analysis made visible the gendered, racialized and classed dynamics operating within the continuum of trauma informed crisis accommodation and women's refuge services. Furthermore, this chapter explored ways in which settler colonial neoliberalism shaped and constrained all trauma

informed care models across the continuum. While very few staff participants named 'neoliberalism' they did identify and comment on the effects of neoliberal policy making. Staff participants also described using diverse strategies to resist and contest the systemic violence of risk management practices and funding constraints, even if they did not explicitly refer to their work in this way. This reflects a key finding from Ready's thesis (2018), that while social workers/human service workers did not identify neoliberalism or settler colonisation by name, they could identify the impacts of these political economies on their services, on their employment and on the lives of women accessing human services.

In the next chapter, Chapter 6, the continuum of trauma informed care models is explored in further detail. This chapter explores how trauma informed services and models enacted the trauma informed principle of 'Cultural Safety'.

CHAPTER 6:

Trauma informed cultural safety?

Introduction

The previous chapter, Chapter 5, considered the implementation of different models of trauma informed care along a continuum, ranging from behaviour management to politicised praxis. This chapter explores the translation of the trauma informed care principle of cultural safety into practice. Given the over-representation of First Nations women, refugee and new migrant women in ‘homelessness’ statistics in Australia and Canada, it was important that this study focused on how trauma informed services implemented the principle of cultural safety.

This section of the findings addressed the following research question:

- How do staff understand ‘cultural safety’ (a key principle of trauma informed care) in women’s refuges and crisis accommodation services and how do these understandings influence their work with women?

As discussed in the literature review, the terms ‘cultural safety’, ‘cultural sensitivity’ and ‘cultural competency’ are often cited as key principles of trauma informed care. Specific philosophical and practice-based differences underlie each of these principles. Rather than being a static or discrete measure, cultural safety has also been conceptualised by many theorists and activists as a continuum of practice which incorporates ‘cultural sensitivity’ and ‘cultural competency’ (Land, 2015; Cross, 1988). This continuum of practices and philosophies can move toward cultural safety; by honouring First Nations peoples’ sovereignty, histories, knowledges, languages and cultures and the ongoing impacts of settler colonisation (Land, 2015). Practices and attitudes can also move away from cultural safety, towards racism, white privilege and the disavowal of the historic and ongoing consequences of settler-colonisation (Land, 2015).

While the terms cultural safety and trauma informed care are widely used, the breadth and variation of the translation of these ideas into practice raises some concerns about the quality and integrity of the principle of cultural safety enacted by trauma informed services. Key differences in the concept and application of cultural safety were evident in comparisons between staff participant interviews and in an analysis of the dominant models of trauma informed care. The *Interactional and Discursive View of Violence and Resistance* (Coates & Wade, 2007) heuristic illuminated tensions and contradictions between staff participants descriptions of trauma informed cultural safety practices and the espoused values of a service. These contradictions are regarded as significant as they can signal instances of covert institutionalised racism and the influence of dominant ideologies and discourses related to settler-colonialism. This analytic process also clarified the continuum of cultural safety practice in trauma informed services which ranged from low/limited cultural safety to an integrated model of cultural safety which permeated all levels of service provision.

The findings explored in this chapter build on previous theoretical work which has conceptualised cultural safety as a continuum of practice (Berger & Peerson, 2015). The findings presented in this chapter also elaborate on the continuum model of trauma informed care that was presented in Chapter 5. An early analysis of the data suggested that the way ‘trauma’ was conceptualised by individual staff participants influenced the way the principle of cultural safety was enacted. However, following the second stage of analysis, the implementation of cultural safety was more closely associated with the politicised model of trauma informed practice as outlined in the previous chapter. For instance, services using a politicised model of trauma informed care prioritised and integrated the principle of cultural safety at every level of the service. However, the service that primarily used a behavioural management model of trauma informed care, Hamilton House, demonstrated a very limited engagement with the principle of cultural safety.

This chapter considers the translation and enactment of the trauma informed principle of cultural safety across the following service domains: 1) the identity of the service including guiding philosophies, histories and service aims and priorities; 2) the dominant model of trauma informed care; 3) managers' understandings of trauma informed cultural safety; 4) the employment/or lack of employment of women who have lived experiences of housing injustice, systemic racism and gendered violence (peers), in decision making, managerial and other leadership roles.

Cultural Safety in the context of Behaviour Management Trauma Informed Care:

Cultural Safety is a core principle of trauma informed care, however as discussed in Chapter 2, the literature review, this is often not very well understood or implemented into human services. In Hamilton House, many staff participants said that while the service was 'trauma informed' the service had not at the time of data collection, implemented the principle of cultural safety. The lack of cultural safety in this service identified by management and staff participants as a significant service 'gap' and that this was a priority for further staff development and training.

Most Hamilton House staff participants appeared to be uncomfortable when questioned about the ways in which the service enacts the trauma informed care principle of cultural safety. Several staff participants struggled to demonstrate any understanding of this principle or related concepts such as 'cultural competency' and/or 'cultural awareness'. Many staff participants described ways that they had applied their knowledge of trauma informed care in interactions with First Nations identifying women and women from culturally and linguistically diverse backgrounds. However, the trauma informed care training alone appeared to be an insufficient framework. A few staff members expressed feeling challenged, uncomfortable and ill-

equipped to work with people who had lived experiences of: settler-colonisation, racism, war and refugee trauma, homophobia and transphobia.

In the following example, Terry, a tenancy facilitator support worker at Hamilton House, discussed her interactions with a First Nations woman who had attempted to access crisis accommodation at Hamilton House. Terry described the First Nations woman as a ‘long term rough sleeper’ who frequently used alcohol and other drugs. Terry emphasised that the woman’s behaviour was ‘extremely violent. Vocal and yelling and screaming. So much so that people were looking...she was saying “you’re doing this to me, you’re doing this to me”’. Terry said that in response to the First Nations woman’s challenging and distressing behaviours the service exited her prematurely.

During the interview Terry said that she had applied trauma informed concepts to understand the situation and to inform her responses. Terry shared some of her prior knowledge and understanding about settler-colonisation in Australia: ‘Going back to the systems stuff is to acknowledge the trauma that they (First Nations people) have gone through, through the whole history of our country and colonisation. To be honest, I was ignorant to it, until I went to uni and I was so angry and frustrated of how it was all happening and why’. As the interview progressed Terry provided another reason for exiting the First Nations woman early:

Terry: ...She ended up being exited from our service. I still to this day think if I had filled in those forms with her earlier on that morning she would have had further accommodation with us. But then would I have been creating a culture of dependence with her. So, that was a big dilemma for me. Because that’s an issue from our history as well, creating a whole culture of dependence. We re-engaged but totally on her terms, which is fine. But then it came to, am I enabling her to continue on a road that she’s been on if I sit down and play it at her time?

In this statement Terry utilises the discourse of *welfare dependency* and the psychotherapeutic discourse of *enabling* to, in part, justify the withdrawal of service supports and crisis accommodation from the First Nations woman in this example.

In an Australian context, the welfare dependency discourse is highly racialized and classed and has been mobilised to justify welfare reforms, such as increasing the number of punitive and paternalistic ‘mutual obligation’ requirements designed to incentivise and coerce welfare recipients back into jobs (Wright, 2016; Cooper, 2012).. This discourse assumes that First Nations people are especially ‘vulnerable’ to becoming dependent on welfare provisions throughout their lifetime and that this ‘dependency’ can be ‘transmitted’ to subsequent generations. This discourse reconstructs any long-term reliance of welfare provisions as pathological.

The psychotherapeutic discourse of ‘enabling’ is associated with the fields of alcohol and other drug use and addiction management and recovery approaches. Enabling has been described as any behaviour that complies, supports or fails to challenge the harmful behaviours of another person (Rotunda, West, & O'Farrell, 2004). In other words, the enabling behaviours of friends, family and human services workers can undermine the capacity for an individual or community to recover from harmful and addictive behaviours (Rotunda, West, & O'Farrell, 2004). In the context of Terry’s example, the discourses of welfare dependency and enabling are mutually reinforcing, pathologising and victim blaming. For Terry, withdrawing crisis accommodation from a First Nations woman was anticipated as having a positive disciplinary effect associated with breaking the ‘addiction’ or ‘dependency’ on welfare/crisis accommodation support. Similarly, Terry professed to understand the trauma associated with settler-colonisation experienced by First Nations people and yet she continued to hold the view that sharing power and meeting a First Nations woman ‘on her own terms’ may only further ‘enable’ the woman’s substance use, homelessness and aggressive behaviours. In this example, the welfare

dependency and enabling discourses destabilised the principles of trauma informed care and cultural safety, which would have led to the accommodation and extension of service supports for the woman in the example.

Most of the staff participants from Hamilton House, including Angela, the service manager, identified as being non-First Nations, Anglo Celtic in background and English was the first language spoken at home. Some staff participants indicated that they did not feel very confident working with First Nations women and women from refugee and new migrant backgrounds. Megan, a case-manager at Hamilton House, suggested that this difficulty was related to language and communication barriers and also indicated that Hamilton House staff took offense at the behaviours of some women from Culturally and Linguistically Diverse Backgrounds:

Megan: I think sometimes there is just a language barrier, that can lead to a bit of frustration. They obviously don't mean it or I don't mean it. So, I do think we need to improve in that area (cultural safety). Because that's really challenging us. We've had situations here where the staff has interpreted women who don't use 'pleases' and 'thank yous' as rude and not having manors. So, it's been having conversations with staff, that 'pleases' and 'thank yous' might not be part of... you know, their culture. So that kind of thing taps into our own values.

Megan's reflection reveals a tense dynamic between staff and women in a service, that while 'trauma informed' was not necessarily culturally safe. Megan's statement also suggests that that some staff members had an expectation that women accessing the service should express gratitude for the services they received.

As discussed in the previous chapter, Hamilton House used the implementation of trauma informed care as a way of transforming the organisational culture and of eliminating

conditional and (re)traumatising practices. However, the psy trauma discourse and behaviour management model of trauma informed care was arguably compatible with the neoliberal risk management and neoliberal governance/governmentality. The influence of neoliberal risk management and governmentality, perhaps explains why many of the punitive, conditional and disciplinary practices remained unchallenged. In this context, the disciplinary expectation that women should express gratitude for receiving services is a possible example of how human services can participate in what has been termed the neoliberal “regime of the self” (Webb, 2006, p.60). The neoliberal regime of the self refers to the intensive order of individual responsibility in which “competent personhood is thought to depend one’s success or failure in acquiring the skills and making the choices to actualise oneself” (Webb, 2006 p.60). In the context of Megan’s example, training women to express gratitude and to demonstrate correct and polite ‘manors’ through a white Western lens, may also be understood to be disciplining, responsabilising and also assimilating.

Furthermore, Megan’s statement implied that the dominant English speaking and white Western culture and worldview at Hamilton House may have created an ‘us and them’ dichotomy that marginalised First Nations women, women of colour and women from CALD backgrounds. The dominance of white Western frameworks in human and health care services, euphemistically referred to as ‘mainstream’ service provision, has been criticised as a form of institutional racism (Australian Human Rights Commission, 2016). In contemporary settler colonial societies such as Sydney and Vancouver, the dominance of white mainstream services has been built by “government officials and medical practitioners who sought to impose their own systems of medicine on First Nations peoples as part of their larger colonizing agenda” (Kelm, 1998 p.175). As Kelm (1998), argues, health and human services historically and contemporaneously colonise and assimilate First Nations peoples, and indeed all citizens of settler colonial nations, under the “guise” of “humanitarianism” and “aid” (p. 175). Through

this lens, the dominance of white Western values, attitudes and cultural expectations in human services in the context of British settler-colonial societies cannot be viewed as a neutral and incidental phenomenon. Therefore, many First Nations women and CALD women do not trust and do not feel safe accessing whitestream/mainstream services health and violence prevention services leading to a significant under-utilisation of services (NSW Ombudsman's Report, 2010). While all the staff participants at Hamilton House were very passionate about their work and were kind, compassionate and generous people and who could not be described as overtly racist, the lack of organisational commitment to the trauma informed care principle of cultural safety created uncertainties for staff and possible covert forms of discrimination and institutional racism against First Nations women, women of colour, refugee and new migrant women and women from CALD backgrounds. Staff participants from this service were also limited by the psy training and supervision that they received as this training did not include any focus on the concept of intergenerational trauma/intergenerational oppression experienced by First Nations peoples in the context of settler colonisation.

[Cultural Safety in the context of Politicised Trauma Informed Care:](#)

Staff participants and key informants who endorsed a politicised model of trauma informed care were conscious that services could not only (re)traumatise women, but re-enact and reproduce whitestream, racist and settler-colonial forms of violence. Developing cultural safety was viewed by politicised services including Amelia's Place and Coast Salish Place as a long-term, dynamic and constantly evolving practice that needed to be guided by First Nations women, and women with lived experiences of housing injustice and gendered violence. In the absence of cultural safety, First Nations women accessing crisis accommodation services are more likely to be harassed, assaulted and discriminated against (Browne-Yung, Ziersch, Baum, & Gallaher, 2016). For example, First Nations woman and key informant, Stella,

outlined harrowing experiences of being assaulted by racist staff and of being misunderstood and dismissed while staying in a faith-based crisis accommodation service:

Stella: Well as far as I am concerned homelessness started in this country in 1788...I am Aboriginal, basically none of the shelters I have ever said in did anything to respect me or my culture. There was a shelter in Liverpool and I got assaulted by a couple of case workers there. They also stood in front of the door to stop me from leaving. Some of the shelters, like the big one up in Woolloomooloo is not a very conducive place for people to stay there. They are Baptist. Because they've got people working there who don't know what they are doing. They don't know anything about Aboriginal people or our history or colonisation or all the institutions and churches that abused us as children. They employ people with religious beliefs that have no idea about our people. It just upset me.

Stella was a very passionate advocate for First Nations women with lived experiences of 'homelessness' and housing injustice to design and run services for women seeking shelter. The two services that implemented a politicised model of trauma informed care, Amelia's Place and Coast Salish Place, the principle of cultural safety was highly integrated across organisational structures of these services.

At Coast Salish Place the principle of cultural safety was clearly articulated in the service mission, was considered mandatory in staff training and development, and was evident in the hiring practices that prioritised the employment of women who had shared lived experiences with the women accessing the service (peers) who were primarily First Nations women with lived experiences of housing injustice and gendered violence, alcohol and other drug use and sex work. The employment of First Nations women and peers in managerial and decision-

making roles was a defining characteristic of cultural safety in politicised trauma informed services:

Researcher: Can you talk about cultural safety and how your organisation provides that for First Nations women?

Joan: So, I think that the biggest way or the main way that we provide it is through our hiring practices. We believe absolutely that we have an obligation to hire women who will reflect the diversity the women we are providing service to and this has been a hiring and recruitment practice that's been in place since about 1993, I think. So, when I started here in 1992 it was the typical kind of requirement to have an undergraduate degree, and now instead we started looking for women with lived experience and looking to hire women who actually, like I say, reflected the women walking in through the front door and I think that's the best way we can create cultural safety. I guess we have probably have fifty to sixty percent of our staff is Aboriginal, Aboriginal ancestry and that's probably close to who we're seeing in our service. About thirty percent are women of colour and immigrant women, which is our next biggest population group. I think we speak around thirty odd languages between all the women who work for us including some Indigenous languages that are still prevalent in Canada.

Joan implicitly critiqued the assumption that staff without these lived experiences can be trained to gain 'cultural competency'. Similarly, key informant, Vikki Reynolds argued that the meaningful and supported peer leadership model at Coast Salish Place, was successful because it attracted "women that refuse to go to other housing services" – that is to say the most traumatised, marginalised and disenfranchised women. The high representation of First Nations, Metis and other women of colour in leadership and managerial positions at Coast Salish Place also reduced the unequal, classed and racialized power dynamics that often operate

between domiciled, middle class, university educated and white crisis accommodation staff and women who are accessing housing services. Vikki Reynolds also suggested that while other services widely “acknowledge lived experience, they don’t necessarily hire to it”. Vikki Reynolds named this as a subtle yet pervasive form of institutionalised racism that prevents many First Nations people from gaining employment in services that primarily serve First Nations peoples. Vikki Reynolds also argued that within a neoliberal political economy, peer-led hiring practices are often “measured down” or not valued and therefore are not funded as highly as services that primarily employ white ‘professionals’. Social stigmas attached to other social positionalities including; working class/poor women, women of colour, women engaged in sex work, women who use alcohol and other drugs, women living with mental health concerns/problems and women who speak English as a second language, can also experience overt and covert barriers to employment in managerial and leadership roles.

The model of trauma informed cultural safety offered by Coast Salish Place aimed to connect First Nations women and refugee and new migrant women accessing the service to members of staff with shared life experiences, shared languages, shared cultural and tribal identities. For example, Mahala said that a First Nations worldview permeates the service provision model at Coast Salish Place which could be attributed to the strong connection and continuity between Coast Salish Place services and the First Nations communities that reside in urban Vancouver. Mahala also described the role of First Nations Elders who, through an outreach program, mentored young women experiencing housing injustice and gendered violence in the community. The model of First Nations led cultural safety offered by Coast Salish Place, was regarded by most staff participants as a healing service framework for all women accessing the service regardless of their cultural identity.

There were some similarities between the model of cultural safety offered at Coast Salish Place and Amelia’s Place. Amelia’s Place women’s refuge also prioritised the employment of First

Nations women who had lived experiences of domestic and family violence and housing injustice. Amelia's Place also had an entire crisis accommodation branch that was run exclusively by First Nations women, that could accommodate up to seven First Nations women with their children. Kayleen, a First Nations woman from Amelia's place described the way she enacts the trauma informed principle of cultural safety and also described how the service encouraged and inspired First Nations women who attended the service to become future refuge staff members:

Kayleen: I value each and every woman. I value what they have to say and I take everything into consideration. It's her journey and I am walking that journey beside her. And I always encourage that they make their own decisions and I support those decisions. One woman that was part of the service a couple of years ago, she came back to be a case worker. She went to TAFE and got some certificates and she came back to work here... In the past, we have had an Aboriginal women's group and we've taken them out to sites, to eat bush-tucker. It depends on what it is so we do NAIDOC week. We provide all Aboriginal cultural awareness into the service. Child support also has a very culturally safe framework and those children are assessed if they are in need. We've had Aboriginal women in the past that are self-referrals to this service because they have heard from other Aboriginal women about this service.

The First Nations-led and designed service challenged the potential for politicised trauma informed services to reproduce covert and unintentional institutional racism and increased the accountability of non-First Nations and non-peer workers to the women and communities they were working with. Coast Salish Place and Amelia's Place also actively incorporated First Nations cultural activities and ceremonies into the everyday running of the women's refuge and the crisis accommodation service including but not limited to; facilitating sharing circles

or yarning circles, attending massacre sites, running beading and drum making groups and holding smudging ceremonies.

When staff participants from politicised trauma informed care services were asked to describe how the service enacted the principle of cultural safety, all staff members participants offered a socio-political analysis of gendered violence, racism and housing injustice. Furthermore, most staff participants from politicised trauma informed services elaborated on the ongoing impacts of settler-colonisation on the lives of women, particularly First Nations women, and also for refugee and new migrant women who attend their services. Most Amelia's Place staff participants argued that having a socio-political analysis of gendered violence and racism in the context of settler-colonialism in Australia was foundational to the trauma informed approach offered by the service.

This view was also shared by Coast Salish Place participants. For example, Mahala, a First Nations woman and case-worker, described the critical importance of using an intersectional feminist analysis of housing injustice to work in anti-oppressive and empowering ways with women:

Mahala: It's understand how racism piles on top of homophobia, piles on top of sexism, piles on top of ableism and how all of those things can, um, quite frankly, impact on a women's ability to get out of where's she's at... So, it's understanding on a kind of intrinsic level how all of those things work against our women to, to keep them from being able to do things differently then they're doing.

By naming and exposing these forms of state-based violence, Mahala actively resisted settler colonial and neoliberal victim blaming language that is often used to further misrepresent and subjugate women who are experiencing housing injustice. Therefore, a clear analysis of systemic and intersectional oppressions can illuminate for staff and women possible sites of

resistance, advocacy and solidarity work in pursuit of housing justice and ultimately land rights. Advocacy and activism was an important part of the work at Coast Salish Place. Joan explained that the service has a long-standing history of engaging in sector-wide advocacy against systemic forms of racism. The manager of the service, identified racism within the British Columbia child protection system as an ongoing threat to the aim of keeping First Nations women and their children together. Removal of children and especially First Nations children by the State potentially replicates the practices under the Stolen Generations in an Australian context, and the Residential Schools in a Canadian context. By supporting First Nations women who “are struggling with their children” Joan argued that Coast Salish Place is actively involved in resisting ongoing colonial violence against First Nations women and their children.

According to Joan, manager of Coast Salish Place, Joan, the term ‘settler-colonisation’ more accurately describes the injustices experienced by women than the concept of ‘homelessness’ and or, the concept of ‘trauma’. Here Joan locates the issue of homelessness within the occupying British/European colonial culture specific to the concept of land ownership. Unlike the concept of psychological trauma, the understanding used by staff participants at Coast Salish Place was that the ‘settler-colonisation’, ‘genocide’ and ‘assimilation’ of the *past* not only had psychological and intergenerational impacts, but that these forms of state-based violence materially contributed to injustices experienced by First Nations peoples in the present. For instance, Joan and other staff participants from Coast Salish Place, argued that the over representation of First Nations women in homelessness, violence against women and homicide statistics are a direct result of past and ongoing settler colonisation in Canada. Joan indicated that many perpetrators have attempted to target women that use Coast Salish Place who also could be identified as First Nations women, Métis women, transgender women and women who are sleeping rough, accessing alcohol and drugs, and working in sex industries (including survival sex work).

Coast Salish Place staff participants also said that understanding intergenerational trauma has contextualised patterns of: inter-personal violence, emotional trauma, low self-worth, forms of self-neglect/self-harm and the widespread use of alcohol and other drugs among women accessing their service. Dan a case-worker from Coast Salish Place indicated that staff need to hold these understandings so that they can educate and empower the women who access the service:

Dan: Some women don't know that their struggle is because their grandmother was in a Residential School. When First Nations women begin to see what's been done to them, to their families, to their ancestors, it takes the blame off their shoulders.

Alongside acknowledging settler-colonial trauma and intergenerational trauma/intergenerational injustice, all Coast Salish Place and Amelia's Place staff participants emphasised the importance of valuing and acknowledging First Nations; worldviews, languages, cultures, child rearing practices, health and healing practices as well as First Nations peoples' strength, resilience and resistance to invasion, settler-colonisation and occupation of the past and the present.

[Conclusion to the chapter:](#)

The service that primarily used a behaviour management model of trauma informed care, Hamilton House, did not have a strong understanding of cultural safety and did not incorporate this principle into the service design and delivery. Staff participants from this service were aware of the limited use of the trauma informed principle of cultural safety and identified this as an area for future service development and training. The interviews with staff participants from Hamilton House suggested that the model of behaviour management trauma informed care did not adequately equip staff to work with First Nations women who are victims/survivors of intergenerational trauma and injustice in the context of settler colonisation. Staff

participants from Hamilton House tended to draw from pre-existing, socially dominant and historically located discourses about the ‘deserving and underserving poor’, ‘welfare dependency’ and ‘individual responsibility’ which contradicted the espoused aims of the trauma informed care model and resulted in at least one First Nations woman being prematurely exited from the service.

Conversely, services that used a politicised model of trauma informed care, Amelia’s Place and Coast Salish Place, actively prioritised the principle of cultural safety throughout all levels of the service. In politicised trauma informed services, cultural safety was primarily understood in terms of peer leadership and ensuring that women with lived experiences of housing injustice were employed and supported within the services. Both Amelia’s Place and Coast Salish place minimised the risk of ‘tokenistic representation’ by ensuring that First Nations women and other women of colour were employed at all levels of service provision including in senior management roles with key decision-making responsibilities and opportunities. However, the dominance of neoliberal risk management and psy trauma informed discourses also challenged First Nations and feminist practices of sharing power equally with women accessing services and promoting women with lived experiences of housing injustice to positions of leadership.

Both politicised trauma informed services recognised the significance of historic and ongoing settler-colonisation in the reproduction of intersecting oppressions including; gendered violence, systemic racism and housing injustice. Therefore, cultural safety at these services, was facilitated by mandatory staff training and education which focused explicitly on the history of settler-colonisation and ongoing systemic racism. These understandings were enacted through the commitment to ensuring First Nations women, refugee and new migrant women had extensive service supports and low barrier access to crisis accommodation and transitional housing.

Politicised services were engaged in multiple anti-systemic racism advocacy and activist campaigns such as the Missing and Murdered Women's Memorial march and advocacy to reduce the over representation of First Nations children and young people who are removed from their families by statutory child protection systems.

The next chapter, chapter 7, explores women's experiences of services using a model of trauma informed care. This chapter also looks at some of the structural limitations to trauma informed care services and the situations of ongoing poverty and housing injustice experienced by many of the women who took part in this study.

CHAPTER 7

“Like my own home”: Listening to women’s experiences of trauma informed refuges and shelters

The previous chapters, 5 and 6, focused primarily on staff participant perspectives on models of trauma informed care. This chapter is primarily devoted to the women participant’s experiences of trauma informed services. Interview data were analysed according to the following research questions:

- How does an espoused trauma informed care/cultural safety model shape women’s experiences in women’s refuges and crisis accommodation services?
- What service gaps and contradictions are addressed or unaddressed by the implementation of trauma informed care?

While this chapter mainly focuses on women’s experiences of accessing a trauma informed service, some staff perspectives are also included. This chapter also considers the circumstances that precipitated women’s decisions to access either a women’s refuge or crisis accommodation service and explores women’s reflections and experiences upon leaving trauma informed services. As some women participants came to re-experience housing injustice, this chapter also considers the structural constraints imposed on models of trauma informed care as they were illuminated through women’s lived experiences.

Seeking refuge, seeking safety:

Almost all women who participated in the interviews who accessed either Amelia’s Place or Hamilton House crisis accommodation service, did so in the aftermath of leaving a violent partner or family member(s). Each woman described living through and surviving situations

of extreme emotional and physical deprivation, fear and violation perpetrated by current or former partners and family members.

For instance, Anita, a 36-year-old woman, came to Hamilton House after she left her violent partner:

Anita: I can't, I can't... My husband, he hurt me very badly... You know when you're in this situation you lose your pride and your self-esteem...Because it's really demoralising when you have been through a lot when you have been through hell, your integrity is all crushed...when someone takes that away from you. That's really the kicker because you know I was just crying, I couldn't stop crying at nights I was crying myself to sleep. I had no one to talk to, I couldn't open up. I couldn't ask for help I didn't know where I was going.

Similarly, Cindy, a 19-year-old woman came to Hamilton House after she was forced to leave her home due to family violence perpetrated by her father and brother.

Cindy: I was really afraid that my family might try and find out where I am. I was running away from their religion. My brother and father...they bashed me. I had to stay in my room. It was like I was being punished just for existing.

For Cindy, being stalked and found by her abusive family members was an ongoing threat while she was staying at Hamilton House. Cindy and Anita, stated that they continued to experience distress and other traumatic impacts related to the ongoing threat of harm posed by domestic and family violence perpetrators. While these interviews were not representative of all women who accessed Hamilton House, they do provide some evidence indicating that there are many women who seek crisis accommodation at this service as a direct result of gender-based violence and domestic and family violence. This finding sharply contrasts the assumptions held by many staff participants from Hamilton House that 1) 'trauma' is a *past* event in women's lives and 2) that majority of women who have accessed the service have not

done so due to domestic and family violence and 3) as such, women are no longer at risk of further harm. However, Hamilton House staff participants said that they were proactive and responsive to women's disclosures of domestic and family violence when they arose. For instance, staff participants said that they ensured that women were referred to specialist domestic and family violence services, women's refuges and the rape crisis service. Hamilton House also attempted to keep women safe during their stay at the crisis accommodation service safety by ensuring the service was discreet and unlisted with 24-hour surveillance and security systems. These safety measures were critically important in the prevention of violence against women. However, recent research has recommended that health and human service professionals anticipate that all women may be at ongoing risk of domestic and family violence regardless of whether women have discussed their concerns about perpetrators or not (Spangaro et al, 2016). Therefore, it was recommended that health and human service workers ask all women *directly* about experiences of domestic and family violence (Spangaro et al, 2016). It was also recommended that human service workers ask women about their concerns regarding partners and family members who have perpetrated violence, using a 'trauma informed' and caring approach as workers who demonstrated 'care' were found to elicit more disclosures from women than staff were perceived as disinterested and uncaring (Spangaro et al, 2016). The research by Spangaro and colleagues (2016), demonstrates that trauma informed understandings and anti-gender-based violence work can and should be complimentary. The reluctance of Hamilton House to incorporate anti-gendered violence work into their model of trauma informed care, was likely due to the range of issues highlighted in Chapter 5, and also due to the structural constraints which are detailed in the subsequent section entitled; Ongoing housing injustice and the limits of trauma informed care.

[Positive experiences of trauma informed care service models:](#)

All women who participated in this study described very positive experiences of the trauma informed services that they attended. For instance, all women who had stayed in Amelia's Place women's refuge said that the service felt like a second home. Changying said that the staff 'treat you like family, like a sister' and Daiyu expressed 'I feel this is like a home. Like my own home'. Similarly, Julie also described her stay at Amelia's Place as homelike:

Researcher: I'm wondering how you felt staying here?

Julie: I really feel like I'm at home when I'm here.

Researcher: What is it that makes you feel at home?

Julie: Yeah, it's just like, um, there's no pressure and you can have someone talk to. When you've gone home that um, you have that free feeling, you feel like you have nothing to worry about. You can stay in your room, whatever. It's just a really freeing feeling. Yeah. So, I feel very good here. Yes, they (Amelia's Place staff) always encourage me. So, they always say things like; "we respect your decisions", "we will always be your support", you know, it's really nice. I think in general, you feel very, you know some like uh... before you're really lost, especially when everything was messed up and you lost yourself. So, the staff here encouraged me to find my way back to myself. Yeah, I think they really, really care about you.

The combination of care and connection demonstrated by staff towards the women and staff member's respect for women's autonomy and choice were central to the women's positive experiences of Amelia's Place. Several other factors contributed to women's positive experiences of Amelia's Place including; 1) women felt that staff respected and supported their decision making. Women also reported that they didn't feel negatively judged by staff members. For example, Julie stated, "I feel in control of making my own decisions here"; 2) staff were continuously engaged and communicated with women frequently. For example,

Changying said “workers are persistent making sure all needs are met” and that “workers take the time to get to know you” 3) The service provided the option for First Nations women to work with First Nations staff members. The cultural safety at Amelia’s Place made the service more accessible and comfortable for First Nations women 4) Women who stayed at Amelia’s Place valued the physical safety of the building and especially valued having their own private bedroom space; “having a door you can lock and safety buzzer, which was great”(Julie, 2013) and “knowing you can contact staff anytime” (Changying, 2013), 5) Women with children also appreciated the dedicated child care service and the day trips offered by the service (such as trips to the zoo, movies and restaurants) which helped women and children to rebuild their connection and relationship following housing injustice and domestic and family violence, 6) Women who had left the service valued the ongoing support provided by Amelia’s Place staff.

Women who had stayed at Hamilton House also shared very positive experiences of the trauma informed service. Women identified the following aspects of service provision that helped them to feel the safest; 1) That Hamilton House was a women’s only crisis accommodation service, 2) That all crisis accommodation bedrooms were private and lockable. For example, Anita stated that the women’s only space and lockable private room helped her to feel safe:

Researcher: Did you feel safe here?

Anita: Yeah. Absolutely. Yeah, first of all because it’s female dominated and so I had my own room. You know the residents have their own room so at least... you know, if you have your own space to breathe and do your own thing and if you want to be by yourself you just, you know, stay in your own room...

These findings add to literature that supports a gender-specific, women’s only model of crisis accommodation service delivery that is managed and staffed by women and peers (David et al, 2015). Gender specific, women’s only crisis accommodation services are also preferred by transgender women and two-spirit identifying First Nations peoples who do not feel safe

accessing services which co-accommodate cis-gendered men (Lyons et al, 2016). Despite this evidence, few shelters in Sydney or in Vancouver offer women's specific accommodation. Women (including transgender women and two-spirit identifying people) who are victims/survivors of male violence often do not feel safe accessing these mixed gender, dormitory accommodation. These findings also support the use of private and lockable bedroom units for women as opposed to the open plan dormitory style accommodation that is offered by many 'homelessness' services in Sydney and Vancouver.

Women who participated in this study from Hamilton House also said the security of the building increased their sense of safety. All women who stayed in Hamilton House said that the staff were demonstrably kind and accessible. For example, Cindy referred to the Hamilton House staff as her 'angels'. Similarly, Claire stated "the most important thing is, that you can share what's on your mind and I didn't have to worry about doing everything on my own". For Claire, the service support in navigating the complex public housing system in Australia meant that she was able to access housing within a 6-month period after being 'homeless' for over a year.

[Sharing spaces with other women:](#)

Some women reported that sharing residential spaces with other women at Hamilton House and Amelia's Place led to the development of trusted, long-term friendships and relationships. The meaningful support from other women who shared similar stories and experiences of resistance and resilience in the face of multiple and intersecting forms of injustice; poverty, domestic and family violence, housing injustice, child removals, alcohol and other drug use recovery, were highly valued by many of the women who participated in this study. However, a number of women from Hamilton House and Amelia's Place noted that the most challenging aspect of staying in the trauma informed care services was having to share common area spaces

(e.g. the kitchen, laundry and television room) with other women. For example, Anita who stayed at Hamilton House, described feeling “threatened” and “unsafe” while sharing the common area spaces. Similarly, Claire who was a victim/survivor of domestic and family violence, also described being (re)traumatised by the aggressive behaviours used by other women who were staying at Hamilton House:

Claire: My struggle for so many years has been abuse, both physical and mental, so I didn't want things to go that way again...but when people go to that level of intensity, where they are accusing you and threatening you... It only happened once to me where I had the situation happen which was quite frightening...but it's not just frightening for me it is frightening for the other women there too. Women can be funny but there are also some wonderful women that I've met here and still have a friendship with, while other women will run you down, scream at you and steal from you.

These experiences suggest that despite the use of strategies such as private lockable rooms, surveillance cameras and the implementation of behaviour management trauma informed care, interpersonal violence between women undermined the services attempts at providing physical and emotional safety and a therapeutic space. Anita indicated that the disciplinary approaches and conditions at Hamilton House were challenging but conceded that the service needed to manage some of the very aggressive and harmful behaviours used by some women towards other women and staff:

Anita: As long as you follow the rules, otherwise, if there were no rules there would be chaos. They have these rules, they impose these rules, but they are best for everybody...I was actually threatened by another woman here, but eventually the person involved said sorry and apologised.

Women from Amelia's Place also stated that sharing residential quarters with other women and children presented challenges, including; experiencing an inability to sleep due to noise from

other women and fear that other women would disclose the location of the women's refuge to their friends, relatives and partners, thus compromising the safety of the service.

The issue of interpersonal conflict and (threatened) violence between women staying at Hamilton House and Amelia's Place was not widely discussed by staff participants. There is a dearth of literature describing conflict and possible violence between women staying in women's refuges and crisis accommodation services. Furthermore, the available literature exploring the implications and recommendations for the delivery of safer spaces in gender specific crisis accommodation services is also limited. Some staff participants, including Brandy, a First Nations woman and housing support worker from Coast Salish Place, spoke indirectly about the issue of interpersonal conflict and violence between women who were staying in the crisis accommodation service:

Brandy: We talked earlier about the impacts of colonisation, and I mean, that's violence from your society onto your people. That equates to a community of hurt people and people who are hurt don't know how to act healthy to one another.

Interpersonal conflict between women at Hamilton House, Amelia's Place and Coast Salish Place was largely managed through weekly or fortnightly 'house' meetings that were mediated by crisis accommodation and women's refuge staff. As previously discussed in Chapter 5, women's challenging and aggressive behaviours at Hamilton House tended to be managed through surveillance (primarily through the use of surveillance cameras), conditional requirements (service supports were contingent on women's compliance to service rules) and risk averse practices (the punitive, early exiting of women from the service for women who had broken service rules). However, as these trauma informed care services continued to be experienced as 'retraumatising' due to the aggressive and harmful behaviours of some women, this then raises questions about the efficacy of these strategies and prompts questions about

what additional service supports are required to de-escalate and to prevent interpersonal conflict, harassment and violence between women. This also raises questions about the use of possible mediation approaches that could be employed by staff to increase women's capacities to resolve conflicts and to live safely and respectfully together. Given that almost all women at the service, including those who use harmful behaviours, are victims/survivors, the lack of organisational focus on anticipating and mediating inter-personal conflicts between women, appears to be a gap in both behavioural management and politicised models of trauma informed care models.

Ongoing housing injustice and the limits of trauma informed care:

All three trauma informed care services that participated in this study were committed to facilitating long term, sustainable housing for the women. For some women, the support these services provided resulted in tenancies that they were very satisfied with and that enabled them to begin to rebuild their lives. However, the aim of housing justice for all women who attended trauma informed women's refuges and crisis accommodation services, was elusive. For many women, despite the hard work and dedication of staff at these services, life beyond the trauma informed women's refuge and crisis accommodation service was marked by ongoing poverty and forms of housing injustice. For example, Daiyu a new migrant woman, who stayed in Amelia's Place after she and her one-year old son had escaped domestic and family violence. At the time of the interview Daiyu, was considering leaving Amelia's Place refuge and she had begun to search for private rental accommodation options:

Daiyu: I actually just want to stay here (Amelia's Place women's refuge). Because I got, I have no ability to pay the rent. If I go other place I need to pay the rent. Here I also need to pay but just a little. If I go somewhere else, I need to find apartment it's hard for me. I even don't know which area I need to live in and I even don't, I even don't

have driver licence. I have no car. If I live a very long, a very different place how can I go shopping. I don't get how it all works, it's like I'm blind and I just got from Centrelink, only a little money. Just can buy food or just can buy nappy for baby, but I can't pay the rent. I do not have a job. I have no permanent relative here.

Daiyu's story highlights several intersecting systemic injustices that could coalesce to compromise her safety and the safety of her child. As a new migrant woman, Daiyu and her child were isolated from supportive friends and family members. Daiyu's violent and controlling partner was Daiyu's main economic and housing support in Australia. As Daiyu identified, as a woman reliant on Centrelink welfare payments, she would not likely be able to afford to cover the daily cost of living with a small child and while managing a private rental tenancy. Researchers and advocacy groups have calculated that people receiving income support and who live in Sydney and surrounding suburbs are likely to be living in poverty and are at a high risk of homelessness (Saunders, 2018; Coady, 2017). The combination of inadequate income support and unaffordable housing leaves new migrant women and single mothers who are also victims/survivors of domestic and family violence, like Daiyu, in an impossible situation. Daiyu expressed during this interview that these pressures had made her consider returning to live with her violent ex-partner. Fortunately, Amelia's Place refuge was able to extend the period of accommodation for Daiyu and her child, however her long term housing remained in question. Daiyu's experience was also shared by several other women reported positive experiences of services which had extended periods of accommodation and provided additional brokerage support. For instance, Cindy from Hamilton House and Julie from Amelia's Place had been offered accommodation support for up to one year. All women who received long term crisis accommodation support described the service as feeling like a "home" and were reluctant to leave.

Similarly, Paula, came to Hamilton House after escaping her violent and controlling husband. Paula described her experience of staying in the crisis accommodation service at Hamilton House as very positive and she mentioned that she had forged close trusting connections with case-management staff. However, Paula described feeling pressured by staff to accept the public housing property offer which she felt very unsatisfied with.

Researcher: Are you still in touch with anyone from Hamilton House?

Paula: Every now and then I hear from them. You know, they do stuff here and there. But I understand, you have to move on. They have their job... But the worst part is that you're literally isolated. There is no buses on weekends. The buses on weekdays, the last bus is six o'clock. You cannot walk 'cause it's really far. So, that's very limiting on your life, you know? You can't have music. I can't even get a small radio because, you know, it's like walking on egg shells all your life. 'Cause apparently the walls are, I mean people, you hear people washing dishes, you know? They thump on my walls because I'm making noise. Really, it's washing dishes, you know? That's why I'm not getting a radio. I don't have television. I don't have a radio and you walk every day on egg shells, but I can do that because I'm really quiet myself. But not to be able to go out and explore and do voluntary jobs, get a job, get a life, you know, meet people from... meet friends. You have to hurry all the time to go home. Otherwise you will pay for the taxi to go home. It's just not for me. I never felt so alive when I was staying here in the city.

Due to the shortage of long term public housing in Australia, many human services working with people who are experiencing housing injustice do exert pressure on housing applicants to accept the first or second offer of housing. If a housing offer is not accepted, there is a risk that public housing will be offered to another person, leaving the 'homeless person' with extremely

limited prospects of obtaining a long-term, secure and affordable housing tenancy. This means that many people experiencing housing injustice are coerced into accepting housing that is substandard or that presents other challenges to their physical and mental health and wellbeing (Novoa et al, 2015). In Paula's case, although she was no longer homeless, Paula indicated that she experienced geographical isolation, lack of public transport and that this has had numerous impacts on her capacity to find work and to form a supportive social network. Paula also conveyed that she felt uncomfortable in her home and was frequently harassed by neighbours for making any noise related to her daily activities of living. In other words, while Paula finally had 'housing' of her own, she did not necessarily have housing justice. For victims/survivors of domestic and family violence, like Paula, ongoing housing injustice in the form of substandard public housing coupled with geographic isolation, are the structural levers that coerce women into returning to live with perpetrators of domestic and family violence. Paula's situation also highlights the issue of the neoliberal rezoning of cities and urban centres for commercial profit, revanchism and gentrification and while shifting public housing stock to impoverished outer-suburban and regional areas which often lack basic amenities, infrastructure, employment opportunities and access to health and human services (Watt, 2018). The expulsion of public housing stock and therefore of public housing tenants, from wealthy urban areas can be interpreted in many ways, however it is clearly congruent with the neoliberal transformation of the welfare state. Where once welfare acted as a 'safety net' designed to catch the most socio-economically disadvantaged people, the welfare safety net has been reconfigured under neoliberalism as a "welfare trampoline" designed to rebound people back into employment and into the private housing market as the financial or housing 'benefits' are too insufficient and or too humiliating to be endured (Macleavy, 2010, p.134). Therefore, neoliberal welfare can be understood as a harsh system of deterrence rather than a

system of life-sustaining support based on universal access to human rights and human dignity (Macleavy, 2010).

The issue of ongoing housing injustice experienced by women who had stayed at Hamilton House was also raised by several staff participants. For example, Angela, the service manager at Hamilton House, indicated that due to the significant constraints within the Australian public housing system, the model of trauma informed care could only be applied within the narrow parameters of the crisis accommodation service. Therefore, the model of trauma informed care would not translate into long-term housing justice for women:

Angela: One of the stated goals in the (trauma informed care) project initially was to have better housing outcomes for women. Um, I said from the outset, ‘if nothing changed in the broader system, how are we going to have better housing outcomes?’ A lot of the women from here move into transitional accommodation. That means they move into another shared environment. It might mean moving to an area that is not where they feel safe and the most comfortable... Housing NSW properties are you know, the garden is not maintained, the picket fence is falling down, there isn’t any curtains or security on the windows. You’re lucky if there’s light bulbs in some of them. It feels substandard for the women.

Angela’s acknowledgement of the substandard, unsafe and uncomfortable conditions of public housing, raises questions about the potential efficacy and indeed the meaning of offering trauma informed care within a broader neoliberal welfare system that relentlessly penalises and marginalises women and places them at ongoing risk of housing injustice, poverty and gendered violence. This finding resonates with criticisms raised by McKenzie Mohr and colleagues (2011), who argued that:

Trauma informed care principles and guidelines for service delivery, as currently conceptualised, holds an individualised and de-politicised framing of trauma, and offers a reactive and mainly ameliorative approach to assisting individuals (p.139).

In the context of neoliberal welfarism, the potential for trauma informed care to effect a significant ‘paradigm shift’ (Elliott et al., 2005a) in human service delivery, has been reduced to little more than the provision of temporary respite from ongoing housing injustice, grinding poverty and the ongoing risk of gendered and racialized violence. The model of behaviour management trauma informed care was also used to manage women’s resistance to definitive service exit dates. Angela and many other Hamilton House staff felt that the trauma informed care training helped staff to gently persuade women to accept public housing offers or to find private rental accommodation. Furthermore, staff participants suggested that the trauma informed care practice framework was particularly useful in managing women’s frustration and resistance when women were confronted with substandard public housing properties and the prospect of living in poor and disenfranchised neighbourhoods in outer suburban and regional areas.

Julian, a case-manager at Hamilton House, appeared pessimistic as he discussed the issue of lack of affordable private rentals and the shortage of public housing stock in Sydney:

Julian: Yeah and you run the risk of providing a really great service, and a lot of our clients may come from Western Sydney and they are on the priority (housing) list for where they are from. But they end up liking living in the city and they want to change their application to the inner city or something like that. They think, ‘I think I want to rent around here’ and it’s like, the prices are that much more expensive, you’ve got to be realistic about society and there are people here that have really high paying jobs and that also work hard that are competing to live in the city.

Julian's statement is simultaneously pragmatic and is possibly resigned to the forces of 'no-alternative' neoliberalism. In the context of neoliberalism, being "realistic about society" tacitly invites acceptance of the ideology of individual responsibility and the notion that living in the city is contingent on hard work and competition in the labour market. Therefore, rather than homelessness being understood in terms of classed, gendered and racialized inequities and injustices, the urban neoliberal landscape is simply divided into winners and losers. Traumatized and 'homeless' women are cast as losers and the underserving poor, who are no longer permitted to dwell or to live in the affluent urban areas. Instead, women are made to be content and grateful for the substandard housing and insufficient income support provided by the settler colonial neoliberal state. In this context, the pragmatic acceptance of neoliberal ideologies and discourses threatens to undermine the potential for human services and staff to engage in a meaningful politics of solidarity with women experiencing homelessness and limits the scope for systemic advocacy and activism. According to Stella, a First Nations woman who slept rough on the streets of Sydney for over thirty years, and who was interviewed as a key informant in this study, as the dream of housing justice under the welfare state died, most crisis accommodation services in Australia content to operate as 'business' models:

Stella: They don't want it fixed... If the system is supposed to be getting fixed, why have the spending figures blown out to nearly double. There are people who are genuinely trying to make a difference. But if homelessness didn't exist you would genuinely have people who wouldn't have a job. But realistically your aim should be to not have a job, your aim should be to solve the problems so that homelessness didn't exist anymore.

Conclusion to the chapter:

Domestic and family violence had thrown most of the women who participated in this study into situations of housing injustice and homelessness. Women's descriptions of being both victims/survivors of gendered violence and housing injustice, indicated that all women had experienced significant distress and 'trauma'. Therefore, this finding endorses the attempt for human services to prioritise, if not 'trauma informed care', then 'violence-informed care. Many women who participated in this study continued to be stalked and harassed by current/former partners and family members which made gendered violence a continuous and ongoing risk. In the service using a behaviour management model of trauma informed care, the psychiatric construction of 'trauma' as a past event in combination with the widespread staff assumption that most women at the service do not, and have not, experienced domestic and family violence, arguably obscured the ongoing risk of harm to women at the service.

Some women from Hamilton House and Amelia's Place also reported experiencing interpersonal conflict with other women who were staying at the services. While, this did not pose the same direct threats to women's safety and wellbeing in comparison with perpetrators of domestic and family violence, in some instances, interpersonal conflict between women undermined the otherwise positive experiences of trauma informed services.

Similarly, while women mostly described positive experiences of the trauma informed Hamilton House and Amelia's Place services, women identified a range of systemic barriers to housing justice which they faced upon leaving the services. All staff who participated in the interviews across the three services sites, identified a range of systemic constraints which undermined the capacity for the services to be trauma informed. The primary systemic constraint to trauma informed care identified by women, staff and key informant participants was the neoliberal welfare system and ongoing threats and abuse from perpetrators. Following

a period of respite in trauma informed crisis accommodation and women's refuge services, many women continued to experience homelessness, housing deprivation and poverty due to substandard, geographically and socially isolating public housing tenancies, unaffordable private rental tenancies and insufficient income support.

This chapter concludes the commentary on the research data. The next chapter will provide a discussion on the key theoretical, methodological, training and education and practice based implications arising from these findings. This chapter will discuss trauma informed care as an important site of social struggle and will provide suggestions for advocacy and activism beyond the non-for-profit-industrial complex.

CHAPTER 8

DISCUSSION: Beyond the not-for-profit-industrial complex: Responding to gendered violence, systemic racism and housing injustice?

This thesis responds to several gaps in the ‘trauma informed care’, ‘homelessness’ and ‘housing’ literature through a critical exploration of the translation and enactment of trauma informed care principles, including cultural safety, into women’s refuges and crisis accommodation services located in Sydney and Vancouver. More broadly, this thesis offers several theoretical contributions to the emerging body of critical social work literature which will be further elaborated upon in this chapter.

This chapter also reflects on the strengths and limitations of the study. This chapter considers the possible implications for trauma informed care, social work practice, advocacy and activism beyond the settler-colonial not-for-profit industrial complex. Recommendations for the delivery of trauma informed care education and training and along with suggestions for future research have been provided.

The following section provides a reflection on the significant theoretical findings from this study.

Trauma informed care as a site of social struggle:

“Those who exercise power through language must constantly be involved in struggle with others to defend (or lose) their position” (Fairclough, 1989, p.29).

It is important to acknowledge that all the trauma informed services that participated in this study attempted to provide just and compassionate services. Staff participants across the three sites were committed to increasing women’s safety and were energised in the pursuit of improving services with the aim of increasing women’s safety and reducing punitive and coercive practices. Many staff members also extended their advocacy and activism beyond

their work in refuges and or crisis accommodation services by participating in anti-gendered violence, housing justice, decolonising and anti-racism campaigns and protest movements. In other words, for many staff participants, their work was much more than ‘just a job’. Trauma informed service provision was also viewed by some staff participants as a triumph in the context of the broader human service system (in Sydney and Vancouver) which approached women experiencing housing injustice with apparent indifference.

It is also important to emphasise that overwhelmingly, the women with lived experiences of housing injustice (including some staff) who participated in the interviews shared positive experiences of trauma informed women’s refuges and crisis accommodation services. Women said that the trauma informed services provided a space to reclaim a sense of dignity and self-worth. Women who had extended periods of accommodation and who received additional brokerage support reported the most positive experiences. Increased service supports enabled some women to reconnect with their children, to build meaningful and supportive relationships with other women at the services, to enrol in higher education, and for a few women, to develop an interest in becoming future refuge or crisis accommodation staff and or anti-violence against women activists. However, for many women, trauma informed care and the dedicated commitment of staff within services did little to ameliorate the lack of affordable housing and poverty caused by inadequate welfare support systems. Upon leaving trauma informed services many women faced ongoing housing injustice, mostly in the form of substandard public housing properties or inadequate, precarious and unaffordable private rental properties. Upon leaving trauma informed services, many women also continued to face ongoing risk of gendered violence, domestic and family violence.

Using an intersectional and materialist feminist analysis, it was argued that the limitations of trauma informed care, across the three participating services, were largely created and maintained by interlocking systemic and ideological forms of settler colonial and neoliberal

violence. Therefore, this analysis attempted to resist attributing the limitations of models of trauma informed care to staff members. To some extent, staff need to be accountable to the women that they work with. Staff were responsible for the translation of trauma informed care into practice, and staff were also in positions of power over the women accessing the service. However, to blame staff for ongoing reproduction of women's housing injustice only reinforces the neoliberal discourse of responsabilisation.

The intersectional and materialist feminist analysis also elucidated significant gaps and contradictions concerning the translation of trauma informed care into practice between and within participating services and how these differences were shaped by settler colonial and neoliberal processes, policies and ideologies about who is deserving and who is underserving of care, safety and housing. Interviews with staff participants across various crisis accommodation services and women's refuges, revealed multiple and competing discourses of trauma and trauma informed care between services. As discussed in the previous findings chapters, the interpretation and application of trauma theories and of trauma informed care significantly mediated decision making about increasing, maintaining or withdrawing service supports from women.

As discussed in chapter 5, the differences in conceptualising and enacting trauma informed care were imagined using a continuum ranging from, what was termed, behavioural management trauma informed care to politicised trauma informed care. The continuum aimed to avoid constructing models of trauma informed care in binary opposition. However, it was argued that the differences between trauma informed care models should not be understood as neutral or A-political. Rather, these key differences were seen to represent significant political and ethical sites of social struggle. These struggles were reflected in the literature and were mirrored at the level of social policy and government funding.

Politicised service models such as Amelia's Place in Sydney and to some extent, Coast Salish Place in Vancouver, struggled to maintain legitimacy in a neoliberal climate which presented unrelenting challenges to First Nations, community-led and collectivised, feminist oriented women's refuge services. As a resource intensive model, trauma informed care in all three participating service sites faced obstacles from the neoliberal, risk-averse governments in Australia and Canada. However, politicised models of responding to women victims/survivors experiencing housing injustice were actively undermined by severe funding cuts and competitive tendering processes which were introduced by neoliberal governments. During the research period, funding cuts led to widespread closures of women's refuges in NSW, Australia. The closures of women's refuges were viewed as an ideological attack on politicised, feminist and First Nations-led services as funding was redirected to gender-neutral and less politicised homelessness services and crisis accommodation NGO's. In this context, politicised trauma informed models struggled to assert a praxis of responding to gendered violence and systemic racism. Compounding these funding cuts, the dominance of psychiatric, psychological and psychotherapeutic (psy) trauma and trauma informed care discourses also threatened to undermine politicised trauma informed care models. The dominance of the psy trauma discourse also created numerous challenges and contradictions within the behaviour management model of trauma informed care.

The behavioural management model of trauma informed care implemented at Sydney based Hamilton House, also encountered numerous pressures from the neoliberal political economy. Neoliberalism produced two main constraints on this model. The first constraint was the pervasive threat of funding withdrawal. While Hamilton House was among the well-resourced crisis accommodation NGO's that retained government funding at the time of data collection, Hamilton House experienced difficulties in retaining funding specific to operating trauma informed care. This organisation shouldered substantial financial risks by increasing training

and supervision to staff and by increasing resources to women and especially to those who were perceived by staff as having ‘challenging’ or ‘distressing’ behaviours. The second constraint experienced by this organisation was the implementation of the psy trauma informed care discourse which was introduced to staff via training and supervision.

Most staff participants at Hamilton House felt very strongly that it was important for all human services to understand that most women experiencing housing injustice are likely to be victims/survivors of a past traumatic event (childhood trauma) and that these early experiences of trauma are often expressed in a range of challenging and distressing behaviours. As Hamilton House had no prior organisational history of responding to trauma or gendered violence, these understandings were revelatory to most staff participants. Staff worked hard to integrate the trauma informed understandings and to bring an end to the punitive and conditional practices which were understood to be retraumatising. Despite the obvious passion of staff to improve the practices and organisational culture at Hamilton House, it was argued that the trauma informed care training and supervision did not adequately equip staff to work in emancipatory ways with women experiencing housing justice and intersecting oppressions. Furthermore, the model of trauma informed care implemented at Hamilton House contradicted some of the espoused trauma informed care principles,

The high demand for crisis accommodation or ‘bed-pressure’ also constrained the potential for trauma informed care at Hamilton House as staff were required to exit women quickly out of the service to cope. Many women who would have benefitted from a prolonged residential stay who, due to limitations in resourcing and capacity, were not granted this. The constrained model of trauma informed care used at Hamilton House was described as a behaviour management approach. Staff used trauma informed care as way of reducing women’s aggressive and distressing behaviours, which tended to decrease as the service increased supports and when staff responded to women’s distress empathically. Staff also used trauma

informed care to increase women's compliance to service rules and conditions. The use of trauma informed care as a behaviour management approach arguably subverts the original intention of the practice framework; to better meet the needs of victims/survivors as opposed to better meeting the needs of services (Bloom & Farragher, 2011; Hales et al, 2018). It has been suggested that the trauma informed care framework eases some pressures on services including an "increased rate of planned client discharges...enhanced client engagement and retention in treatment" (Hales et al, 2018 p.8). While these service outcomes are significant and supports the utility of trauma informed care, from a materialist feminist perspective, the emphasis on service efficiency and human behaviour management reflects the ideology and the demands of the neoliberal political economy (Brown, 2016). The danger in this emphasis is that women's rights, women's voices and women's needs are rendered unintelligible or irrelevant as they are subsumed within the corporate calculus of human service delivery.

Drawing from the psy trauma training and supervision, Hamilton House staff participants understood 'trauma' as an event located an individual's past, usually originating in childhood. The construction of trauma as a psychological wound or reaction to a past event obscured the current and ongoing risks of gendered violence experienced by women seeking shelter. As trauma was believed to be an issue of the past and rather than a possible concern of the present, the responses to 'traumatised' women accessing the service were predominately therapeutic. The therapeutic approach taken by Hamilton House staff was intended to increase women's sense of emotional safety while accessing the service. Amelia's Place, a woman's refuge, also prioritised women's emotional safety, however this service also developed preventative, physical safety plans with women victims/survivors of *past* and *current* gendered violence, domestic and family violence. These safety plans ensured that multi-agency support would be available if women became concerned for their physical safety beyond the walls of the service. Conversely staff participants from Hamilton House argued that trauma informed care was

neither a gendered violence response or violence prevention framework. The organisational and discursive distinction between ‘trauma’ and ‘violence’ was a surprising finding given many of the women who participated in this study, explained that they came to Hamilton House in the immediate aftermath of leaving a violent partner or family member. It has also been well established in the literature that women who cannot access women’s refuges will often attempt to access generalist homelessness crisis accommodation services (Williams, 2016).

The behavioural management model of trauma informed care at Hamilton House also did not incorporate the trauma informed principle of cultural safety. As was argued in Chapter 6, the psy trauma discourse limited staff participants understanding of ‘trauma’ to an *individual* and *psychological* phenomenon rather than a *collective* experience of trauma. Staff were trained to understand trauma as a *past* event in an *individual’s* life, however staff were not trained to understand *intergenerational trauma* experienced by First Nations peoples nor were staff provided any analysis of settler-colonisation, systemic racism and the reproduction of racialized and gendered housing injustice. While staff participants from Hamilton House tried to apply the (psy) trauma training while working with First Nations women, these understandings did not sufficiently interrupt preconceived disciplinary, punitive and neoliberal welfare discourses. In one key example discussed in Chapter 6, a non-First Nations staff participant described holding a fear of creating ‘welfare dependency’ for First Nations people. This staff participant felt that in this instance, the premature withdrawal of accommodation and service supports from a First Nations woman would prevent the First Nations woman from developing a ‘dependency’ on human services. Conversely, politicised trauma informed services, Coast Salish Place and Amelia’s Place were critical of the psy trauma discourse and behavioural management models of trauma informed care. Both services had embedded trauma informed cultural safety within the whole organisational framework. Politicised services also augmented the trauma informed care and cultural safety principles with feminist,

anti-colonial, anti-racist, LGBTIQ pride and harm reduction concepts and praxis. These politicised services also recruited and employed First Nations women, refugee and new migrant women, LGTBIQ women, and women with lived experiences of housing injustice into positions across all levels of the service from management to staff. Amelia's Place and Coast Salish Place also actively resisted psy trauma theories and settler colonial discourses through continuous staff training detailing the history of settler-colonialism from invasion to the present exploring intersections between systemic racism, systemic sexism, gendered violence and housing injustice and training on the intergenerational impacts of trauma and injustice. The First Nations leadership in Amelia's Place and Coast Salish place also resisted the dominant psy trauma discourse through the implementation of First Nations-led healing, such as women's yarning circles and ceremonies, that while therapeutic were also grounded in social and political justice. Both politicised trauma informed services, also utilised minimal service restrictions (low barrier entry) to ensure that disenfranchised women were not excluded.

In summary, the multiple theories of trauma and the broad interpretation of trauma informed care are not neutral phenomena, these are active and critically important sites of social struggle and of resistance. Behaviour management trauma informed care bypasses the social and political context of 'trauma' and constructs 'trauma' as an A-historical, A-political psychological problem. This model was less effective in countering hegemonic settler-colonial and neoliberal welfare discourses than politicised models of trauma informed care and therefore less able to support severely disenfranchised victims/survivors.

Settler colonial and neoliberal welfare discourses and policies establish two possible causes of 'homelessness' both of which are designed to negate or reduce the responsibility of governments: a) Deserving poor; that homelessness is caused by unfortunate individual life circumstances (Abramovitz, 2018; Willse, 2015; Smith, 2005) or b) Underserving poor; that homelessness is caused by an individual's own 'immoral' life choices (Abramovitz, 2018;

Willse 2015; Smith, 2005). By representing ‘homeless’ women as victims of childhood or a past traumatic experiences, the psy trauma discourse possibly broadens the category of ‘deserving poor’ to include a few more ‘homeless’ women who have distressing and challenging behaviours. However, through a psy trauma lens, not all women were constructed equally as ‘deserving’ care and additional service supports.

By omitting an analysis and therefore praxis of trauma in the context of gendered violence, and racism (and violence against women) in the context of settler-colonisation, the behaviour management model of trauma informed care was arguably complicit in the maintenance of the category of the ‘undeserving poor’, leaving extremely disenfranchised women, without safety. However, this must also be balanced with a critique of the broader human service system (including state Housing and financial Welfare assistance), which left women leaving trauma informed refuges with limited hope of accessing long-term, affordable and secure housing.

In a service landscape where service collaboration and advocacy are contingent on effective and shared communication, the neoliberal psy trauma discourse and the behavioural management model of trauma informed care, both confused and undermined the aims of anti-violence against women work and marginalised cultural safety. This finding also reflects First Nations theorists (Clark, 2016b) who have argued that psy trauma informed care is an assimilating discourse. Under the guise of responding to trauma, settler colonial neoliberal states extend and justify the surveillance and management of impoverished First Nation’s communities living without housing justice through human services (Clark, 2016b). This is precisely why politicised trauma discourses in human services threaten to unsettle the social-political and economic order that perpetuates gendered and racialized violence and housing injustice from the settler colonial past to the settler colonial and neoliberal present. Likewise, politicised trauma informed care models encourage victims/survivors to mobilise collectively

and to resist the application of medicalising, pathologising and responsabilising narratives to their life stories.

Building on the work of Roy (2014), the psy trauma discourse and behavioural management trauma informed care represents a covert conceptual and practice based co-option of politicised models of trauma informed care and earlier First Nations-led and feminist women's refuges. Psy trauma discourses and the behavioural management model of trauma informed care are more compatible with neoliberal pathologising, medicalising, responsabilising, victim-blaming and individualising discourses than politicised models. These findings echo critical social work theorists (Tseris, 2014; Stringer, 2014; Bumiller, 2008), who have argued the psychiatric and psychological trauma discourses not only reinforce the neoliberal discourse of responsabilisation and the medicalisation of victim/survivors of gendered violence, but that these discourses have rapidly transformed anti-violence against women work into a trauma recovery industry.

As Roy (2014), Brown (2015), and Willse (2015) have argued neoliberalism has introduced a corporate, economic calculus into human services. Neoliberal governments have significantly eroded the welfare state and has recalibrated responses to social problems through the creation of "more markets, more financialisation, new technologies and new ways to monetise" (Brown, 2015 p.221). The restricted provision of government funding is primarily directed towards human services able to demonstrate efficiency and cost effectiveness or "value for money human rights" (Ishkanian, 2014 p.10). Increasingly, crisis accommodation NGO's struggle to provide basic and ameliorative aid to the growing populations of women and their children who are living without shelter. Yet, human services are expected to rehabilitate victims/survivors who are experiencing housing injustice to ensure their return to the labour market.

In this context, human services are less able to name and therefore less able to resist systemic violence due to their reliance on government and or corporate funding. Furthermore, Roy (2014), argues the intrusion of neoliberal corporatism into NGO's almost completely subverts the potential for NGOs to facilitate housing justice for all women. For instance, following an ethnographic study of Vancouver's medically supervised injecting site (Insite), Elliot (2014) concluded that the ideology of neoliberalism undermined the original intentions of Insite and transformed this progressive health care service into a technology to "survey, manage, and regulate the urban poor, while reducing state expenditures, relying increasingly on non-state actors to govern" (p.30). The findings reported in this thesis supports these claims. The psy trauma discourse and behaviour management model of trauma informed care represents a significant departure from the intended social justice and social change agendas of politicised models of trauma informed care. When social justice aims are covertly replaced with neoliberal governance and governmentality, human services are recast as industries. As industries, human services do not seek to interrupt the 'logic' of the structures that cause and perpetuate housing injustice, racism and gendered violence experienced by the very people they claim to service. In this context, human services are not only coerced into a position of complicity with structural violence, but are recalibrated as instruments to manage poor and disenfranchised populations. Similarly, the intention to provide 'care' is transformed by neoliberal states into an apparatus for greater disciplinary control (Rendo, 2013). Finally, the corporatisation of the human service sector is perversely reliant on the supply of homeless and traumatised women for business. The title of this thesis, *In the Business of Trauma*, refers to the perversity of human service industry built around therapeutic behaviour management as opposed the work of ending gendered violence, systemic racism and housing injustice. Since the 1970s, alongside the infiltration of neoliberalism into human services, politicised crisis accommodation services and women's refuge have aimed to "do themselves out of a job" (Murray, 2002 p.179). However,

as this thesis has discussed, the capacity for politicised services to resist settler-colonial neoliberalism is increasingly constrained as resources are tightened and politicised concepts are co-opted and distorted. This assessment may be interpreted as harsh, or polemical, however, I am reminded of the words of Judith Herman (1992) who utilised an interesting hybrid of psychiatric and political perspectives to assert:

All the perpetrator asks is that the bystander do nothing...the victim demands action, engagement and remembering (Herman, 1992. pp.7-8).

This lucid reflection, may be applied to the relationship between settler colonial neoliberal governments and human services. If we as social workers and human service workers are so often the bystanders of systemic violence (gendered and racialized violence), are we, not required to act, engage and remember? While resistance to the violence of the settler-colonial neoliberal state is constrained, resistance is still possible. Human services, including crisis accommodation and women's refuge services can be important sites of resistance, however this is contingent on understanding and strategising against the reproduction of structural violence within services, within sectors and within the broader socio-political environment.

Limitations:

This study was not undertaken as an evaluation of effectiveness, which would have called for a different methodology. However, this project offered an exploratory analysis of trauma informed care in crisis accommodation and women's refuge services in Sydney and Vancouver. Due to time and resourcing limitations only three purposely selected services were included in this research project. As such the findings are neither representative nor generalisable of trauma informed services in women's refuges and crisis accommodation services.

This study involved staff, key informants and women who largely had positive experiences of the trauma informed services or were passionate about trauma informed care and were,

therefore, willing to share their time and knowledge. However, the approach to recruit interview participants may have also excluded women, staff members and key informants who did not have positive experiences of the participating services or of trauma informed care in other service contexts.

At the time of conducting in-depth interviews, I did not ask participants to name intersectional identities beyond their gender identity, and status as First Nations or non-First Nations, or refugee or new migrant identities. Therefore, this research project did not explicitly focus on the sexual orientation of staff or women participants. I was concerned at the time of interviewing participants that asking questions about sexual orientation may not be perceived as relevant to the research topic. In retrospect, these data would have strengthened the intersectional and materialist feminist analysis and would have responded to a critical gap in women's refuge and crisis accommodation service use research concerning the intersection of sexuality, specifically LGTBIQ identifying people, and their experiences of trauma informed services. The translation of trauma informed/cultural safety principles may increase safety for LGTBIQ people attempting to access women's refuges and crisis accommodation services.

[Recommendations for Training and Education and Practice:](#)

This thesis presented arguments against the uncritical importation of psychiatric psychological 'psy' trauma discourses in trauma informed care training and supervision. This is not to say that insights from the 'psy' disciplines should never be used in training or in practice. Rather, human service and social workers should receive trauma informed training that is balanced with an analysis of the social, political and economic context of gendered and racialized violence and housing injustice. In settler-colonial societies such as Australia and Canada, it is necessary for any trauma informed care training provide a history of settler colonisation

alongside a history of First Nations peoples resistance struggles. Likewise, it is important to balance theories of intergenerational trauma with theories of intergenerational injustice.

The history of invasion and colonisation (from the past to the present) should not be relegated to ‘cultural awareness’, ‘cultural competency’ or even ‘cultural safety/cultural capability’ training. Rather, all social work/human service training arguably would benefit from focusing on the intersections between past settler-colonial atrocities and the ongoing reproduction of systemic and institutionalised settler-colonial racism, sexism, heteronormativity, cis-sexism, classism, poverty and housing injustice. These understandings would likely improve the cultural safety of services for all people accessing human services including non-First Nations peoples who are victims/survivors of intersecting systemic and institutionalised forms of violence and housing injustice.

It is also recommended that trauma informed training and education bridge the gap between ‘trauma’ and ‘violence’ by emphasising the ongoing risk of gendered violence experienced by women who are ‘homeless’. Specifically, crisis accommodation staff could receive training focused on responding to and planning the prevention of assaults including the high risk of lethality experienced by women in the immediate aftermath of leaving a violent partner or family member(s).

The psy trauma discourse tends to construct trauma as a distant event in the *past* that continues to be re-experienced in the mind and body of victim/survivors. However, social workers and human service staff should not assume that because a woman was ‘traumatised’ in the past or as a child that she is now in a position of safety. It is possible to hold both understandings that: 1) a woman experiencing housing injustice is likely to be a victim/survivor of past gendered violence possibly including child sexual assault and domestic and family violence and 2) that a woman experiencing housing injustice is also likely to be a victim/survivor of current assaults

and may be at risk of ongoing and escalating violence (Laing, Irwin, & Toivonen, 2012) perpetrated by current or former partner, carer and or family member(s). Staff are more likely to use a gendered violence response and prevention framework when they have received adequate training and supervision.

The primary recommendation for practice follows the model of peer leadership and encourages trauma informed services to be staffed and managed by people who have similar lived experiences as those who attend the service. For instance, First Nations women, refugee and new migrant women, women with lived experiences of housing injustice and gendered violence, LGTBIQ identifying people, could be supported to take leadership roles within services and broader housing justice movements. Peer led service provision holds the greatest potential for services to be culturally safe and trauma informed. Shared lived experiences between managers, staff and women accessing the service can meaningfully unsettle classed, gendered, racialized power dynamics that frequently create unrecognised barriers for disenfranchised women accessing service supports. It can also offer women who are accessing peer-led services a potential pathway as a future staff member, advocate or leader in the field.

[Recommendations for Future Research:](#)

This research project touched on the implications of neoliberal policy making on trauma informed services. However, as focus of this research was the implementation of the trauma informed practice model, attention to the policy landscape was limited. However, there is potentially endless scope for materialist and intersectional feminist research which incorporates an analysis of settler colonial neoliberal policy making and its influences on social work/human service practice.

First Nations-led social work scholarship and research methodologies are emerging fields (Clark 2016a; 2016b; Johnson, 2014; Herring, Spangaro, Lauw & McNamara, 2013; Tuhiwai

Smith, 1999). This study has touched on the implementation of trauma informed cultural safety, however, further research is needed to explore concepts such as First Nations-led anti-colonial and decolonising practices in human services. Future research may focus on social work and human service resistance and complicity in the neoliberal political economy.

Conclusion:

This thesis builds on a significant body of activist and social work literature, which has drawn attention forms of structural violence that facilitates the reproduction of gendered, classed and racialized oppression and that manifests in dispossession, housing injustice and homelessness. As others have suggested, the work of theorising and exploring how it is that people come to be ‘traumatised’ and ‘homeless’ invites the consideration of the manifold structural and systemic roots of violence and injustice (Smith, 2011). It is also an invitation to consider ways in which human services (such as the women’s refuges and crisis accommodation services in this study) can become complicit in misusing power, reproducing oppression and (re)traumatising victims and survivors despite the best intentions and ‘care’ of front-line staff. Simultaneously, this analysis also shines a light on the possible sites of resistance to settler-colonialism and neoliberalism enacted by social workers/human service workers. Bourdieu (1998), claims that social actors in the tradition of civil and public servants and employees of state institutions, although undermined and co-opted by neoliberal processes, have the potential to subvert the systemic violence and hegemonic power of neoliberalism by defending the principles of the welfare state. Furthermore, Webb (2006), extends this by arguing that significant potential exists for social workers to resist neoliberalism in the United Kingdom:

...Public sector institutions like social work can take a deliberate stance against the dominant forms of political rule in advanced capitalist societies. We need to take steps to reawaken core ethical practices and activate the moral sources of social work, thereby

harnessing the logic of resistance to neoliberal rule both within and outwith the profession (Webb, 2006, p. 233).

The first step in 'reawakening' social work ethics and practices must begin with a broad campaign to educate social and human service workers to make visible the processes of neoliberalism and settler colonialism. As many activists and theorists, cited in Chapter 3, have noted 'co-optation', 'invisibility' and 'normalisation' are the central apparatus which maintains the power and 'legitimacy' of settler colonial, neoliberal states. Without a deep appreciation of settler colonialism and neoliberalism, these forms of power and influence on human services and on the lives of people accessing human services are often not recognised at all (Ready, 2012). Thus, the systemic abuses of power often go unquestioned and uncontested as people adjust to the ever-decreasing potential for social justice, meaningful social change and solidarity work. A critique of settler colonialism and neoliberalism may facilitate a range of understandings that may transform not only social work practice but all aspects of human life, including but not limited to:

- 1) A broad understanding of how social justice concepts and frameworks are co-opted and undermined through neoliberal policy making and corporatised services models;
- 2) A critical stance against the depoliticisation and 'depth' of social work practice in favour of risk-averse, data driven 'shallow' or 'superficial' human management technologies;
- 3) Ways of understanding and resisting neoliberal policies and funding models which concretise service siloing despite agitation for greater service collaboration;
- 4) A deep appreciation of the ways in which the settler colonial state codifies racialized, gendered and classed hierarchies. Understanding the relationship between settler colonial private property relations, capitalist labour exploitation of working class poor and 'black'

people (specifically First Nations peoples, refugee and new migrant peoples) and the creation and maintenance of housing injustice and gendered violence.

If ‘we’, victims/survivors of gendered violence and housing injustice, social workers, human service staff, activists, social policy makers, intersectional and materialist feminists are genuinely concerned with ending gendered violence and housing injustice this involves ending the structures of violence; settler colonialism and neoliberalism (Smith, 2005). This demands minimally, questioning the human service system, which, in the context of neoliberal political economies, promotes the industrialisation of social problems, including ‘trauma’. Without the courage to imagine the fundamental reorganisation of our societies centred on emancipation from settler-colonial and neoliberal regimes, “the conditions for housing insecurity (and gendered violence) will remain intact even as the technologies of homelessness management are recalibrated and modernised” (Willse, 2015, p. 136).

The creative work of envisioning other social, political and economic realities is a potentially daunting and exhausting task especially as settler colonisation and neoliberalism have “infiltrated normality, colonised ordinariness, such that challenging it seems almost as absurd as challenging reality itself” (Roy, 2014, p.32). However, rather than imaging an entirely new socio-economic system, it is necessary to begin again with a serious reflection on First Nations peoples’ governance systems. Many First Nations peoples describe living in settler-colonial societies as an experience of living in ‘two-worlds’ (Terare, 2018). One world encapsulates First Nations epistemologies, egalitarian social relations, First Nations histories, ceremonies, languages and cultures, and the other world is the settler-colonial paradigm that demands entrepreneurial assimilation into the labour market relations, capitalist consumerism, the ownership of land, the settler-colonial system of housing, hierarchical social relations, white Western culture and English language. First Nations peoples from Darug land to Musqueam land understand that housing injustice and gendered violence are not inevitable, rather, that

these are the consequences of a relentlessly violent settler colonial capitalist system. From this perspective, no model of trauma informed cultural safety could ever adequately challenge the system of housing injustice in settler colonial states. Decolonisation and the complete restoration of sovereign power to Darug and Bijjigal First Nations peoples and Musqueam, Squamish and Tsleil-Waututh First Nations peoples, would likely constitute the end of the racialized, gendered system of housing injustice as we know it.

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APPENDICES:

Appendix A:



Research Integrity
Human Research Ethics Committee

Thursday, 7 November 2013

Dr Lesley Laing
Social Work & Policy Studies; Faculty of Education & Social Work
Email: lesley.laing@sydney.edu.au

Dear Dr Lesley Laing

I am pleased to inform you that the University of Sydney Human Research Ethics Committee (HREC) has approved your project entitled "Exploring Trauma Informed Practice and Cultural Safety in services working with women who are experiencing homelessness".

Details of the approval are as follows:

Project No.: 2013/753
Approval Date: 5 November 2013
First Annual Report Due: 5 November 2014
Authorised Personnel: Laing Lesley; Funston Leticia;

Documents Approved:

Date Uploaded	Type	Document Name
30/09/2013	Participant Consent Form	staff consent form
30/09/2013	Participant Info Statement	staff participant information sheet
16/07/2013	Interview Questions	interview guide for in depth client interviews
16/07/2013	Interview Questions	interview guide for in depth interviews with staff

HREC approval is valid for four (4) years from the approval date stated in this letter and is granted pending the following conditions being met:

Condition/s of Approval

- Continuing compliance with the National Statement on Ethical Conduct in Research Involving Humans.
- Provision of an annual report on this research to the Human Research Ethics Committee from the approval date and at the completion of the study. Failure to submit reports will result in withdrawal of ethics approval for the project.
- All serious and unexpected adverse events should be reported to the HREC within 72 hours.

Research Integrity
Research Portfolio
Level 2, Margaret Telfer
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ABN 15 211 515 464
CRICOS 00026A

- All unforeseen events that might affect continued ethical acceptability of the project should be reported to the HREC as soon as possible.
- Any changes to the project including changes to research personnel must be approved by the HREC before the research project can proceed.

Chief Investigator / Supervisor's responsibilities:

1. You must retain copies of all signed Consent Forms (if applicable) and provide these to the HREC on request.
2. It is your responsibility to provide a copy of this letter to any internal/external granting agencies if requested.

Please do not hesitate to contact Research Integrity (Human Ethics) should you require further information or clarification.

Yours sincerely



E

Professor Glen Davis
Chair
Human Research Ethics Committee

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2007), NHMRC and Universities Australia Australian Code for the Responsible Conduct of Research (2007) and the CPMP/ICH Note for Guidance on Good Clinical Practice.

Appendix B:



The University of British Columbia
 Office of Research Services
**Behavioural Research Ethics
 Board**
 Suite 102, 6190 Agronomy Road,
 Vancouver, B.C. V6T 1Z3

CERTIFICATE OF APPROVAL - FULL BOARD

PRINCIPAL INVESTIGATOR: Natalie Clark	INSTITUTION / DEPARTMENT: UBC/Arts/Social Work	UBC BREB NUMBER: H13-02705
INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:		
Institution		Site
Other locations where the research will be conducted: I intend to conduct research in two agencies located in Vancouver that work with women, transgender women, two-spirit and intersex people.		
CO-INVESTIGATOR(S): N/A		
SPONSORING AGENCIES: University of Sydney - "Exploring Trauma Informed Practice and Cultural Safety in services working with women experiencing homelessness"		
PROJECT TITLE: Exploring Trauma Informed Practice and Cultural Safety in services working with women experiencing homelessness		
REB MEETING DATE: December 12, 2013	CERTIFICATE EXPIRY DATE: December 12, 2014	
DOCUMENTS INCLUDED IN THIS APPROVAL:		DATE APPROVED:

February 28, 2014

Document Name	Version	Date
<u>Protocol:</u>		
funding grant letter from University of Sydney	N/A	November 1, 2012
Sydney University Ethics Approval Letter	N/A	November 1, 2013
Trauma Informed and Cultural Safety Research Proposal	N/A	September 1, 2013
<u>Consent Forms:</u>		
Staff Consent form	4	February 1, 2014
Women's consent form	3	February 1, 2014
<u>Questionnaire, Questionnaire Cover Letter, Tests:</u>		
Interview guide clients	N/A	July 1, 2013
interview guide staff	N/A	July 1, 2013
<u>Letter of Initial Contact:</u>		
agency recruitment letter	N/A	September 1, 2013
<u>Other Documents:</u>		
cover letter	N/A	November 1, 2013
Agency Consent Letter	1	February 1, 2014

The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

*This study has been approved either by the full Behavioural REB
or by an authorized delegated reviewer*

Appendix C:

THE UNIVERSITY OF BRITISH COLUMBIA



School of Social Work
2080 West Mall
Vancouver, B.C. Canada V6T 1Z2
Tel: (604) 822-0782 Fax: (604) 822-8656

Office of the Director

May 14, 2013

Ms. Leticia Funston
Faculty of Education and Social Work
Education Building, A35
The University of Sydney NSW 2006
Australia

Dear Ms. Funston:

The enclosed letter provides the necessary details regarding your appointment at UBC to facilitate the issuance of the necessary permit/visa from Citizenship and Immigration Canada (CIC) as a Visiting Scholar.

You are required to apply for a work permit and/or visitor visa from CIC. Please include our letter to CIC in your application. Detailed information on the immigration process and links to application forms are available at: www.hr.ubc.ca/faculty_relations/immigration/visitors.html. Please ensure you read this information thoroughly.

Please note that there will be a processing fee for your permit/visa application. A fee schedule is found on the CIC website at: www.cic.gc.ca/english/information/fees/index.asp. Fees are payable upon application. If you are accompanied by dependents and/or are from a country requiring a temporary resident visa, additional fees will apply.

Before you arrive at UBC, it is imperative that you take time to familiarize yourself with your obligations while in Canada, as well as UBC, and the benefits and amenities of the campus and surrounding area. Please ensure you review this information which is found on the Faculty Relations website at: www.hr.ubc.ca/faculty_relations/immigration/toknow.html.

I would like to take this opportunity to welcome you to UBC and to wish you every success in your new position. Dr. Natalie Clark, a faculty member of our School, has kindly agreed to mentor you during this period. Our School will provide you with a shared office space equipped with a computer, printer and internet access. Please do not hesitate to contact our office if more information is required.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Tim Stainton'.

Dr. Tim Stainton
Professor and Director

Cc: Nancy Kan, Natalie Clark, Faculty Relations



ABN 15 211 513 464

Leticia Funston / Dr. Lesley Laing
Chief Investigator / Supervisor Title

Room A35.742
Education Building
The University of Sydney
NSW 2006 AUSTRALIA
Telephone: +61 2401 188 509
Email: lfun3269@sydney.edu.au
Web: <http://www.sydney.edu.au/>

PARTICIPANT INFORMATION STATEMENT

Exploring Trauma Informed Practice and Cultural Safety in services working with women who are experiencing homelessness

(1) What is the study about?

You are invited to participate in a study of *your experience of the service you are currently staying at.*

(2) Who is carrying out the study?

The study is being conducted by Leticia Funston and will form the basis for the degree of Doctor of Philosophy degree at The University of Sydney under the supervision of Dr. Lesley Laing and Dr. Margot Rawsthorne

(3) What does the study involve?

This study involves an interview conversation with you about your experiences of the service you have been staying at.

- This interview involves audio taping
- The interviews will take place in a private room in the service you are staying at.

(4) How much time will the study take?

It is anticipated that this interview will take approximately 30 – 40 minutes of your time.

(5) Can I withdraw from the study?

Being in this study is completely voluntary - you are not under any obligation to consent and - if you do consent - you can withdraw at any time without affecting your relationship with the service you are current staying with.

You may stop the interview at any time if you do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.

(6) Will anyone else know the results?

Exploring Trauma Informed Practice and Cultural Safety in services working with women who are experiencing homelessness

Version 1 July 2013

All aspects of the study, including results, will be strictly confidential and only the researchers will have access to information on participants

A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

(7) Will the study benefit me?

We cannot and do not guarantee or promise that you will receive any benefits from the study. However we hope that your contribution to this study informs and improves the delivery of this service.

(8) Can I tell other people about the study?

Yes

(9) What if I require further information about the study or my involvement in it?

When you have read this information, *Leticia Funston* will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact *Leticia Funston*; lfun3250@uni.sydney.edu.au

(10) What if I have a complaint or any concerns?

Any person with concerns or complaints about the conduct of a research study can contact The Manager, Human Ethics Administration, University of Sydney on +61 2 8627 8178 (Telephone); +61 2 8627 8177 (Facsimile) or ro.humanethics@sydney.edu.au (Email).

This information sheet is for you to keep

Appendix E:



School of Social Work
Faculty of Education and
Social Work

ABN 15 211 513 464

Leticia Funston / Dr. Lesley Laing
Chief Investigator / Supervisor title

Room A35.548
Education Building
The University of Sydney
NSW 2006 AUSTRALIA
Telephone: +61 2401 188 509
Email: lfun3269@sydney.edu.au
Web: <http://www.sydney.edu.au/>

PARTICIPANT CONSENT FORM

I,[PRINT NAME], give consent to
my participation in the research project

TITLE: Exploring Trauma Informed Practice and Cultural Safety in services
working with women who are experiencing homelessness

In giving my consent I acknowledge that:

1. The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.
2. I have read the Participant Information Statement and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.
3. I understand that being in this study is completely voluntary – I am not under any obligation to consent.
4. I understand that my involvement is strictly confidential. I understand that any research data gathered from the results of the study may be published however no information about me will be used in any way that is identifiable.
5. I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher(s) or the services I am currently using now or in the future.

THE UNIVERSITY OF BRITISH COLUMBIA



School of Social Work
2080 West Mall
Vancouver, B.C. Canada V6T 1Z2
Tel: (604) 822-0782 Fax: (604) 822-8656

SUBJECT INFORMATION AND CONSENT FORM

Exploring Trauma Informed Practice and Cultural Safety in services working with women who are experiencing homelessness

Principal Investigator:

Natalie Clark
Natalie Clark, BSW, MSW
Instructor & Chair Field Education
School of Social Work
2080 West Mall,
The University of British Columbia
V6T 1T2
Phone: 604-822-2703
Email: natalie.clark@ubc.ca

Co-Investigator:

Leticia Funston
Leticia Funston, BA(Communications), BSW
PhD Candidate at the University of Sydney and
Visiting Scholar at the University of British Columbia
Social Work
Faculty of Education and Social Work
The University of Sydney, Australia
Email: Lfun3269@uni.sydney.edu.au

The information collected for this research project will be used in a dissertation thesis and a to partially fulfill requirements of a PhD graduate degree. A report of the study may be submitted for publication in journal articles and conferences, but individual subjects will not be identifiable in any way.

Sponsor: This research project is sponsored by the University of Sydney through an Australian Postgraduate Award scholarship and the Katharine Ogilvie Travelling Scholarship.

INTRODUCTION

You are being invited to take part in this research study if you identify as a woman, transgender woman, intersex or two-spirit person and you have stayed at the participating agency for 3 weeks or longer in the last 6 months.

YOUR PARTICIPATION IS VOLUNTARY

Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen to you during the study and the possible benefits, risks and discomforts.

If you wish to participate, you will be asked to sign this form. If you do decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision.

If you do not wish to participate, you do not have to provide any reason for your decision not to participate nor will you lose the benefit of any medical care or agency service to which you are entitled or are presently receiving.

Please take time to read the following information carefully and to discuss it with your family and friends.

WHO IS CONDUCTING THE STUDY?

The study is funded by the University of Sydney and via a federally funded Australian Post-Graduate Award and is being conducted by social work PhD Candidate Leticia Funston. As such there is no perceived conflict of interest with the agency for conducting or being involved with any part of the study.

WHAT IS THE PURPOSE OF THE STUDY?

This international research project explores four services in Sydney and Vancouver working with women, transgender women and intersex people experiencing homelessness and that utilise a trauma informed approach and cultural safety framework. The aim of this research is to improve the way the way services respond to the needs of women experiencing homelessness.

STUDY PROCEDURES

What does the study involve?

- This study involves an interview that will take approximately 30 – 40 minutes of your time. The researcher will seek your permission to audio tape the interview using a digital recording device. The audio recordings will be stored on a password protected computer and erased from the recording device.
- The interviews will take place in a private room in the service.

POTENTIAL RISKS

The risks to subjects during this research are likely to be minor. However, there is a potential risk for subjects to become distressed during the in-depth interviews. The researcher aims to minimise the potential for distress by asking questions about the experience of the agency and not the personal stories of the subjects. Any subject who becomes distressed during the

interview can be assured that the interview will end immediately and the subject will be offered counselling with a case-worker on site at the agency.

POTENTIAL BENEFITS

We cannot guarantee that you will receive any benefits from participating the study. However we hope that your contribution to this study informs and improves the service delivery of the agency.

The researcher will provide results of the study to subjects. A forum will be held at each of the agency sites and subjects will be invited to hear and to discuss the summary - this will be provided by Leticia Funston.

CONFIDENTIALITY

The privacy and confidentiality of all subjects will be prioritized. Only the researcher will have access to information provided by participants. The researcher will not identify you or disclose your views in any communication with the agency provider or another other agencies. Subjects names will be changed and no identifiable information will be used in the planned thesis, report or in any other publication.

All documents will be identified only by code number and kept in a locked filing cabinet. Subjects will not be identified by name in any reports of the completed study.' Electronic copies of interview transcripts will be kept on the researchers computer and will be password protected.

CONTACT FOR INFORMATION ABOUT THE STUDY

When you have read this information, *Leticia Funston* will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact *Leticia Funston*; lfun3269@uni.sydney.edu.au

CONTACT FOR CONCERNS ABOUT THE RIGHTS OF RESEARCH SUBJECTS

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail to RSIL@ors.ubc.ca.

CONSENT

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to any of the services you currently receive or any that you may receive in the future.

Your signature below indicates that you have received a signed and dated copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Subject Signature

Date

6. I understand that I can stop the interview at any time if I do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.

7. I consent to:

- Audio-recording YES NO

- Receiving Feedback YES NO

If you answered YES to the "Receiving Feedback" question, please provide your details i.e. mailing address, email address.

Feedback Option

Address: _____

Email: _____

.....
Signature

.....
Please PRINT name

.....
Date

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Vancouver, B.C. Canada V6T 1Z2
Tel: (604) 822-0782 Fax: (604) 822-8656

SUBJECT INFORMATION AND CONSENT FORM

**Exploring Trauma Informed Practice and Cultural Safety in services working
with women who are experiencing homelessness**

Principal Investigator:

Natalie Clark
Natalie Clark, BSW, MSW
Instructor & Chair Field Education
School of Social Work
2080 West Mall,
The University of British Columbia
V6T 1T2
Phone: 604-822-2703
Email: natalie.clark@ubc.ca

Co-Investigator:

Leticia Funston
Leticia Funston, BA(Communications), BSW
PhD Candidate at the University of Sydney and
Visiting Scholar at the University of British Columbia
Social Work
Faculty of Education and Social Work
The University of Sydney, Australia
Email: Lfun3269@uni.sydney.edu.au

The information collected for this research project will be used in a dissertation thesis and a to partially fulfill requirements of a PhD graduate degree. A report of the study may be submitted for publication in journal articles and conferences, but individual subjects will not be identifiable in any way.

Sponsor: This research project is sponsored by the University of Sydney through an Australian Postgraduate Award scholarship and the Katharine Ogilvie Travelling Scholarship.

INTRODUCTION

You are being invited to take part in this research study if you have worked directly with women, transgender women, two-spirit and intersex people experiencing homelessness in the participating agency for 3 weeks or longer.

YOUR PARTICIPATION IS VOLUNTARY

Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen to you during the study and the possible benefits, risks and discomforts.

If you wish to participate, you will be asked to sign this form. If you do decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision.

If you do not wish to participate, you do not have to provide any reason for your decision not to participate nor will you lose the benefit of any medical care or agency service to which you are entitled or are presently receiving.

Please take time to read the following information carefully and to discuss it with your family and friends.

WHO IS CONDUCTING THE STUDY?

The study is funded by the University of Sydney and via a federally funded Australian Post-Graduate Award and is being conducted by social work PhD Candidate Leticia Funston. As such there is no perceived conflict of interest with the study and the participating agencies.

WHAT IS THE PURPOSE OF THE STUDY?

This international research project explores four services located in Sydney and Vancouver working with women, transgender women and intersex people experiencing homelessness and that utilise a trauma informed approach and cultural safety framework. The aim of this research is to improve the way the way services respond to the needs of women experiencing homelessness.

STUDY PROCEDURES

What does the study involve?

- This study involves an interview that will take approximately 30 – 40 minutes of your time. The researcher will seek your permission to audio tape the interview using a digital recording device. The audio recordings will be stored on a password protected computer and erased from the recording device.
- The interviews will take place in a private room in the service.
- The researcher will also use process observation and will attend up to five team meetings. No identifying staff or client information will be recorded. The aim of the process observation is to develop an understanding of the workplace culture, decision making and communication processes. If you or any other staff members do not consent to the researcher observing all or part of a team meeting, the researcher will discontinue and leave the team meeting immediately. The observations will be recorded via hand written notes. The hard copies of the notes will be kept in a locked filing cabinet

POTENTIAL RISKS

The risks to subjects during this research are likely to be minor. However, there is a potential risk for subjects to become distressed during the in-depth interviews. The researcher aims to minimise the potential for distress by asking questions about the experience of the agency and not the personal stories of the subjects. Any subject who becomes distressed during the interview can be assured that the interview will end immediately and the subject will be offered counselling with the manager on site at the agency.

POTENTIAL BENEFITS

We cannot guarantee that you will receive any benefits from participating the study. However we hope that your contribution to this study informs and improves the service delivery of the agency.

The researcher will provide results of the study to subjects. A forum will be held at each of the agency sites and subjects will be invited to hear and to discuss the summary - this will be provided by Leticia Funston.

CONFIDENTIALITY

The privacy and confidentiality of all subjects will be prioritized. Only the researcher will have access to information provided by participants. The researcher will not identify you or disclose your views in any communication with the agency provider or another other agencies. Subjects names will be changed and no identifiable information will be used in the planned thesis, report or in any other publication.

All documents will be identified only by code number and kept in a locked filing cabinet. Subjects will not be identified by name in any reports of the completed study.' Electronic copies of interview transcripts will be kept on the researchers computer and will be password protected.

CONTACT FOR INFORMATION ABOUT THE STUDY

When you have read this information, *Leticia Funston* will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact *Leticia Funston*; lfun3269@uni.sydney.edu.au

CONTACT FOR CONCERNS ABOUT THE RIGHTS OF RESEARCH SUBJECTS

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail to RSIL@ors.ubc.ca.

CONSENT

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your current or future employment.

Your signature below indicates that you have received a signed and dated copy of this consent form for your own records.

I consent to:

- Participating in an in-depth interview: YES NO
- Audio-recording during the interview: YES NO
- Allowing the researcher to observe the team meeting: YES NO

- Allowing the researcher to be present during staff team meetings and to take written field notes YES NO
- Receiving Feedback of the study YES NO

If you answered YES to the “Receiving Feedback” question, please provide your details i.e. mailing address, email address.

Feedback Option

Address: _____

Email: _____

.....
 Subject Signature Your signature indicates that you consent to participate in this study

.....
 Please PRINT name

Appendix H:

INTERVIEW GUIDE – STAFF

1. Can you tell me a bit about the theories and philosophies that guide your work and that guide the organization?
2. Can you tell me about your understanding of Trauma Informed Practice? How does this service provide this?
3. Can you tell me about your understanding of Cultural Safety? How does this service provide this?
4. What, if any, education and training do the staff members receive?
5. If professional supervision is provided can you tell me how that is structured?
6. Does your organization involve clients of the service in decision making and planning?
7. Is your organization involved in primary prevention of violence?
8. What impact, if any, do you think the service has had on education and training around trauma, ongoing violence and risk and cultural safety?
9. Have you seen any positive or significant outcomes or changes for these women?
10. What aspects of the service working particularly well? Why is that?
11. What aspects seem to be working less well? Why is that?
12. What suggestions do you have as to how this should be addressed in the short-term? In the longer term?
13. Finally, are there any other comments you would like to make in relation to the service?

Appendix I:

INTERVIEW GUIDE – CLIENTS

1. What was the best thing about staying here?
2. What was the worst thing about staying here?
3. I don't need to know in a great amount of detail, just as much as you are comfortable discussing, can you tell me how and why you came to this service?
4. What was it like for you approaching the service for the first time? Did you have any particular hopes or fears about what would happen when you made contact?
5. How have you felt staying here?
6. What does safety mean to you?
7. Were there any times you felt unsafe while staying here?
8. Was there anything about staying here that helped you to feel safe?
9. Did you feel able or encouraged to practice your religious or cultural beliefs?
10. How could this service better reflect your cultural values and worldviews?
12. Were you encouraged to make decisions about your own care here?
13. Was there anything that you needed here but didn't receive?
14. How do you feel about leaving this service?
15. Finally are there any other comments you would like to make about your experiences of the service?
16. How has it been for you today doing this interview?