CAPTURING THE CLIENT PERSPECTIVE WITHIN AN ORGANIZATIONAL NEEDS ASSESSMENT:

A PROJECT TO ENHANCE 'TRAUMA INFORMED CARE' (TIC) IN A HOMELESS HEALTH CLINIC

by
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ABSTRACT

PURPOSE

This research occurred in partnership with a committee of staff and clients at a homeless health clinic. Their goal was to improve 'Trauma Informed Care' (TIC) within the agency.

Trauma is a psychological reaction that can occur after physical harm, sexual assault, and childhood neglect. Research documents the risk of long-term consequences on physical, mental, and behavioral wellbeing. Literature further demonstrates how clients are vulnerable to triggering and re-traumatization within the systems intended to help them (social; legal; medical).

As organizations recognize this issue, there is growing demand for strategies to (1) decrease this risk of accidental re-traumatization; and (2) assist clients towards meaningful, long-term trauma recovery. This bundle of strategies falls under the overarching category of 'Trauma Informed Care.'

METHODS

A first step in enhancing TIC involves an agency-wide assessment. The purpose is to identify: ways in which the clinic is already sensitive and prepared to address trauma; areas and barriers that require attention; and recommendations for improvement.

My role concentrated on gathering the client perspective. In 2013 – 2014, I facilitated in-depth interviews with 30 participants. Their voice became especially valuable to the project.

RESULTS

Three primary themes emerged:

1. The lobby is a critical (though often forgotten) space for agencies to consider. It sets the tone for how safe clients feel. Trauma-informed agencies make effort to ensure adequate comfort in the environment, effective communication (particularly with new clients), and substantial support for front-line staff.

2. A wraparound structure, which integrates healthcare disciplines into a holistic team, is most prepared and efficient in addressing the complex consequences of trauma.

3. Client 'empowerment' is central to long-term trauma recovery. Trauma-informed agencies build opportunities for clients to enhance their sense of control. Strategies include patient-centered care; peer groups; client input to the agency; and client involvement in advocacy / community mobilization.

CONCLUSIONS

Overall, this research demonstrates why TIC is agency-wide, rather than restricted to clinicians. A client's relationship with an organization extends well beyond the provider's office. As such, the effort to be trauma-informed impacts everything from the clinic's structure to the level of support for the front-line worker.

ACKNOWLEDGEMENTS

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LITERATURE REVIEW: WHAT IS TRAUMA-INFORMED CARE (TIC)?

TRAUMA

Trauma is a stress reaction, which can occur in response to an event or series of events that involve the threat of death, physical harm, and / or sexual assault. The literature identifies two kinds of traumatic exposure – acute and complex.[1-3] Acute incidents are short-lived, one-time encounters with violence. These include vehicular accidents, isolated physical or sexual assault, natural disaster, and public shootings.[4]

Complex trauma, on the other hand, involves events that occur repeatedly over a long period of time. This includes child abuse, intimate partner violence, slavery, and war.[4] The perpetual exposure to violence, which defines complex trauma, generally brings the most severe and long-term impact to mental, behavioral, and physical health.[5, 6] Consequences can even span across generations, in the form of historical and structural trauma (relating to systematic oppression and poverty).[7, 8]

ADVERSE CHILDHOOD EXPERIENCES (ACE) STUDY

The Adverse Childhood Experiences (ACE) study was one of the first research projects to illustrate a connection between traumatic events and long-term risks to health and well-being. Kaiser Permanente partnered with the Center for Disease Control (CDC) to survey 17,000 of its members. Participants responded to 10 'yes or no' questions about their childhood exposure to abuse, neglect, separation, and family members with histories of substance abuse and / or incarceration. Individuals who indicated 'yes' to 4 or more questions reported significantly higher

health risks in adulthood. When compared to people without childhood adversity, these respondents were:

- 2x more likely to smoke
- 2x more likely to have a cancer diagnosis
- 2x more likely to have heart disease
- 4x more likely to have emphysema or chronic bronchitis
- 6x more likely to report sex before age 15
- 7x more likely to have alcoholism
- 10x more likely to have injected street drugs
- 12x more likely to have attempted suicide [9]

One challenge to this study was its observational design. Ethical and moral issues generally prevent researchers from conducting trauma-related projects with experimental (gold standard) designs. As such, the literature primarily restricts itself to observational and historical survey data. While this cannot generate the same level of authority as randomized prospective cohort studies, the observational results provide the most compelling data available within the realm of (ethical) possibility.

CYCLE OF TRAUMA

Beyond the ACE study, a number of research projects illustrate how traumatic events might not only contribute to health problems, but can also increase the risk of future trauma. Current evidence suggests that a cyclical pattern of victimization can develop after prolonged, perpetual, and / or severe violence. This

cycle evolves primarily from two psychological reactions that can stem from a traumatic event: [10, 11]

1. **Decreased Sense of Safety**

After encountering violence, many people struggle to distinguish between harmful and harmless circumstances. They can enter a state of hyper-vigilance, in which they are perpetually on alert. In these situations, they might perceive danger regardless of the objective reality. Once triggered, they can struggle to control or calm their reactions. [4, 5, 10-15]

Over the long-term, this state of continuous stress and hyper-vigilance can interfere with higher-level cognitive processes and development. Some people experience lasting challenges with attention, learning, skill development, reasoning, problem solving, abstract thinking, and anticipating the future. [4, 5, 10-15]

2. **Decreased Sense of Personal Control / Agency / Self-Esteem**

Traumatic experiences can also threaten a person's self-worth. Many people develop a perception that they have been 'damaged.' They might feel guilt or shame, often blaming themselves for the violence they encounter. This can accompany feelings of powerlessness – a sense that they have limited control over their lives and their surroundings. [4, 5, 10-15]

In this situation, people often adopt high-risk behaviors (substance abuse, self-harm, risky sex) as strategies for coping, survival, and / or escape. Their perceived powerlessness can reduce their 'future orientation.' Loss of hope and optimism can encourage harmful, violent, and illegal behaviors, while limiting

protective and 'goal-oriented' behaviors. This can create a repetitive cycle of

trauma: [4, 5, 10-15]

Figure 1: Cycle of Trauma
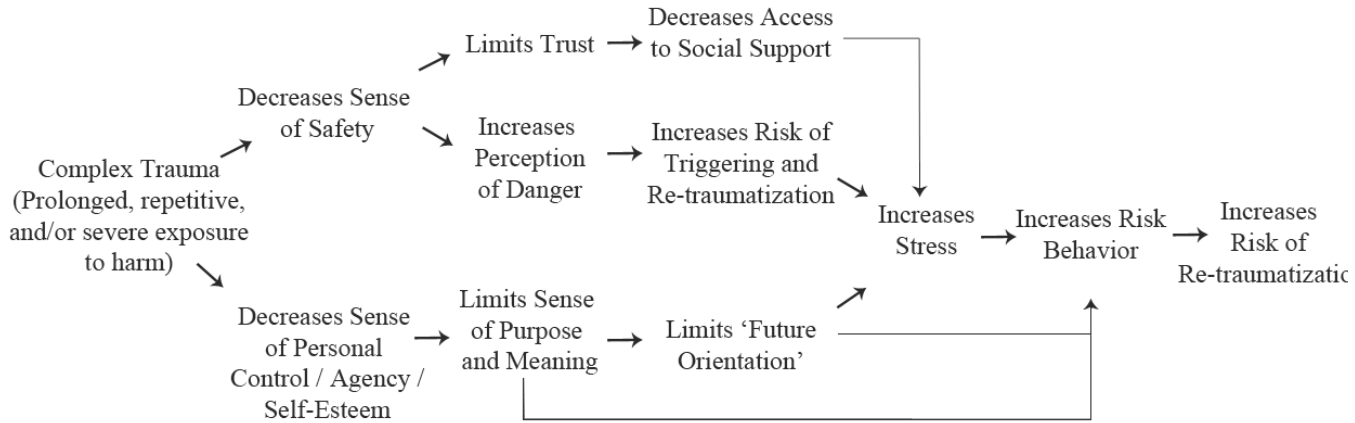
Studies from Native American and Aboriginal populations demonstrate how

this 'powerlessness' can even overtake an entire culture. Authors link how

generations of systematic oppression and poverty have contributed to high rates of

substance abuse and violence within these groups and communities. [16, 17]

RESILIENCE

A discussion about trauma is incomplete without the acknowledgment of

resilience. 'Resilience' refers to people's capacity to protect their mental health

through harmful encounters. What accounts for individuals who don't experience

trauma after experiencing violence? What about those, who display evidence of

strength and recovery, even while they struggle with trauma? Research observes

four trends that can help to predict a person's resilience:

Table 1: Factors that Influence Resilience against Trauma

↑ Level of Exposure to Danger [18-20]	↓ resilience

• Severity and repetition of a violent event • Lifetime load of harmful events	
Demographic and Individual Factors [18-20] • ↓ Age of initial harmful exposure • ↓ Income / SES • ↓ Education	↓ resilience
↑ Social Support and resources [18-20] • Connection, bonding, and social interaction with family, community, and fellow survivors • Positive emotion and humor / laughter • Knowledge and use of protective coping skills	↑ resilience
↑ Hardiness [18-20] • Self-esteem, self-efficacy, and self-confidence • Belief that one can influence one's surroundings • Having a meaningful purpose in life • Belief that one can learn and grow from positive and negative experiences • Ability to make meaning from the harmful experience and life afterwards	↑ resilience

Past study has demonstrated how these 'resilient' characteristics (or combinations of them) can protect people from the effects of trauma (PTSD; depression; anxiety; etc.). [21] This evidence helps to explain the varied reactions that

people can have to violent events. It also illustrates a foundation for trauma intervention.

TRAUMA INFORMED CARE (TIC)

Trauma-Informed Care (TIC) is an umbrella approach that is gathering attention from a wide range of organizations and systems that work with vulnerable populations: hospitals, direct service agencies, schools, departments of health and social services, etc. It represents a paradigm shift in the culture of organizations, as they adjust to emerging knowledge around trauma and resilience. The overarching goal of Trauma Informed Care is to replace 'What's wrong with you?' with 'What happened to you?' when working with populations that have been impacted by trauma. [22]

This perspective encourages agencies and staff to place a person's behavior into the larger context of their history and circumstance. Instead of exclusively considering how a behavior appears in an isolated snapshot of time, employees can reflect on how past experiences might be motivating / stimulating a client's actions. For example, instead of acting aggressively, a client might be reacting to a memory of a past trauma. Instead of exhibiting either overly trusting or distrustful / standoffish behaviors, a client might never have developed appropriate attachment because of a history of childhood neglect. This awareness and consideration can promote empathy, tolerance, and non-judgment. [23, 24]

<u>A distinction between Trauma Informed Care (Organizational Culture) and Trauma Sensitive Services (Clinical Intervention)</u>

Organizations benefit when they recognize the difference between Trauma Informed Care (TIC) and Trauma Sensitive Services (TSS). Trauma Sensitive Services refer to specific clinical interventions that mental health professionals can consider for trauma treatment (Cognitive Behavioral Therapy; Eye Movement Desensitization and Reprocessing; etc.). Trauma Informed Care is a more general concept, referring to the agency as a whole. [25-28]

This distinction can be confusing for organizations that mistake the availability of clinical, mental health intervention for Trauma Informed Care. While TIC supports the use of psychological treatment, it has a broader intent. The goal is to influence the entire culture of an organization – impacting all clinical and non-clinical staff, programs, and environments. [25-28]

An analogy to help illustrate this point – when organizations provide wheelchair access and convenient parking to individuals with disabilities, they are not offering clinical services. Instead, they are designing their overall environments to be sensitive and welcoming to people with handicaps. Agencies can apply this same concept to their work with those who experience trauma. [25-28]

THREE TYPES OF TRAUMA THAT IMPACT ORGANIZATIONS

Considering its holistic nature, TIC addresses not just one, but three categories of trauma that can impact organizations:

1. Client Trauma (the trauma impacting clients)

2. Vicarious Trauma (impacting staff)

3. Organizational Trauma (impacting the agency culture) [29]

Addressing Client Trauma

'Client trauma' refers to the trauma that clients carry with them in their lives and into the organization. As previously stated, people who have experienced violence might perceive danger or experience triggers from objectively benign stimuli. They might react severely when triggered, with limited ability to self-regulate. This brings a risk that agencies might unintentionally trigger or re-traumatize clients. [4, 11, 15]

Accompanying this challenge is the fact that, by the time clients enter an agency, they are often in a state of immediate crisis. With a continuous influx of people arriving under urgent threat to their wellbeing, many organizations and professionals have historically (and understandably) concentrated on the emergency response. This means addressing immediate threats to clients' health – moving them out of dangerous situations; providing emergency shelter; assisting with emergency medical, legal, or case management needs. [30]

The problem with this strategy (when considering the impact of trauma) is that the long-term damage to a person's coping and overall sense of control can keep that individual in a constant state of crisis. So, when agencies exclusively address the short-term needs of individuals, they – in turn – can remain in a constant state of crisis response. [30]

For many clients who experience trauma, this can create a revolving door. Even when organizations work overtime to respond to emergencies, the clients often linger in conditions of vulnerability. The result is overwhelmed agencies and perpetually sick clients. [30]

Considering these challenges, Trauma-Informed Care highlights two central goals for organizations that work with clients who have trauma:*

(1) Protect clients from triggering and re-traumatization – Establish a level of safety and trust in the organization by way of predictable services / environments and positive relationships (staff-client; peer-peer).

(2) Promoting long-term trauma recovery – Break out of a short-term response model and move towards a path of long-term and stainable recovery. This doesn't mean staying with the consumer for an indefinite amount of time. It means building structures and opportunities to help people enhance their perceived sense of control over their own behavior and their surroundings. Strategies include: patient-centered care; gathering client feedback and input to inform agency programs and policies; inviting clients to participate in peer-to-peer, community mobilization, and advocacy work; and introducing client-centered care, wherein clients take a lead role in determining their treatment plan. [24, 28, 30]

*When considering these goals, it's important to note that TIC does not replace necessary services. 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. [25, 26]

<u>Addressing Vicarious (Staff) Trauma</u>

Trauma-informed agencies further recognize that trauma can extend well beyond the client population. Research documents the risk of vicarious trauma for employees, who regularly interact with vulnerable populations. [29, 31-33]

Continuous exposure to client trauma and workplace stress can decrease staff members' productivity and commitment to their jobs. Burned out employees often report feelings of disconnection, sensitivity to violence, loss of purpose, lack of energy, cynicism, changes in identity and worldview, problems at home, and even health risks. [29, 31-34]

In recognition of this threat, the literature provides a list of risk factors that can increase employees' vulnerability to vicarious trauma and burnout. In this case, 'burnout' has three identifying characteristics: (1) emotional exhaustion; (2) depersonalization – negative attitude towards clients, a personal detachment, or loss of ideals; and (3) reduced sense of personal accomplishment and commitment to the profession. [35]

While much of the discussion about vicarious trauma is theoretical, several studies provide survey and qualitative data to identify risk-factors. These exist at both the individual and organizational levels: [31-41]

Table 2: Individual and Organizational Risk Factors around Vicarious Trauma

Individual Risk Factors	Organizational Risk Factors
Overwork • When an employee has taken on	Role ambiguity / overload • Ambiguity – Lack of clarity for

too many tasks that threaten a healthy work / life balance	employees about their roles, responsibilities, and expectations of supervisors and the agency • Overload – Too many tasks in one role
Too high of a caseload with trauma survivors	Perpetually high caseloads for employees
Past history of trauma	Failure to identify vicarious trauma in employees
Poor respect of boundaries	Failure to create systems for employees to see their successes
Less experience	No opportunities for continuing education
Too many negative clinical outcomes	Insufficient vacation time
Limited training in client trauma and vicarious trauma	No support for personal therapy

At the same time, articles have identified several protective factors that can decrease the risk of vicarious trauma and burnout: [31-42]

Table 3: Individual and Organizational Protective Factors around Vicarious Trauma

Individual Protective Factors	**Organizational Protective Factors**
Availability of social support inside and	Restrictions on long work hours and high

outside of the workplace	caseloads
Resolution of one's personal issues	Workplace flexibility
Awareness of vicarious trauma	Accepts employee stressors as real and legitimate
Strong principles	High tolerance for individual differences
Feelings of competence	Systems to express support clearly, directly and abundantly
	Availability of conflict management tools

Addressing Organizational Trauma

In addition to vicarious trauma, several authors on workplace culture describe a phenomenon wherein an entire organization has become 'traumatized.' This occurs when a collective sense of crisis or stress begins to define the culture and climate across the agency. An organization has entered a traumatized state when vicarious trauma has become systematic – no longer impacting one person at a time, but becoming an agency norm. [22, 29, 43]

According to both theory and observational study, this situation generally emerges inside of workplaces that have experienced a breakdown of intra-agency communication. Organizations are particularly vulnerable when they maintain autocratic structures, where decisions occur in an exclusively top-down format. The atmosphere lacks the participatory element that is critical to maintaining healthy communication. As a result, workers develop the perception that they don't have a voice. This can create an atmosphere of disconnected employees, learned

helplessness, and ultimately high turnover. As with individual trauma,

organizational trauma can take on a cyclical form: [22, 29, 43-45]

Figure 2: Cycle of Organizational Trauma
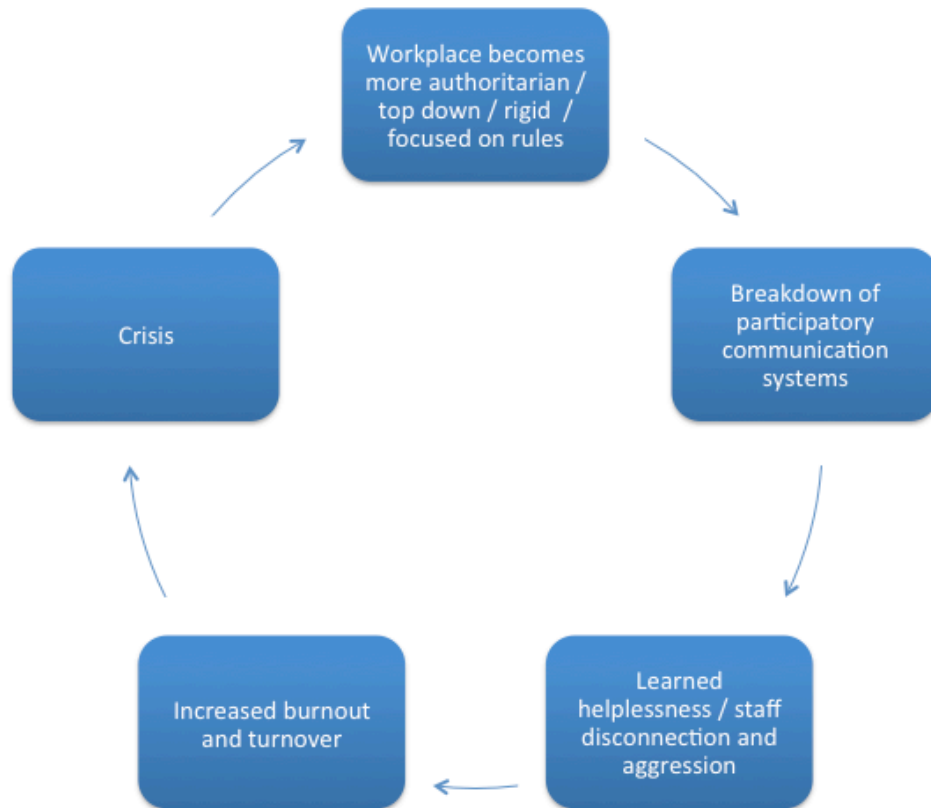
The negative impact of organizational trauma can extend beyond the

workplace and trickle down to the clients. Research consistently demonstrates the

importance of the staff-client relationship. Survey findings, including data from

randomized control trials, indicate an association between positive and consistent

staff-client relationships and positive client experiences, as well as improved

outcomes. Negative or disconnected staff interactions can bring the opposite result,

even to the point of harming the client. [44-50]

Authors describe how, when employees feel supported by their organizations, they can focus on providing a critical source of positive support to clients. A lack of attention to staff needs can interrupt this process. It can increase the risk of employee burnout, as well as contribute to the high turnover that disrupts the opportunity for clients to build consistent and reliable relationships with employees. [29, 43-45, 50]

A breakdown of organizational communication can also create challenges for leadership. Without healthy communication streams, higher administration employees might receive incomplete or inaccurate information from their front lines. This can limit their capacity to fully can understand the operations, weaknesses and strengths within their organizations. In this situation, leaders cannot see how their policies carry through into real practice. This can disrupt their ability to make decisions that are most appropriate to the success and overall health of their agencies. [22, 29, 43]

The following table identifies traits that can help to protect organizations from this situation. It contrasts these characteristics with traits that place agencies at increased risk. (Considering that 'organizational trauma' describes a situation in which 'vicarious trauma' has become the cultural norm, there is conceptual overlap between this table and the above two tables.) [22, 25, 26, 29, 35, 43, 46, 51-54]

Table 4: Comparing Protective and Risk Factors around Organizational Trauma

Most protected from workplace	Most at risk for workplace trauma

trauma and systematic burnout	and systematic burnout
Engaged, Participatory, and Transparent Decision-making	Top-down, Secretive Decision-making
Reflective Supervision • Encouraging reflection and introspection	Exclusively task-oriented supervision
Relationship-based care • Staff / client relationship • Supervisor / supervisee relationship • Inter / intra-team relationships	Lack of attention to relationships
Addressing Conflict	Ignoring conflict
Competent staff • Investment in in-house and external trainings / orientations	Unprepared and overwhelmed staff
Clear expectations for staff	Role confusion and role overload among workers
Supportive, flexible, and positive-reinforcement style among supervisors • Acknowledging staff for their successes and stamina	Authoritarian, rigid, punishment-oriented style among supervisors
Long-term approach to hiring (growth-	Short-term approach to hiring (crisis-

oriented) • Ensuring a personality 'fit' with the desired culture of the team, department, and organization; resisting the urge to hire the first person who meets the minimum requirements	oriented)
Open-minded / Continuous learning	Apathetic / Resistant and critical of change
Shared vision and goals	Disconnected vision and goals

Six Key Principles of Trauma-Informed Care

One of the challenges to Trauma Informed Care is that it contains many different facets. As such, the literature has taken a long time to come up with a concrete definition. In an effort to address this gap, the Substance Abuse and Mental Health Services Administration (SAMHSA) has identified and defined six primary principles: [24, 28, 30]

Table 5: Six Key Principles of Trauma-Informed Care (Identified by SAMSHA)

Principle	Definition
(1) Safety	Throughout the organization, staff and clients feel psychologically and physically safe. The physical

	environment is comforting, and interactions promote a sense of safety.
(2) Trustworthiness and Transparency	Leadership maintains a level of transparency in organizational decision-making. Maintaining trust with staff and clients is a priority.
(3) Peer Support	The organization establishes structures for formal and informal peer connection. This includes positive relationships between staff, as well as opportunities for 'trauma survivors' to connect with one another.
(4) Collaboration and Mutuality	Partnership and leveling of power is important, both between clients and staff, and staff across every hierarchical level within the agency (direct service to leadership). Every member of the organization maintains meaningful sharing of power and decision-making. Every person has a role to play in Trauma Informed Care. "One does not have to be a therapist to be therapeutic."

(5) Empowerment, Voice, and Choice	The organization supports empowerment opportunities for staff and clients. Employees and clients have a role in goal-setting to determine their path for moving forward. They have a voice in the organization. The agency takes on a strengths-based approach that acknowledges people's 'expertise' and their opinions.
(6) Cultural, Holistic, and Gender Issues	The organization intentionally works towards cultural awareness. It supports efforts to as move past stereotypes and judgments. Policies, programs, and staff are sensitive and accepting of different genders, sexualities, and ethnicities, while recognizing historical trauma.

IMPLEMENTING TRAUMA INFORMED CARE (TIC)

Leadership Buy-In

Because so much of TIC relates to agency-wide practices, policies, procedures, and environments, successful implementation requires leadership buy-in. Decision-makers at the top of the organization play a substantial role in the culture and communication-style of the workplace. They lead by example, while dictating the

resources and time available to ensure trauma-awareness and sensitivity across the agency. [22, 29, 43, 55, 56]

According to both theory and observational studies, cultural shifts within agencies tend to be most successful when the leadership is open-minded. Administrators, who are flexible and welcoming of new ideas for improvement, are in the best position to create positive change within their organizations. [22, 29, 43, 55, 56]

Multi-Level Implementation Team: TIC 'Champions'

While leadership buy-in is a critical component for effective implementation, the ultimate goal is to spread trauma-awareness and sensitivity throughout the agency – across different departments and levels of hierarchy. Instead of relying exclusively on a top-down approach, agencies can consider the value of multi-level team to participate in implementation. An ideal group will bring representation from at least one member at every level of the agency (clients; support staff; providers; leadership). [22, 29, 43]

This structure can help to ensure that employees and clients at every level of the organization will have a voice. It can also help to spread ideas more easily, as each department / level will have its own 'TIC Champion' – i.e. an individual who embraces and models the principles of Trauma-Informed Care. [22, 29, 43]

This strategy emerges from the idea of 'positive deviance' – a behavior change technique that has been successful in several public health efforts. Prominent examples include efforts to enhance child nutrition to decrease de-hydration-related mortality in developing countries. Public health officials identified and educated prominent members within communities to encourage adoption and

sharing of the technique. These informal leaders then spread the practice throughout their immediate circles. According to several observational studies, this intervention has proven highly successful in promoting positive behavior change and enhancing sustained community health. [57-59]

An example of 'positive deviance' that relates more closely to organizational culture involves the adoption of relationship-based care (RBC) among nurses. Similar to the public health campaigns, these initiatives located informal leaders within the nursing structure to act as 'early adopters' / 'change-agents.' Their task was to introduce RBC within their immediate teams. These champions were responsible for modeling the practice in their own work and keeping their peers accountable. Their persistence helped to push RBC adoption across multiple nursing environments, leading to a drop in burnout and increase in patient satisfaction. [53-55]

Despite its success, there are some risks and caveats to the use of informal leaders in the promotion of Trauma Informed Care. In the first place, successful RBC adoption in hospitals may not generalize to successful TIC adoption in various organizations. Less-involved staff may interpret TIC as not applying to them. They might grate against receiving direction from peers. Lower-level staff members also often do not carry decision-making authority to implement agency-wide change. This is where the involvement of formal leadership proves most valuable. [60-62]

Top administrator involvement can effectively communicate that TIC is not just a responsibility of the specific 'champions,' but in fact, an expectation for the entire staff. It also ensures that top-level decision-makers are at the table and invested. Without this involvement, many policy and program changes are not

feasible on an agency-wide scale. Therefore, a combined bottom-up and top-down

approach may be ideal for effective cultural shift towards a trauma-informed

workplace. [60-62]

A Need for Assessment

Having acquired leadership buy-in and developed a multi-level

implementation team, the next step involves an organizational assessment. One of

the biggest challenges in Trauma Informed Care is that – more than any single

intervention – it is a collection of different practices and features that share a

common goal (i.e. to protect against client, vicarious, and organizational trauma). In

fact, many TIC strategies overlap with 'best practices' that already exist in direct

service and management. Trauma awareness simply adds extra incentive and

motivation to create policies and practices that promote organizational health.

Considering that many aspects of TIC are nothing new, agencies might find that they

already have multiple structures in place to protect against client, staff, and

organizational trauma. They just never before called it Trauma Informed Care.

This can make it difficult for organizations to know what TIC is, how to track

its implementation, and how to measure its impact. An agency-wide assessment can

help organizations clarify where to start and create a roadmap through the process.

It can identify already-existing strengths, as well as locate areas in which the agency,

staff, and/or clients might be vulnerable to trauma. Overall, a comprehensive TIC

assessment will help to: [63-65]

- Identify strengths and weaknesses in the current situation
- Identify challenges and barriers to the desired condition

- Identify solutions and opportunities for improvement

Various templates are available in the literature for performing such assessments. These templates primarily derive from theory-based discussion and brainstorming. Two prominent examples include the *Trauma Informed Organizational Toolkit,* published by the National Center on Family Homelessness, and the *Sanctuary Model Implementation Overview,* published by the Sanctuary Institute. These guides, among others, promote a range of methods, including surveys, interviews, observations, and material review. They address the following areas: [66, 67]

- Staff training and awareness of trauma / vicarious trauma and its influence on behavior
- Safety and comfort within the physical environment
- The level of support that staff receive within the workplace
- Cultural competency
- Systems to maintain client privacy and confidentiality
- Protocols for crisis prevention and intervention
- Open and respectful communication (staff-client communication; inter-agency communication)
- Consistency and predictability of structures and services
- Structures to promote Peer Support
- Availability of Trauma Specific Services

- Funding streams to support Trauma-Informed training, environments, and practices

- Involvement of staff and clients in agency feedback and growth

- Presence and awareness of written policies to promote Trauma-Informed Care

- Hiring practices to ensure the selection of applicants who best match the culture of Trauma-Informed Care

Whether agencies choose to tailor their approach from templates or to design their own, the strongest data collection will incorporate methods for triangulation – i.e. capturing perspectives from different members of the agency (direct service employees; leadership; clients). Considering that TIC aims to incorporate the entire agency, the most appropriate assessment will take on a holistic quality. [68, 69]

Qualitative methods (interviews; focus groups) are especially valuable tools for capturing the staff and client perspectives. While they require a dedicated amount of time and effort from both researchers and participants, these methods introduce a level of engagement and in-depth review that is absent from a quantitative design. Participants have a voice in deciding the topics and perspectives that are most important to them. There is also a heightened level of interaction and communication between those offering the data and those collecting it. Especially if leadership are involved in the face-to-face process of data collection, this brings an opportunity for management to convey their genuine interest in the perspectives of those at the front line. [70-75]

When designed in this way, the assessment becomes more than just a system for data collection. It becomes the first step of introducing and explaining Trauma-Informed Care. People have an opportunity to discuss what the initiative might mean to them. Most importantly, staff and clients can develop a sense of ownership over the assessment. This can evolve into an opportunity for them to develop a sense of ownership in the overall effort to become trauma-informed. [70-74]

What to do with this assessment? Moving forward

The assessment results dictate the path that each agency can take in its effort to become trauma-informed. As such, there is no specific template for implementation. TIC initiatives can involve trainings, policy updates, and program development. But the specifics vary according to the identified needs, strengths, barriers, and opportunities of the respective organization.

At this stage, the team can create a roadmap for ongoing implementation. This process primarily involves setting priorities, based on the results from the assessment: [63-65]

- In what order can / should the agency address its needs, weaknesses, and barriers?
- What is the plan for expanding strengths within the organization?

While the collective team can address these questions for the entire organization, individual 'champions' can also set priorities for their specific departments / levels.

This written roadmap can help the team keep track of its goals, objectives, intermediate steps, and methods for evaluation. This tool is particularly valuable

because culture change is often slow and intangible. Rather than acting as one large intervention or training, Trauma Informed Care is a collection of small details and strategies that can collectively help to create a safe and comforting environment for staff and clients. It is less about designing a specific program and more about influencing how every person in the agency interacts with one another. In this light, TIC can be much harder to implement than another type of intervention. [76]

A living document that keeps track of committee efforts and accomplishments can help to maintain motivation among members. It offers a clear direction, while setting expectations to keep the agency and leadership accountable. It also offers documentation that the team can then make available to any stakeholder in the organization. Communicating a laid-out plan to the remainder of the agency is an important step to ensure that clients and staff understand how the agency is responding to their feedback. [29]

PURPOSE OF THIS DISSERTATION

ADDRESSING A GAP IN THE LITERATURE

The research has made a strong case for why trauma is an important concept for consideration in the public health world. Based on this evidence, many organizations have enhanced their understanding for why trauma awareness / sensitivity / preparedness is valuable.

The literature further outlines many of the pieces that exist within Trauma Informed Care and have grounding in observational or experimental studies (for example, trauma-sensitive interventions and reflective supervision). It also provides theory-based discussion about conducting self-assessments and first steps of TIC implementation.

However, there is still a visible gap. Available articles provide very few concrete observations of organizations and systems that have performed a complete TIC assessment, analyzed the results, implemented changes, and evaluated their impact. Also notably absent is documentation of 'real-world' perspectives from staff and clients who would feel the most effect from this kind of organizational change.

This lack of practical examples creates a challenge for agencies that seek guidance on how to realistically take on TIC implementation – not just piecemeal, but as a comprehensive, agency-wide effort. How can staff or leadership, who are directing the efforts, navigate the difficulties that can emerge in taking on such a task? How do they overcome challenges and barriers, such as time management, limited funding or resources to dedicate towards such a project, as well as the 'slowness' and frustrations of cultural shifts?

Furthermore, what are the perspectives of the clients and staff who would feel the most impact? What aspects of the organization do they find to be most trauma-informed versus trauma-ignorant? What are their recommendations that derive not just from the theoretical literature, but from their lived experience?

Considering this gap in the literature, the goal of this dissertation is to begin to fill a small portion of it. Within this body of work, I present the qualitative results from client interviews that took place in the context of a 'Trauma Informed Care' assessment of a community-based clinic that serves people in homelessness.

THE INTERSECTION OF TRAUMA AND HOMELESSNESS

But, why perform such research in a clinic that focuses on homelessness? Why might this be an appropriate site for establishing Trauma-Informed Care?

Trauma as a Precedent to Homelessness

Many people in homelessness report an elaborate history of traumatic experiences – typically beginning in childhood. [77] Several studies have documented high rates of caretaker abuse and neglect (physical, sexual, emotional) among runaway youth and homeless adults. [78-81]

For many individuals, their exposure to violence continues into adulthood. Women often report how their childhood abuse preceded years of intimate partner violence. These events collectively contributed to their current homelessness. [82] A similar pattern of childhood → adulthood violence is common among homeless veterans. People report a combination of childhood adversity, military-related trauma, post-military abuse and adversity, and post-military mental health concerns as the primary contributors to their homelessness. [83, 84]

Trauma as a Result of Homelessness

Once people enter homelessness, their risk of trauma significantly increases.
Compared to 2% of the general population, an estimated ¼ to ½ of people in
homelessness experience violent events. [85] Women are especially vulnerable to
sexual assault and exploitation. When compared to housed African American
women, the residents of a New York based shelter were "106 times more likely to be
raped, 41 times more likely to be robbed, and 15 times more likely to be assaulted."
[86] Studies have found similar exposure to violence among homeless men and
transgendered individuals. [86-89]

A state of homelessness itself is a traumatic experience. People experience
stigma, discrimination, rejection, and isolation. Many lose their sense of identity,
along with their feelings of purpose and meaning. These stressors combine with a
level of uncertainty and unpredictability around maintaining health and wellbeing.
People face challenges in meeting basic needs, such as food, clothing, and shelter.
This situation tends to exacerbate, as well as create physical, mental, and behavioral
health problems. [30]

RESEARCH AIMS

Having established the substantial overlap between trauma and
homelessness, this project provides data based (rather than strictly theory-based)
guidelines for creating a trauma-informed environment in a relevant clinic. It
highlight the client perspective as one of the most important viewpoints in the
discussion around Trauma-Informed Care. Clients have the most intimate
knowledge of both their trauma and the ways in which the agency has exacerbated

and/or mitigated this stress. Their perspective is extremely valuable to organizations. As such, my two primary research aims involve:

1. Gathering perspectives from people, who experience homelessness, on the current ways in which their clinic provides services, environments, policies, and staff-interactions that are trauma-informed versus trauma-ignorant

2. Learning client recommendations for improving a trauma-informed approach in such a clinic

METHODS

A COMMUNITY-BASED PARTNERSHIP

Health Equity Committee

In May 2013, I partnered with the 'Health Equity Committee' (HEC) – an internal committee of 10-15 staff and clients at a comprehensive health clinic that provides care to people in homelessness. Services include primary care, mental health therapy, addiction treatment, dentistry, case management, and peer groups.

The HEC originally formed with a goal to enhance access and sensitivity for Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) clients. Upon recognizing the impact that trauma has on all clients, regardless of their sexual and gender identity, the focus expanded to enhancing 'Trauma-Informed Care' in general. Having recognized the many aspects of TIC implementation, the committee created several subgroups:

- Assessment sub-committee – to design and facilitate a comprehensive TIC needs assessment across the entire agency
- Program sub-committee – to recommend changes in programming, based on the results of the assessment
- Training sub-committee – to provide trauma-awareness of training for staff, based on the results of the assessment
- LGBTQ sub-committee – to continue working towards the original goal of the committee (i.e. enhanced access, services and sensitivity towards LGBTQ clients)

My introduction to the Health Equity Committee

I learned about the HEC through a connection at the clinic that I made the year prior. In the winter of 2013, I participated in a qualitative research class at JHSPH. This class involved an applied group project. I joined a team of students to investigate the mental health benefits of advocacy-involvement among clients who educate the public and lobby for improved legislation to address homelessness. For this project, my team partnered with the same homeless health clinic that would become the site of my dissertation.

A year later, in Spring 2014, I presented the results of the study at a national health and homelessness conference. This gave me an opportunity to re-connect with the community partners at the clinic. At this time, I learned about the Health Equity Committee and the effort to improve Trauma Informed Care (TIC).

Previous Interest in Trauma Informed Care

I had become interested in the concept of TIC through my Doctoral Practicum at an inpatient adolescent unit that performs court-ordered mental health evaluations for youth involved in the juvenile justice system. I provided health education and harm-reduction counseling, touching on issues of sexual / reproductive health, substance use, and suicidal ideation (varying my topic, depending on the specific needs of the adolescents).

During this experience, I found that a substantial proportion of the youth had exposure to some forms of child abuse and neglect. A majority of the girls experienced sexual assault, abuse, and/or exploitation. This knowledge encouraged

critical thinking about the unit in which these youth were currently receiving

treatment.

The environment, programs, and relationships with employees seemed to

increase the risk of triggering and re-traumatization. Trauma-awareness and

sufficient training appeared minimal among the staff members with whom the

youth spent most of their time. Crisis incidents, including violent clashes, were

common. The unit regularly responded with strategies that can aggravate trauma,

such as seclusion, restraint, and chemical injection.

After my exposure to this environment, which seemed to exacerbate trauma

symptoms rather than provide meaningful recovery, I reflected on my experience

and began heavily researching the idea of Trauma Informed Care. I spent the

following year learning as much as I could about the theory and available evidence

on designing and implementing TIC.

Establishing the terms of my partnership with the HEC

When I learned about the Health Equity Committee, I contacted the staff

member who was leading 'assessment sub-group' to express my interest in their

work. The timing proved to be serendipitous, as I made the connection just before

their very first meeting (which I was able to attend).

At this meeting, I introduced myself to the group of five social workers, who

were participating on the assessment sub-committee. I explained my background,

sharing both my experience on the adolescent unit, as well as my research in

Trauma-Informed Care. I expressed my desire to assist with the research design,

data collection, and analysis. In exchange for my effort, I requested permission to base my dissertation on this project.

After conferring with the clinic's leadership, the committee agreed to bring me on as a research partner. I received consent from the organization to focus my dissertation on this project. Under the established terms of agreement, I would be allowed to publish and present independently on the work. I would remove the name of the clinic, as well as the location, to protect confidentiality of the site and participants. I would also have the option to publish and present in partnership with the clinic, in which case anonymity would not be required.

Navigating the Partnership: Balancing between Academic and Practical Demands

Beyond the research itself, this project has been a wonderful growth opportunity for me as a professional. Through this experience, I have improved my knowledge in how to create and maintain a healthy partnership between the researcher and the community-based organization. I have learned to navigate and balance between the different demands and schedules of the academic world versus the practical world.

On the one hand, I was able to provide my partners with information about research ethics, informed consent, and the process of the Internal Review Board (IRB). On the other hand, I learned how to operate as a team that works to accommodate the needs of all parties – ensuring that the research can both serve the specific needs of the organization, while creating knowledge that can benefit the larger service and research community that holds interest in Trauma Informed Care.

This balance involves compromise, for instance, on the speed of research design and data collection – requiring agreement among all parties, rather than moving quickly forward as one could as an independent researcher. It would also result in multiple versions of the final deliverable – both short, punctuated reports that synthesize the research into easily absorbed forms for the leadership, as well as longer, more detailed accounts that can guide external parties on the process and results.

MULTI-METHOD NEEDS ASSESSMENT

Given the comprehensive nature of Trauma-Informed Care, the assessment sub-committee decided on a multi-method design to capture multiple viewpoints in the agency. Our two primary goals involved gathering perspectives from staff (particularly direct service staff members who engage more intimately and regularly with clients than administrative staff) and clients.

<u>**Gathering the Staff Perspective**</u>

In seeking the staff perspective, we utilized the template available in the *Trauma Informed Organizational Toolkit* by the National Center on Family Homelessness. Over the summer of 2014, I met with the sub-committee on a monthly basis. We convened in order to tailor questions so that they would be appropriate to the clinic employees. Our final draft included 120 Likert-scale questions, covering a range of topics:

- Trauma training and awareness
- Staff supervision, support and self-care
- Physical environment

- Safety and crisis prevention planning

- Intra-staff and staff-client communication

- Trauma-related intakes and assessments

- Strengths-based programming

- Availability of trauma-specific services

- Involvement of consumers in providing feedback and offering input to programs and policy

- Presence of trauma-informed policy

Once we applied for and received approval from the IRB at JHSPH, we used the platform 'Survey Monkey' to send out an electronic version to the entire staff population. Categories included:

- Client Support (Client Services Assistants; Unit Clerks; Security)

- Behavioral Health (Psychiatrists; Mental Health Therapists; Additions)

- Case Management (Benefits; Case Managers or those that provide Case Management Services; Patient Advocates; Outreach)

- Medical / Pediatrics / Dental (Medical, Pediatrics, and Dental providers and other staff involved in direct patient care)

- Administration (Finance; Fund Raising; Policy and Advocacy; Medical Records; Executive Level Staff; Information Services; Human Resources)

From November 2013 to January 2014, we received 80 responses out of a population of a little over 100 employees. Participation was strong in all categories except for 'Client Support.' To make up for this gap in the results, I conducted focus

groups and interviews with these employees. These sessions included the same

question categories as the survey.   Having collected this data, we cross-tabulated

the data on the survey to compare results across the departments. This, combined

with review of patterns and trends from the 'Client Support' focus groups and

interviews, offered a general view of the staff perspective.

Gathering the Client Perspective

While the team worked collectively to capture the staff viewpoint, I took

primary responsibility in gathering the client perspective. This became my primary

contribution to the project. As such, I have focused my entire dissertation on the

results of this process. I have included a detailed description of my methodology in

the below section titled "Using Qualitative Interviews to Capture the Client Voice."

Introduction of a Research Assistant

To assist with data collection and analysis, we enlisted the support of a

research assistant (RA). The team submitted an advertisement for a JHSPH student

to participate through the 'Baltimore Community Practicum.' Through this avenue,

an MPH student came on to the project. She assisted with survey analysis and

creating a report to synthesize the results for the Health Equity Committee. After

receiving training, she also assisted with a small portion of data collection and

analysis for the in-depth interviews with clients.

USING QUALITATIVE INTERVIEWS TO CAPTURE THE CLIENT VOICE

I selected in-depth interviews as my strategy for collecting client data. This

method allows for rich exploration of the clients' perspective, with a level of depth

that is not feasible in a survey. [74] Considering the low literacy rates that can exist for

people in homelessness, it was also helpful to select a method where reading was not a barrier. [90]

Advantages of Qualitative Research

One of the biggest advantages to this design was that it gave the participants a voice in determining the topics and themes that were most valuable to them. Surveys are limited to the questions and subjects that the researchers deem important. By contrast, interviews use open-ended questions to allow participants to direct the conversation. [74]

This method encourages respondents to provide new ideas and recommendations for agencies to consider. Rather than solely giving feedback to current programming, participants had the opportunity to brainstorm changes and improvements to the agency. [70]

In this light, the study became an opportunity for 'research as intervention.' [73, 91] During their sessions, many respondents expressed their appreciation for the interviews. They described how their participation has helped them feel valuable within the agency. They experienced an increased sense of purpose, because they felt that their responses might help somebody. In this light, the interviews themselves became a strategy for enhancing 'hardiness' – one of the traits associated with resilience against trauma.

Constructivist Foundation

The constructivist paradigm has shaped my approach to this project. This philosophy argues that people construct their own understanding and knowledge of the world, based on their personal experiences, social interactions, culture, and

reflections on those experiences. Based on this understanding, there is no one 'truth.' All truth is relative. It is constructed by society and by the individual. [71, 72, 92]

When considering ontology, constructivism assumes that, instead of having one objective 'reality,' each person has his or her own perceived 'reality.' This is a helpful perspective, particularly when thinking about the impact of trauma. For instance, a person's history of encountering violence can dictate whether or not a situation is triggering or harmful. Circumstances may be re-traumatizing for some people, but not for others. The goal of this research therefore is to fully understand and appreciate the participants' perspective. Their perception is their reality. [71, 72, 92]

When considering epistemology, learning and knowledge are also 'constructed.' The researcher is not attempting to find one objective answer. Learning instead occurs through dialogue between the researcher and participants. The researcher therefore becomes a central tool of data collection. [71, 72, 92]

Introspection

As such, constructivist theory encourages researchers to recognize the influence of their personal background on study choices and outcomes. Data collection and analysis involves a number of decisions – what research design to adopt; how to recruit participants; what questions to ask; what interview technique to use; what themes to prioritize in the data; what quotes to attach to different themes; how to organize these themes and quotes into a larger dialogue. The researchers' agenda, assumptions, personal beliefs, emotions, history, training, perspective, style, and experiences influence all of these factors. [93]

Given this heavy impact, the constructivist paradigm encourages researchers to adopt an introspective approach – to remain mindful of how their personal biases and viewpoints might skew the outcomes. [71, 93] In facilitating this study, I witnessed how my cultural background, experiences, education, and previous understanding of trauma influenced the process and results. As such, I made conscious effort to temper my bias, ground my perspective in the current literature, and promote participants as the primary voice in the research.

For this project specifically, I had a pre-conceived preference for Trauma-Informed Care. My experience at the adolescent health unit, as well as my investigation of the current research, has made me a strong proponent and advocate for trauma awareness and sensitivity. This threatens to create a bias in my interview style – for instance, the type of questions asked – as well as my data analysis – searching for patterns that favor my original assumption. Without careful reflection, it would be easy for me to direct the conversation and pull quotes that favor my assumption.

I used several strategies to enhance my awareness of my bias and bring transparency to the process. Before beginning the interviews, I created a document that answered questions to help map out and predict how I might influence the situation:

- How has my personal history led to my interest in Trauma Informed Care?
- What are my personal values? What are my subjective biases, particularly when it comes to this topic?

- How does my ethnicity, gender, social class, and cultural background influence my relationship, not only with this topic, but with the participants?

- Where is the power in this project? Where do I land in the power hierarchy?

This process not only highlighted my bias towards Trauma Informed Care, but it also revealed the power dynamic that could influence the quality and validity of the interview data. Not only does my social class offer me a higher level of privilege than the interview participants, but I am also asking people to reveal their honest and perhaps critical opinion about the same clinic in which I am conducting the interviews.

Recognizing this power dynamic, I learned to emphasize the confidential nature of the interviews – along with the fact that I was operating as an external researcher. Before beginning my questions, I stressed that responses would not lead to any changes in their services or access. Once I began the interviews, I approached the participants as 'experts' over their own lives. I used a flexible and open-ended interview style in order to allow clients to direct the conversation and address the topics important to them.

As I continued in this process, I periodically wrote down my reflections and reactions. This helped me to continuously tweak my interview guide in order to remove questions that appeared to be leading – instead including prompts that would encourage participants to speak freely on the chosen topic (for instance, altering questions such as 'how safe do you feel with your provider?' to 'how do you feel when you are with your provider?'). This more open style could allow for more

dissenting opinions to emerge from participants, in the event that these were their true feelings on the matter.

I used a similar reflective style in my data analysis. I was cognizant of a risk that I might prioritize patterns and themes that matched my pre-conceived bias towards trauma-informed practices. I made effort, therefore, to look for dissenting trends that might counter my bias. This practice helped to ensure that I approached the data with a more balanced perspective.

The Process of Conducting this Qualitative Research Project

Participant Recruitment

Because transience can be common among people in homelessness, I simplified my recruitment strategy.[94] I used convenience sampling with a set list of inclusion/exclusion criteria. All participants had to have received at least one service from the clinic in the past year. To ensure voluntary consent, I excluded minors from the sample. Participants also required the cognitive ability to consent to the interview. They did not receive payment or material incentive for their involvement.

Recruitment occurred entirely at the site of the clinic. I gathered 24 volunteers through announcements in peer groups. Another 5 received direct referrals from individual providers. 1 more volunteered after seeing a flyer posted in one of the waiting areas. 4 of these 30 participated in a second interview, because they wanted to talk beyond a single session. Each of these second interviews drew out additional useful data. Sessions across all participants ranged from 35 to 115 minutes, with an average of 72 minutes.

Even while using convenience sampling, the final distribution of participants ended up closely matching the clinic population. Notably absent, however, was representation from Hispanic individuals, who make up 8% of the clients, or youth (aged 0-19), who make up 9% of clients. I was also not able to capture viewpoints from clients who identify as transgender. These are three important demographic categories that would have added valuable perspectives to the study. More targeted recruitment efforts to gather participation from these groups would be appropriate for future research.

Study Demographics – Ethnicity

	African American	Caucasian	Native American	Total
Number	21	7	2	30
Percentage	70%	23.33%	6.67%	100%

Clinic Demographics – Ethnicity

	African American	Caucasian	Other	Total
Percentage	60%	28%	12% (8% Hispanic)	100%

Study Demographics – Gender

	Male	Female	Total

Number	21	9	30
Percentage	70%	30%	100%

Clinic Demographics - Gender

	Male	Female	Total
Percentage	**66%**	34%	100%

Study Demographics – Age

	20s	30s	40s	50s	60s	Total
Number	4	7	7	5	7	30
Percentage	13.33%	23.33%	23.33%	16.67%	23.33%	100%

Clinic Demographics – Age

	0-19	20-24	25-44	45-64	65+	Total
Percentage	9%	7%	36%	47%	2%	100%

Data Collection

Data collection occurred between November 2013 and January 2014. I interviewed 26 of the participants (both first and second interviews). After receiving training, the research assistant (RA) interviewed the remaining 4. (Training consisted of an initial review of the interview guide with opportunity to ask questions, role playing, and listening to audio of sessions that I had already conducted. I also sat in with the RA in her first interview and gave feedback. My

feedback primarily consisted of encouraging the RA to maintain an open interview style and to allow the participants to largely direct the conversation.)

Most sessions took place in private counseling rooms. 2 sessions occurred in a private conference room. Before beginning each interview, I explained the informed consent process. I reviewed the purpose of the research, confidentiality, and the voluntary nature of participation. I also asked permission to tape record.

During the interview, I matched my questions to similar topics addressed in the client survey available in the *Trauma Informed Toolkit.* This included inquiries about the agency's performance around four areas of Trauma-Informed Care:

1. Trauma awareness and preparedness
2. Establishing safety
3. Opportunities for clients to develop healthy relationships
4. Opportunities for clients to gain a sense of personal control and confidence [29, 30, 95-100]

In the earlier interviews that I conducted, I closely matched my prompts to the guide. As interviews progressed, I moved into a more open-ended style – switching question order; dropping redundant questions; adding probes. This flexibility allowed participants to direct the conversation.

I also added questions beyond my original interview guide. These included topics that had come up in earlier interviews (e.g. asking about the lobby), as well as inquiries that I had originally asked as a probe and received very informative

responses (for instance, asking participants to compare experiences between two organizations).

Transcription

While I outsourced 8 of the interviews for transcription, I personally transcribed the remaining 18 of the 26 interviews that I had facilitated. (The RA transcribed her 4 interviews.) While part of this decision was financial, I found a lot of advantage in personally transcribing the bulk of my interviews. Through this process, I was able to intimately familiarize myself with the data. Before beginning official coding, I had developed a thorough idea of what themes and patterns existed in the interviews.

Coding

I relied on the qualitative analysis software, MaxQDA, to assist with my coding of the interviews. I had developed my initial codebook from both the 'trauma-informed' literature, as well as topics that I observed in my process of data collection and transcription. I created a list of header codes – each identifying a different feature / characteristic that is relevant to a trauma-informed environment (for instance, how safe an individual feels in the agency). My sub-codes then specified the participants' perception (e.g. safe, unsafe). I used these codes to begin categorizing segments of text. [101]

Once I started reviewing the data, I adopted a more inductive and iterative strategy. As new themes emerged from the interviews, I added and tailored codes. With each new or altered code, I included descriptions to clarify its meaning. I also

deleted original codes that, upon closer review of the data, did not reflect notable patterns or themes in the interviews.

As I went further into the analysis, I began reviewing the linkages and overlap that existed between the codes. This process helped me to locate the major patterns and themes in the data. [101] I also looked for dissenting opinions / exceptions in the interviews. This helped to create a more nuanced view, for instance, of why certain individuals might feel safe in a space or with a provider while others didn't.

After I analyzed the majority of my interviews, I reviewed my updated codebook with the research assistant (RA). I also reviewed coded transcripts with her to ensure that she received examples of how each code applies to the data. She then used this tool to analyze her 4 interviews. We brought our transcripts together for the complete data set.

Member Checking / Peer Debriefing

As patterns and themes emerged from the data, I discussed them with groups of staff, clients, and former clients. The clients (mostly non-participants) described whether they had similar experiences or perceptions. Staff also explained if they noticed similar patterns in their work, or heard similar things from their clients. This process helped me to verify a level of mutual believability. All of results in my data papers have received this kind of confirmation from members of the agency (either staff, clients, or both). [102]

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ARTICLE 1:

ADDRESSING CLIENT PERCEPTIONS OF SAFETY IN THE LOBBY

INTRODUCTION

'Trauma Informed Care' (TIC) is an umbrella approach that has received attention from a range of direct service agencies. Interested organizations include schools, community-based organizations, and inpatient / secure facilities. [25, 26, 28, 30, 103] TIC has evolved out of a growing awareness of trauma and its impact on clients, staff members, and organizations. [104] It includes a number of strategies that agencies can adopt or enhance to improve their preparedness, sensitivity, and response to trauma.

'Safety' (i.e. physical, psychological and emotional comfort) is a central component of TIC. [105] Emerging research reveals how a history of trauma can increase a person's hyper-vigilance and perception of danger. [11] Based on this evidence, one of the primary goals within TIC is to reduce the risk that an organization will accidentally trigger or re-traumatize clients. [23]

The purpose of this article is to examine the lobby as a principle area for TIC. This is frequently the first space that clients encounter when they arrive. It often serves as the central access point for individuals that wish to learn about and enroll in services. As such, I explore the idea that predictable and comforting experiences in the lobby can prevent unintended triggering. This can establish clients' perceptions of safety from the moment they begin their relationship with the agency.

This study examines the perspectives of clients at a homeless health clinic. Across a series of in-depth interviews, participants describe their perceptions of

safety inside the lobby. They identify features and experiences that have either mitigated or exacerbated their feelings of vulnerability.

Trauma

Trauma is a psychological reaction that can occur as a response to an event or series of events that involve the threat of death, physical harm, and/or sexual assault. [4] Precipitating incidents include child abuse and neglect, domestic and community violence, war, natural disasters, sexual abuse, and homelessness. [106]

The intersection of trauma and homelessness

Research illustrates how trauma can both precede and result from homelessness. Early developmental stress is a strong predictor of future vulnerability. [9, 30, 80] People in homelessness regularly report a history of childhood abuse and neglect. [77-79, 81] In many cases, this exposure to violence continues into adulthood, often in the form of domestic violence, community violence, and incarceration. [80, 107]

Once a person becomes homeless, their risk of harm significantly increases. Compared to 2% of the general population, an estimated ¼ to ½ of people in homelessness have experienced a violent attack. [85] People also report isolation, stigma and discrimination, uncertainty about their health and wellbeing, and a loss of meaning, purpose, and identity. They often face challenges around eating, drinking, sleeping, and maintaining daily hygiene. This situation can exacerbate and create physical, social, mental, and behavioral health risks. [30]

Risk of triggering and re-traumatization

Exposure to prolonged, repeated and/or severe violence brings a risk of long-term psychological challenges. Impacted individuals often struggle to distinguish between harmful and harmless circumstances. Once triggered, many have a hard time controlling their reactions. [4, 5, 10-15] Their behaviors might appear aggressive, erratic, or volatile. At another extreme, people might disassociate (i.e. mentally separate themselves from the experience, thereby creating an impression that they are 'spacing out' or not paying attention). [4, 5, 10-15]

Trauma can also impact an individual's self-worth, sense of value, and sense of control. Many individuals experience guilt, shame, and self-blame. They often feel powerless to change their lives or influence the world around them. [4, 5, 10-15] This can stimulate challenges with mental health, as well as high-risk behaviors, including self-harm, violence, and substance abuse. For some individuals, this situation creates a pattern of perpetual crisis: [4, 5, 10-15]

Complex Trauma (Prolonged, repetitive, and/or severe exposure to harm) → Decreases Sense of Safety → Limits Trust → Decreases Access to Social Support; Decreases Sense of Safety → Increases Perception of Danger → Increases Risk of Triggering and Re-traumatization → Increases Stress → Increases Risk Behavior → Increases Risk of Re-traumatization. Complex Trauma → Decreases Sense of Personal Control / Agency / Self-Esteem → Limits Sense of Purpose and Meaning → Limits 'Future Orientation'

The above figure illustrates a challenge for agencies that serve people in homelessness. Not only is there a need to respond to immediate / crisis-oriented issues (e.g. food, shelter, and emergency healthcare) but there is also growing recognition for the need to address the cycle of trauma. [30]

<u>**Trauma Informed Care (TIC)**</u>

Trauma Informed Care (TIC) represents a paradigm shift that occurs inside organizations as they adjust to emerging knowledge about trauma and its impact. The goal is to promote a level of awareness and sensitivity that shapes all staff, policies, programs, and environments. [25, 26]

A Distinction between 'Trauma Specific Services' (Clinical Treatments) and Trauma Informed Care (Organizational Culture)

In their effort to become trauma-informed, agencies benefit from understanding the difference between Trauma Informed Care (TIC) and Trauma-Sensitive Services (TSS). TSS refers to clinical therapies that specifically provide psychological treatment (e.g. cognitive behavioral therapy; eye movement desensitization and reprocessing; etc.). By contrast, TIC is a general concept that influences both clinical and non-clinical staff, programs, and environments. [25, 26]

This distinction often emerges as a point of confusion for agencies, which might mistake the availability of clinical interventions as Trauma Informed Care. While TIC supports the use of TSS, it has a much broader scope. It recognizes that all direct-service employees play a role in creating a welcoming setting for clients. [25, 26]

Even staff members who do not engage directly with clients have a role to play. Leadership and administrative staff are especially relevant, because they help determine what kind of organizational culture exists within the workplace. They are in a position to make critical decisions that can protect both clients and staff from the impact of trauma. [25, 26]

What are the goals of TIC?

The literature identifies two goals for organizations that aim to interact with clients in a trauma-informed manner:

1. Minimize the risk of accidental triggering and re-traumatization

2. Guide clients into sustainable recovery by helping them break their cycle of trauma.

<u>Resilience</u>

When reflecting on these two goals, 'resilience' is a valuable factor for consideration. 'Resilience' refers to an individual's capacity to encounter a harmful event, but not experience trauma. What protects the mental health of some people, while others encounter severe psychological consequences? Evidence points towards four general trends:

↑ Level of Exposure to Danger • Severity and repetition of a violent event • Lifetime load of harmful events	↓ resilience
Demographic Factors • ↓ Age of initial harmful exposure • ↓ Income / SES • ↓ Education	↓ resilience
↑ Social Support and resources • Connection, bonding, and social interaction with family, community, and fellow survivors • Positive emotion and humor / laughter	↑ resilience

• Knowledge and use of protective coping skills	
↑ Hardiness • Self-esteem, self-efficacy, and self-confidence • Belief that one can influence one's surroundings • Having a meaningful purpose in life • Belief that one can learn and grow from positive and negative experiences • Ability to make meaning from the harmful experience and life afterwards	↑ resilience

These patterns shed light on how agencies can protect clients from triggering and re-traumatization. The influence of 'social support' and 'hardiness' on resilience introduces an interesting question for organizations. Can agencies increase clients' sense of safety by designing practices and environments that enhance their 'sense of support' (i.e. feelings of social comfort) and 'sense of control' (i.e. sense that they are in a predictable environment, where they understand their surroundings and have different options / opportunities to influence their situation)? [29, 30, 95-100]

Purpose of this article

The impact of the lobby on a client's perception of safety?

This article applies this question to the lobby of a direct service agency. I identify different features in the space that can either enhance or detract from the clients' perceptions of support and control. I then relate these features to their perceptions of safety.

I also explore how clients' experiences in the lobby can influence their relationship with the entire agency. Literature from primary care clinics and emergency rooms points to a link between patient satisfaction and wait times. [108, 109] There is some evidence that the physical features of the waiting area (e.g. quality of furnishings, lighting, artwork) can influence a patient's impression of the quality of care. [110] Research from inpatient psychiatric wards also reveals how crowding and loud noises can increase psychological distress. [111]

Beyond this, the research is limited. Most available studies concentrate on tangible features, with less emphasis on how people behave. Very little research has reviewed how lobby experiences can impact clients' perceptions of safety, particularly when they have a history of trauma and/or homelessness.

Even the trauma literature, which stresses the importance of safety, offers minimal guidance for lobbies. Recommendations include: ensuring sufficient space for a comfortable physical environment; removing violent and sexual material; and ensuring sufficient staff to monitor behavior. [24] Beyond this, there is limited discussion.

Within this article, I provide an in-depth review of safety issues that clients perceive in a lobby environment. I illustrate how these factors relate to their sense of control and support within the space. I also present how the lobby can influence their overall relationship with the agency.

METHODS

The study occurred in an outpatient, comprehensive healthcare clinic for people in homelessness. In 2013, I partnered with an internal committee of staff and

clients to review the agency's current strengths and challenges around TIC. – i.e.

How prepared and sensitive is the clinic at addressing the traumas that impact

clients and staff? [63, 64]

A central part of the assessment involved in-depth interviews to gather the

clients' perspective. This method allowed participants to determine the feedback

that was most important to them, as well as brainstorm new ideas and

recommendations. [70-73]

Participants / Recruitment

I used convenience sampling with a set list of inclusion/exclusion criteria. All

participants had to have received at least one service from the clinic in the past year.

To ensure voluntary consent, I excluded minors from the sample. Participants also

required the cognitive ability to consent to the interview. They did not receive

payment or material incentive for their involvement.

Recruitment occurred entirely at the site of the clinic. I gathered 24

volunteers through announcements in peer groups. Another 5 received direct

referrals from individual providers. 1 more volunteered after seeing a flyer posted

in one of the waiting areas. 4 of these 30 participated in a second interview, because

they wanted to talk beyond a single session.

Even while using convenience sampling, the final distribution of participants

ended up closely matching the clinic population:

	African American male	African American female	Caucasian male	Caucasian female	Native American male	Native American female	Total (age)
20s	3	1	0	0	0	0	4
30s	2	3	0	0	1	1	7

40s	4	2	1	0	0	0	7
50s	2	0	1	2	0	0	5
60s	4	0	3	0	0	0	7
Total (ethnicity)	15	6	5	2	1	1	30

Data Collection

Data collection occurred between November 2013 and January 2014. I interviewed 26 of the participants (both first and second interviews). A research assistant (RA) interviewed the remaining 4.

Most sessions took place in private counseling rooms. 2 sessions occurred in a private conference room. Before beginning each interview, I explained the informed consent process. I reviewed the purpose of the research, confidentiality, and the voluntary nature of participation. I also asked permission to tape record.

During the interview, I inquired about the agency's performance around four areas of Trauma-Informed Care:

5. Trauma awareness and preparedness

6. Establishing safety

7. Opportunities for clients to develop healthy relationships

8. Opportunities for clients to gain a sense of personal control and confidence [29, 30, 95-100]

Sessions ranged from 35 to 115 minutes, with an average of 72 minutes. I maintained a flexible structure with my interview guide – switching question order; dropping redundant questions; adding probes. This flexibility allowed participants to direct the conversation.

Data Analysis

I developed my initial codebook from the 'trauma-informed' literature. I created a list of header codes – each identifying a different feature / characteristic that is relevant to a trauma-informed environment (for instance, how safe an individual feels in the agency). My sub-codes then specified the participants' perception (e.g. safe; unsafe). I used these codes to begin categorizing segments of text. [101]

Once I started reviewing the data, I adopted a more inductive and iterative strategy. As new themes emerged from the interviews, I added and tailored codes. With each new or altered code, I added descriptions to clarify its meaning. As I went further into the analysis, I began reviewing the linkages and overlap that existed between the codes. This process allowed me to locate the major patterns and themes in the data. It helped me to identify the lobby as a valuable area for Trauma Informed Care. [101]

After I analyzed the majority of my interviews, I reviewed my updated codebook with the RA. She used this tool to analyze her 4 interviews. We then brought our transcripts together for the complete data set.

Member Checking / Peer Debriefing

As patterns and themes emerged from the data, I discussed them with groups of staff, clients, and former clients. The clients (mostly non-participants) described whether they had similar experiences or perceptions. Staff also explained if they noticed similar patterns in their work, or heard similar things from their clients. This process helped me to verify a level of mutual believability. All of the following

results have received this kind of confirmation from members of the agency (either

staff, clients, or both). [102]

RESULTS

<u>Overview</u>

Without direct prompting, the majority of participants describe the lobby's

influence on their perceptions of safety within the agency. They explain how their

experience in the waiting area can influence their enthusiasm about coming for

services, their willingness to return after an initial encounter, and their general

sense of confidence that the organization can help them improve their wellbeing.

Participants identify several factors within the lobby that are either

protective or damaging to their sense of safety. Each of these features overlaps with

one of three categories. The first two fit into the literature's larger conversation

about trauma and resilience – (1) sense of control; (2) sense of support. A third

category emerges directly from the data – (3) sense of dignity.

Also emerging from the data is a clear pattern that represents how

employees' comfort in the space can directly impact clients. This suggests that a

trauma-informed environment not only considers the clients' needs, but also

prioritizes factors that enhance employees' sense of control and support.

<u>Potential challenges to safety in the lobby</u>

The majority of interviews portray the clinic as an overall positive

environment. Most participants applaud its mission.

> "I feel that [this clinic] has a very good plan. Their mission is awesome. They
> help a lot of people."

When describing the lobby, respondents highlight several strengths – a welcoming front desk; quick response to fighting or threatening incidents; etc. But, even with evident strategies to create a safe space, the interviews illustrate several challenges that can naturally occur in this environment.

Three threats to clients' sense of control

(1) Decreased familiarity / predictability in the space

The majority of participants express how their perception of safety improves as the setting hosts fewer people. They report feeling more relaxed as they move from the main lobby → smaller waiting areas → group rooms → provider offices.

Some respondents explain that large crowds can create an unpredictable atmosphere inside the lobby. In contrast to a setting where people encounter the same faces every session, the lobby hosts a crowd that changes every day. As such, these participants describe the stress from not knowing what others are thinking or how they will behave.

> *"I think the lobby is about the safest it can get considering that you have so many individuals going in and out of here. [...] But you still don't know who's walking past you. You don't know what they're thinking, or how they'll react. You feel a little better sitting in that classroom. [...] You can let your guard down a little bit. Then your counselor's office is obviously the most comfortable. Cause it's just you and them. But that lobby... it's kind of a mad house down there.*

One respondent further explains how a history of trauma can enhance this anxiety.

> *"[This city] can be a wonderful place. But, it's a terrible place to grow up poor. So... trauma is sort of the thing that is a recurring theme of [city] life. [...] Because of that, I'm generally on edge in most places. Especially where there's a bunch of people mulling around who I don't know. Whenever there's a big crowd like that, I'm on edge."*

(2) Relatively high anxiety and low investment among new consumers

Interview patterns suggest that individuals can experience relatively high stress when they are first new to the agency. Before enrolling in services to improve their wellbeing, nearly half of the participants describe having had limited coping skills to buffer the strain of homelessness.

Several respondents explain how their initial entry to the agency increased this anxiety, rather than relieved it. The limited familiarity with the setting, uncertainty about procedures, and lack of knowing anybody can exacerbate feelings of vulnerability.

> *"It was just frightening and... Because, (1) I never been here before. And (2) I didn't know what to expect from this. Or what's going to be the outcome? Where you gonna end up? Or how they gonna pick you - I don't know. You wait such a long time to be called. [...] It just seemed like it was a frightening experience. You never knew what to expect. It would be better if they would label you as being new. And then they would kinda dealt with you with kid gloves, as they say."*

A couple of participants note that new clients might also have limited investment in the agency. This can lead to premature drop out from services when people experience stress in the waiting area.

> *"Clients get up and walk out because they're out of control. They come here to help them get back under control. And they don't see it happening. They continue to not have control over the situation. So their anxieties and frustrations build to a level where they are even further out of control. [...] So, to make them wait 1, 2, 3, 4, 5 days - your likelihood of losing them and them just saying 'screw it' is greater. So... the thing about - if we call you 3 times, you've got to come back tomorrow. Well, you've called me 3 times, and I come in - I've got to wait till tomorrow, screw it. I'll wait till it's convenient for me again. [...]So I'll be out there again for a week or so, doing what I do. Then I might get the gumption to come back in - more motivation to say 'ok, I'll try this again.' Maybe I'll make sure I sit there. But then the environmental things that I told you about might make somebody else go out. You have people who might stay or leave based on their current mental state. Then you have people*

that just don't care enough to stay. They care enough to walk through the door. But, if it's a stressful experience, they might not care enough to stay. Or to come back."

Most respondents explain that their anxiety decreased as they developed relationships within the agency, became more familiar with the environment, and witnessed improvements to their health. But, this change occurred over an extended period.

When new consumers enter the lobby their anxiety can then influence the entire atmosphere within the space. Study themes illustrate how a number of stressed people in a room can generate a stressed atmosphere.

"When you've got so many people in one place who are stressed out, it can get uncomfortable. Just this air of tension. People don't know what's going on. They don't know who to ask. So everyone's sort of buzzing inside their own stress. It can just make the whole environment heavy."

(3) Limited communication about the wait time

The majority of interviews suggest that long wait times can exacerbate this anxiety. Within this clinic, providers set specific appointments for consumers who are already enrolled. But, the 'walk-in' process for new services occurs on a 'first come / first served' basis. A couple of respondents describe the bottleneck that can result.

"Staff work hard in this place. You can tell. But one thing that makes it challenging is that people just keep coming and coming. You attend to one person, and then there are ten others behind him. The agency does its best to keep up. [...] But it's just tough when people just keep coming. It slows everything down."

Because the specific time of the 'walk-in' session varies by the number of people arriving for services, consumers often don't know how long they will be

waiting. The interviews illustrate four outcomes that can result from this limited knowledge:

(1) People might find themselves unable to mentally prepare for the wait. Several participants explain that knowing approximately when they will see a provider can make a difference between a calm reaction and an agitated reaction.

"I lost it one time. I came in for my appointment to see my psychologist. I was feeling a lot of anxiety and stress that day. So I really needed to talk to her. But she was out sick. And nobody told me. So I was just sitting there the whole time. I was sitting in the waiting room for an hour and a half. I lost it.[...] The main thing that would have helped me the most in terms of calming me down was to let me know what my psychologist was not available and to have that rescheduled."

(2) Individuals might experience a 'stuck' feeling because they worry that they will miss their appointment if they step away from the lobby.

"All it is is when they call you, if you're not here - you didn't hear your name... you been in the bathroom, or the phone - you know, or just sitting outside... right out there. They call your name three times. Then you're gone. Then they don't deal with you no more. [...] You'll have to come back tomorrow. And homeless people and all - they do the thing that they're used to. Or what they want to do - or they get impatient. And they don't want to sit inside. Sometimes some of the clients have a pungent odor of urine and feces. Or whatever. And that permeates for a while. Somebody might call their name and they're outside."

(3) New consumers might not comprehend the difference between appointments and the walk-in process. People can become upset when they don't understand why others might receive services before them.

"And we don't know how long that person sitting there. We know that we've been sitting down there for hours. And this person just walked in the door. Why they call this person? As opposed to why they don't call number 1? It's not clear.

They don't give you a time setting, or when you gonna be called. Or whatever the case may be. And all that. It's just kind of upsetting. Makes you feel like they don't even want you here."

(4) Consumers might feel constrained by rules and curfews of external

organizations. Early curfews, for instance, might restrict a client's ability to

wait for an unpredictable amount of time.

"I'm staying at this halfway house. And they expect me to be back at 4. So I gotta catch that bus. I gotta catch it. I can't afford to wait around here forever. If I'm sitting here waiting for services, or hell… even if I'm gettin' services and my time is running out, I gotta go. They're pretty strict over there. So when they expect you back, you'd better be back."

<u>Three threats to employees' sense of control</u>

1. **Barriers to Communication**

Interviews suggest that it might be difficult for employees to communicate

effectively with clients in large areas with high numbers of people. They explain that

smaller settings allow employees to more easily address consumer questions and

concerns. Even when front desk employees explain the walk-in process to new

clients, the continuous influx of consumers can compete with their desire to answer

questions and to ensure that people fully comprehend the situation.

Several participants point out that the front desk staff might also have

limited information to share with clients – i.e. how many people are in front;

approximately when the client should expect to receive services; how quickly

people are entering services; etc. So, even when employees successfully explain the

general procedure to clients, they might feel restricted by their own limited

knowledge.

2. Role Overload and Safety Concerns

Along similar lines, a few participants note the risk of role overload for lobby employees. The interviews reflect the multitude of jobs that occur at the front desk. Employees act as greeters, gatekeepers, guides, phone operators, etc.

Some respondents observe that this multi-tasking can become even more challenging because staff members engage regularly with unfamiliar and possibly aggressive clients. Just as with consumers, the 'unknown' factor might raise anxiety for employees.

> *"Staff don't know any better than we do who is walking through the door and how they'll act. I could see how that would make any job tough. Plus, they've got so much to do up at that desk. It must be like fifty jobs in one. That would be stressful on any day. And then you've clients coming in who may be getting angry or impatient. So you've got to deal with that too. Plus all the people behind them who need their stuff dealt with too. I could see how it'd be a lot."*

A couple of participants witness how, when clients do become aggressive, this can create, not only a safety concern, but also a distraction. Front desk staff might not be able to delay a line of consumers when one becomes irate. Stopping the line can threaten a roadblock that could aggravate the remaining clients, thereby risking a spiraled situation.

3. Limited Trauma Awareness

Some participants predict that employee stress might increase when they aren't aware of how trauma can impact behavior. These participants point out that client behavior can seem erratic, volatile, or aggressive. They predict that staff members might become frustrated because they don't fully understand what is happening with the client or how to respond.

How might a reduction in employees' sense of control then decrease the consumers' sense of support?

Multiple interviews illustrate how these challenges can create a divide between personnel and clientele. Without adequate support and training, employees can adopt an apprehensive or controlling stance when interacting with consumers.

Around one-third of participants describe this situation with security staff, who have the most exposure to potentially dangerous encounters with clients.

> *"Yeah. I could see how working security would be tough. I certainly wouldn't want to be the guy who's expected to break up a fight. So yeah, I could see how that might put anyone on edge. People get loud up in here, and you're the one supposed to keep control of everything. Yeah, that'd be tough."*

But, multiple participants caution that a controlling and authoritarian demeanor among staff can exacerbate feelings of anxiety among consumers.

> *"Yeah you know they take a very aggressive approach with people who might be hearing voices, people who might just have lost everything they had and have nothing else to lose. [...] If I came in here and I was really agitated, I guess I would want somebody to listen and find out what's going on. Not someone to yell at me. That would just make me more upset."*

Primary threat to consumers' sense of dignity → Hygiene

Interviews define hygiene as the 'elephant in the room' for homeless support agencies. One respondent explains how a lack of personal hygiene can be damaging to a person's sense of dignity.

> *"[Before I was homeless] I was successful with a lot of things in my life. Business and working and so forth. And you start - your humanity starts to go away from you. Like taking a shower. Taking a shower once or twice a day - that's what I was used to. And then maybe not taking a shower - maybe once or twice in a couple of months. Or twice in a couple of months. People don't understand that. [...] That's great if you could take a shower - it means something. [...] That's something that really builds - you get a little self-esteem. You feel better."*

For this reason, several participants appreciate the clinic's attempt to maintain a welcoming and respectful demeanor towards clients, regardless of their hygiene level.

> *"Front desk staff is awesome. [...] They treat me with respect. And so far I've seen - they treat everyone as people. I look at them in awe. [There was a guy who came in] who smelled like crap. I mean, literally, he smelled like feces. And...they treated him with the utmost respect, and were able to communicate with him in a way that made him go and do whatever he needed to do."*

But, the question that follows is how to create a hospitable atmosphere for **all** individuals in the space. When sanitation issues emerge, this can deflate clients' desires to come for services, as well as their overall satisfaction with the environment.

> *"There's people who urinate outside on the walls. And you have an odor as you're walking up. When I first was coming, that was the comments that I was hearing. 'Man, it stinks over there. I don't want to go over there.' That type of situation. So, even though they throw bleach out on it or whatever, occasionally - the people do sleep out there. And they do try to come out and clean it up. The effort is there. But I think it's... I don't know. After a while I guess you get kind of tired of it. It affects people who are coming."*

A multi-pronged approach to safety

Interviews outline multiple strategies that can help to prevent and mitigate the above challenges. The majority of participants agree that a preventative approach to enhance control, support, and dignity can overcome many of the stressful stimuli in the lobby.

Three factors that can improve the clients' sense of control

1. **Communication: The protective influence of information and clarity**

Most participants describe feeling more in control when they have a clear idea of what services are available, how to access these services, and where to go if they have questions.

"Like, when I came in here, I was a walk-in. When I came in, everything just all moved fast. But it was certain things I didn't know.[...] I felt almost stupid. [...]

But if I [had somebody to guide me], that would have made a big difference. [...] Even if you was given like a guideline book [...] it would make a big difference."

A large majority of respondents highlight the value of information, particularly regarding wait times. Even if the clinic can't give a specific time, most participants stress that increased communication could help to relieve their anxiety.

"People get emotional downstairs. Maybe some of the reason is the waiting. But most of it is the lack of control. The lack of knowledge. If you know what how long you're waiting… or even that your provider may be late or had an accident or the flu and couldn't come in or something like that – meaning that you're waiting for nothing – that kind of situation is more of a trigger than almost anything else. The solution is to give people more knowledge about what to expect."

Participants provided various communication-related suggestions for the agency to consider:

- Updating consumers on how many people are in front

- Utilizing technology (screens; loudspeakers; a 'restaurant buzzer' system) to ensure that people are aware when an employee is calling them for their appointment

- Clarifying that different services (appointments vs. walk-ins vs. groups) and departments (e.g. physical health vs. mental health) generate different wait times

- Staff members can defuse anxiety by occasionally checking in to see how a person is doing and to provide an idea of how much longer the wait will be.

- Creating a designated place where clients can ask questions without disrupting the line at the front desk

- A logbook could offer the clinician an idea of where to find an individual who is not in the waiting area (i.e. in a group room; on the porch; in the bathroom). It could also record additional details to help providers locate consumers. One respondent uses an example of a deaf individual who couldn't hear his name. Even though he waited several hours, he missed his session. A system to alert the necessary personnel might have helped to prevent this situation.

Most respondents explain that increased communication can help to alleviate their stress by allowing them to plan. They generally feel less concerned about waiting if (1) they have an idea of when they will receive services; and (2) they have more freedom to move around without concern that they will miss their appointment.

2. **Offering clients various options to relieve their boredom**

The interviews reveal how boredom can exacerbate the anxiety associated with long wait times. Several participants recommend different techniques to reduce stress by keeping consumers occupied.

Multiple respondents describe groups as a valuable option for waiting individuals. The bonus of this strategy is that, when consumers use groups to

occupy their wait, they are actively building relationships with providers and peers – thereby increasing their familiarity and investment in the agency.

> *"I originally didn't care too much about joining groups. Really, I only went because I was sitting out in the lobby with nothing to do. When I was sitting out there waiting for so long for my appointment, I got really bored. So, I just went in there. I'm glad I went. But the main reason was just to give me something to do."*

Some participants point out two primary hurdles around this strategy. (1) Consumers may not know what groups are available. (2) They may worry that they will miss their appointment time if they are in a group session (i.e. by not hearing their name because they are out of the waiting area). These issues relate back to the 'communication' piece as a critical strategy to improve the lobby experience.

Beyond groups and peer interaction, the interviews include recommendations of simple activities to keep consumers occupied – magazines; coloring books; puzzle books; decks of cards; etc.

A couple of respondents also recommend using the wait time to learn more about services. Agencies can provide informational materials that outline internal services, as well as services available across the city. This strategy might help clients feel more productive during the wait.

3. **Using the design of the space to enhance clients' sense of predictability**

Participants advocate for three design features that can enhance comfort within the space:

(1) Visual cues (signs and structures) to maximize clarity and relieve confusion, particularly for new clients.

(2) A layout that prevents over-crowding and enhances peer-interaction (e.g.

placing chairs in small circles or off to the side for those who wish to sit

alone).

(3) Restricted access in the building.

> *"They don't let anybody get on the elevator. I like that. Yeah, cause anybody could walk in from the outside and walk around here. [...] I like that they don't have much access. It makes me feel safety. Most other clinics I went to don't have things like that. You sit there, and you never know who can come in. [...] Certain people might be up here tryin' to get up here and maybe steal somethin' for drugs or steal somethin' to put some money in their pockets. Everything. Everything happens."*

Four factors that can enhance consumers' sense of support

1. **Hospitality / Welcoming staff**

Most participants highlight the value of relatively simple acts, such as

greeting an individual with a comforting message. Several describe how they feel

especially welcome when staff members remember their name. Warm interactions

like this can help to relay a message of respect and dignity.

Multiple participants describe how employees, who maintain a calming

presence, can be effective at preventing agitation among clients. Several

respondents assert that, when people do become upset, staff members can best

defuse the situation by responding in a calm and understanding manner.

2. **Peer Involvement**

The majority of participants report having an easier time in the lobby if they

have friends and familiar faces with whom they can interact. Several describe how

getting to know peers in small groups has helped to build their comfort level in the lobby.

> *"I've built a lot of friendships in the groups. It makes me feel good. It gives me something to look forward to. It takes away the stress. You know, anxiety. It makes it less anxious. Cause every day I walk in – when I come in, I'm trying to wind down. And it's good to know that I got somebody in here I can talk to. You know, talk slack with, whatever, even if it's only for a minute, it helps. You know? And it's a good – to me, it's a good thing. It's a good thing."*

Along similar lines, a few respondents explain that they originally came to the agency with a friend or relative, who was also enrolling or had already enrolled. One respondent explains that her husband's presence prevented the stress she would have otherwise experienced. She goes on to recommend peer mentors as a strategy to provide similar comfort for new clients.

> *"My husband was with me when I first came here. So I wasn't nervous. He told me what to expect, and was with me the whole time. That helped a lot. I'm really glad I had him. I woulda been scared otherwise. New place. New people. Ya know? But if I had been along… I dunno. If this place had peer mentors or something like that. Just somebody to show you the ropes. A friendly face to talk to. That might help the people who don't have someone like I did. I'm really lucky I had him."*

3. **Preventative De-escalation – identifying agitated clients before an incident occurs**

Multiple participants explain that a bubbling period often precedes aggressive behaviors among clients. During this time, the client becomes increasingly agitated, but has not yet displayed a visible reaction. Respondents advocate for strategies to identify and intervene with these individuals before an incident occurs.

Several participants suggest for the lobby to host at least one staff member, who is trained in spotting signs of agitation, anxiety, and triggering. This employee would focus on preemptively addressing stress, preventing outbursts, and minimizing the escalation of incidents. This might reduce the risk of re-traumatization for both clients and employees. It can also prevent a spiraling situation, in which a public incident upsets or triggers surrounding consumers.

A trained staff member can also identify consumers, who experience stress reactions without visible markers. Many participants describe having small or barely visible reactions when they encounter triggers or re-traumatizing stimuli. This suggests that, for every person who has an anxiety-related outburst, several might be experiencing quiet, but equally painful reactions to stress. Several participants advocate for trained employees who can spot these more subtle signs of trauma.

> *"Let's say somebody's already upset and you know they're not fighting but they're upset or their voices –and all these people coming at you telling you, "You gotta go out, you gotta do this," you know. You know it just seems to escalate whatever that person [is going through]. I've seen them take people down like that and that's hard to see. [...] It would be better if they can get us a security guard but have someone that knows how to de-escalate... that can talk a person down."*

4. Involving security in an empathetic manner

Many participants support security as a last, but still valuable strategy for responding to aggressive behavior among clients. Once all preventative and mitigating efforts fail, efficient security intervention can help to protect staff, as well as other consumers who are witnessing or encountering harm.

Multiple respondents describe how a security presence can also establish a general sense of protection within the environment. This might help to deter, violent, or illegal behavior. It can also bring comfort to staff and consumers who are cautious of unpredictable personalities.

> *"Two guys were clashing on the porch. The one guy hit the other guy with the cane. And then when the security guards - and that's one thing that I like - when the security guards came outside, they were - I was like 'ooo, they came out quick!' The security guard at the door. When he came out, another came out, and another one came out. I said, I like that - how fast they can just get there [...] They out there, and not even quite 5 minutes later, it's over."*

A few participants encourage agencies to include a visible security presence, not just in the lobby, but on the external campus as well. Organizations can be vulnerable to harmful or illegal activity that takes place on or near their facility. This can create triggers for participants who walk through the space to get to the lobby.

In order to minimize this risk, one participant suggests that security staff members make rounds or have visible stations to cover these external areas. This can help to deter harmful activity or drug exposure that might negatively affect clients.

> *"I respect [the hospital in the east part of the city]. Their new buildings have the security outside. They're in booths. That is the best thing they ever done. [...] People feel safe coming up there. [...]It's a deterrent. Ok. A deterrent. Of people who want to do wrong. [...]Because them homeless people - maybe, you know, 80% of them are harmless."*

When security intervention is required, several respondents recommend a delicate response – one that considers the possibility that the respective individual may have a history with trauma (and is potentially displaying a trauma-based reaction). As such, they suggest empathetic and calming tones, while avoiding

actions that could mentally and / or physically harm all parties (physical altercation; arguments; yelling; etc.).

Interviews also touch on the potential value of post-incident debriefing. A few respondents suggest that debriefing and 'mental health first aid' might help to minimize the triggering impact of violent encounters.

These participants encourage the investigation and tracking of incidents to explore why and how they occur. Such procedures can offer the opportunity for all parties to share their perspective on what transpired. They can also provide information, which might help the agency prevent such occurrences in the future.

Protecting consumers by enhancing employees' sense of control and support

Several participants imagine the lobby to be one of the more stressful work settings within an agency. They explain that employees need adequate workplace support in order to sustain a friendly and calm atmosphere for clients.

1. **Relieving Role Overload**

A couple of respondents recommend having enough personnel and / or volunteers within the lobby to relieve the risk of role overload. Within their proposed scenario, some staff would attend to the line, while others would offer information and answer questions. One participant also suggests rotating tasks. This can help employees remain 'fresh' by shifting in and out of the more stressful tasks.

> "*Maybe a therapy session for people who have to deal with that kind of thing all the time. - you know, just to give them a break in some way. To keep them focused on what their job is. I can see myself after a period of time - almost anybody, any job you've had, there gets to be a certain point at times that you need a little break. That's where vacations come in. Maybe little seminars or something. Or - just like we have here - some kind of groups for the staff. Not*

only what's going on with the people, but 'how's everybody doing? What's going on with y'all?' That type of thing - to help rejuvenate. Keep it fresh.

I don't know what else you can do about that, as far as giving people more breaks. Maybe you could also, you know, shift a little responsibility. So it doesn't get so stagnant in the one position."

A few respondents return to the idea of a trained staff member, whose primary job is to pre-emptively intervene with at-risk clients. They express how this employee would be an asset to clients and fellow staff. He or she could minimize the possibility of aggressive incidents, while providing emergency support for consumers in crisis. This could free the remaining employees to focus on their defined tasks.

"You need somebody present along side the front desk staff... who can assist the client, explain the process to them, talk to them before they get upset. So that the front desk can be the front desk. Security can be security."

The potential result is that personnel can concentrate on performing their specific tasks in a welcoming and efficient manner. Some participants predict that, over time, this strategy could prevent costly consequences to the agency, such as burn out and high turnover.

2. **Enhancing Trauma Awareness and Understanding**

Most interviews highlight training as a primary strategy to support employees in their jobs. Multiple participants explain that staff members, who understand why clients become agitated, might feel (1) more understanding and (2) more competent in preventing and mitigating trauma reactions.

A few participants explain that such training might also help employees to recognize their own stressors and anxiety-related reactions. They predict that, when

employees have the skills to monitor their own reactions, this could reduce risk for everybody. Over time, this might help to maintain a safe, empathetic, and predictable culture within the lobby.

3. **Improved Communication and Support Between Lobby Staff and the Rest of the Agency**

Lobby staff members are generally the first employees with whom clients communicate. As such, they act as a primary source of information for clients. Several participants observe that communication gaps between the lobby and the rest of the agency could potentially obstruct information flow. This could create issues, especially if clients become upset when lobby employees are unable to answer questions.

A couple of respondents predict that this might generate frustrations over time for employees. They might feel unfairly exposed to client irritation and aggression over matters that are not their fault.

Some participants therefore advocate for healthy communication and feedback loops between lobby staff and other personnel. Front desk employees can then effectively relay information to clients, as well as respond to questions – e.g. informing consumers that a provider is out for the day or coming in late; reporting a change in protocol, services, or providers; tracking the time of client appointments; etc.

Enhancing clients' sense of dignity by addressing hygiene-issues

The interviews include three strategies that could help to relieve the most apparent hygiene concerns:

1. **Bathroom Maintenance (Frontloaded to the Morning)**

Several respondents describe how, with few alternative opportunities, clients are often using the bathrooms to wash up or change clothes. As soon as doors open in the morning, many individuals make full use of the bathroom after a night where options are more limited. Considering this, a couple of participants suggest frontloading bathroom maintenance to the morning hours (with fewer but still regular cleanings in the afternoon).

2. **Air Circulation**

Some participants assert that air circulation would make a notable difference in relieving objectionable odors. While ventilation systems and ceiling fans can require expensive installation, respondents suggest portable fans as an economical strategy to keep the air moving. This can help to enhance the comfort for everybody sharing the space.

3. **Addressing the Porch / External Areas**

Multiple interviews describe the external areas of the agency as particularly susceptible to sanitation threats. Even though it does not provide official shelter, this clinic allows individuals to sleep on its porch and external areas.

Given this situation, hygiene can become a challenge. Even with a place to sleep, some respondents describe limited overnight possibilities for washing and waste disposal. This can lead to multiple threats to sanitation on the clinic's porch.

Several participants recommend regular attention to maintenance on porches and other external areas, where this situation can occur. Some suggest preventative measures, such as external bathrooms, and designated places for people to camp (away from the entry to the building).

DISCUSSION

A large space exists between the moment a client enters an agency and the moment they enter a provider's office. This study represents why this space matters. A lack of attention to the lobby can bring unforeseen consequences. Clients can experience triggering and re-traumatization within this environment. An unknown number of people might prematurely drop out of services.

On the other hand, the study illustrates the benefits that can occur from positive encounters in the lobby. These experiences can play a valuable role in relieving a client's anxiety. Comfort within the lobby can enhance a client's overall perception of safety, as well as their desire to return. It might also help to prevent vicarious trauma for the staff. This points to an overall conclusion that prioritizing control, support, and dignity in the lobby could be a valuable strategy for enhancing perceived safety among clients who have a history of trauma.

'Front line' safety might bring benefits, not only to the clients and employees in the immediate space, but also to providers. Research reveals that providers can experience strain when working with triggered clients. This suggests that providers

might find an easier time in facilitating services if clients avoid re-traumatization in the lobby. This might help to protect them from burnout and even improve the quality of the service, as providers experience less personal stress in their jobs.[112]

This introduces some practical considerations for agencies. Many non-profit organizations struggle for resources. Even health clinics, which have the ability to bill insurance, can only expect reimbursement for provider services. In this world of limited funding, just how much attention is going to the lobby? How much training and support are front line staff members receiving?

This study introduces justification for agencies to devote considerable focus to the lobby and its staff. The results represent why Trauma Informed Care (TIC) extends well beyond the clinical intervention. While investing in Trauma Sensitive Services is valuable, clients require comfort and safety from the moment they begin their relationship with the organization. They benefit when agencies make extra effort to enhance their sense of control, support, and dignity at this entry point. The interviews identify multiple strategies for organizations to consider:

- Develop a process for welcoming new clients and providing clear information for enrollment
- Ensure that lobby staff are trained in trauma, its impact on clients, and the value of prioritizing welcoming and respectful tones
- Ensure that lobby employees have adequate support from the agency to maintain a comfortable presence for the clients
- Establish reliable structures of communication between staff and clients, as well as between lobby staff and the rest of the agency

- Enhance 'choice' for the clients waiting in the lobby

- Implement a practice of preventative de-escalation

Many of these strategies can also extend beyond brick and mortar lobbies. Agencies often support various avenues of 'first contact.' People might reach out for services through an agency's phone directory or hotline. Ensuring clear delivery of information and support in these areas can help to maintain open access points for potential clients. There might also be a need for agencies to take extra care to support the employees, who work hotlines. Much like lobby staff, these staff be might susceptible to various stressors, as well as burn out, especially if they handle crisis calls.

While the conclusions from this study provide insight into the practice and value of Trauma Informed Care, they come with limitations. While interviews provide depth, they lack the breadth that comes with surveys. [113] It is difficult to ensure that the perspectives of 30 clients expand to the entire client population, especially considering that most of the participants volunteered through groups. Their candidness in providing both critique and praise of the agency suggests that the sampling did not skew towards uncharacteristically happy or angry clients. But, at the same time, these interviews might not reflect the views of new clients. They also cannot represent the potential clients who might have dropped out of services before enrolling.

One advantage to this project is that the study site shares multiple similarities with several organizations that interact with trauma. Its status as a health clinic brings parallels to various healthcare settings. The overlap between

homelessness and many types of trauma – military-related violence; domestic violence; child abuse – also means that the participants probably share similarities with clients at multiple organizations. These parallels suggest that the results can generalize to several different agencies.

That said, future projects are appropriate to verify the patterns and trends noted in this article. Little research has highlighted the lobby as a critical area for Trauma Informed Care. Longitudinal research at this site or elsewhere could measure how changes in the lobby impact consumer perspectives of safety. Similar assessments could also review if these conclusions apply within the lobbies of other agencies.

It would also be valuable to review the perceptions of employees who work in the lobby space. Their perspective could add valuable insight to the staff-related concerns that participants witnessed. Questions could inquire about their job stress, their interactions with clients, their sense of connection to the remainder of the agency, and their recommendations / strategies for improvement.

CONCLUSION

Overall, the results of this study provide insight into the details and logistics of what it means to be trauma informed. This research contributes evidence to the growing conversation of how agencies can practically adjust to their emerging awareness of trauma. Participants describe several concrete examples of features and experiences in the lobby that either enhanced or decreased their perceptions of control, support, and dignity. They explain how these features then influenced their overall sense of safety in agency. This pattern highlights the lobby as a space, which

deserves attention from organizations, which might otherwise forget or not recognize its importance.

Being trauma-informed means stepping out of the clinician's office and reviewing the entire experience within the agency (from the perspective of both staff and clients). This project can help practitioners, administrators, and researchers alike further understand why a holistic, agency-wide approach to safety is critical.

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ARTICLE 2

THE OVERLAP BETWEEN 'TRAUMA-INFORMED CARE' (TIC) AND THE WRAPAROUND MODEL

INTRODUCTION

This article explores the overlap between Trauma-Informed Care (TIC) and a 'wraparound' approach. 'Trauma-Informed Care' refers to a style of service delivery that addresses the potential impact of trauma on both clients and staff. [103, 104] I define 'wraparound' as a model of healthcare that considers the holistic needs of the client. Within its design, providers (physicians; social workers; educators; case managers; etc.) collaborate as equal parties within a multidisciplinary team. This team then partners with clients to create an individualized and strengths-based plan that tailors to their needs, culture, and preferences. [114]

This article explores how a 'wraparound' structure can help agencies engage with clients in a trauma-informed manner. I draw from the perspectives of people in homelessness, who receive services from a comprehensive health clinic. These interviews illustrate how the clinic's wraparound model contributes to the goals within Trauma Informed Care.

LITERATURE REVIEW

Trauma Informed Care

Acute vs. Complex Trauma

Trauma is a psychological reaction that can occur after a person experiences the threat of death, physical injury, sexual assault, and/or childhood neglect. The National Center for Child Traumatic Stress recognizes two categories – acute and complex. [4, 106]

Acute trauma stems from one-time encounters with violence – for instance, vehicular accidents, natural disaster, and isolated incidents of assault. Complex trauma can occur after repeated encounters with violence. In these situations, harm has become a 'normal' aspect of a person's lived experience. Examples include intimate partner violence, child abuse and neglect, slavery, war, and homelessness. Complex trauma tends to bring the most severe and lasting consequences. A phenomenon, known as historical trauma, indicates that these traumatic consequences can even span across generations.. [5-8]

Cycle of Trauma

Traumatic experiences can stimulate two psychological reactions that can then increase the risk of future harm and victimization: [10, 11]

1. **Loss of perceived safety**

After witnessing or directly experiencing harm, some individuals begin to perceive threats, even from objectively benign stimuli. This is an issue, especially among children who have grown up with violence. They can struggle to feel safe. Many have difficulty regulating their emotions when they feel threatened. In this situation, affected individuals can experience persistent anxiety. They might have limited ability to calm themselves down. As a result, their behavior can appear abnormal – hyper-vigilant / aggressive at one end of the spectrum and disconnected / spaced out at the other. [4, 5, 10-15]

Over time, continuous stress can interfere with higher brain functioning. [1, 11-14] Children, who grow up in abusive or neglectful homes, face a risk of long-term

challenges with their cognitive development. They can struggle with learning, abstract thinking, problem solving, attention, and future consideration. [4, 5, 10-15]

2. Loss of perceived control

People who have been through traumatic events can develop a perception of powerlessness. Many feel that they have limited control over their lives and their environments. [2, 3] This lack of perceived control and safety can stimulate high-risk behaviors. People might engage in substance abuse, risky sex, and criminal activity as strategies for survival, coping, and escape. Their loss of optimism and future orientation can further encourage harmful behavior, while limiting protective decision-making. This can create a continuous cycle of trauma: [4, 5, 10-15]
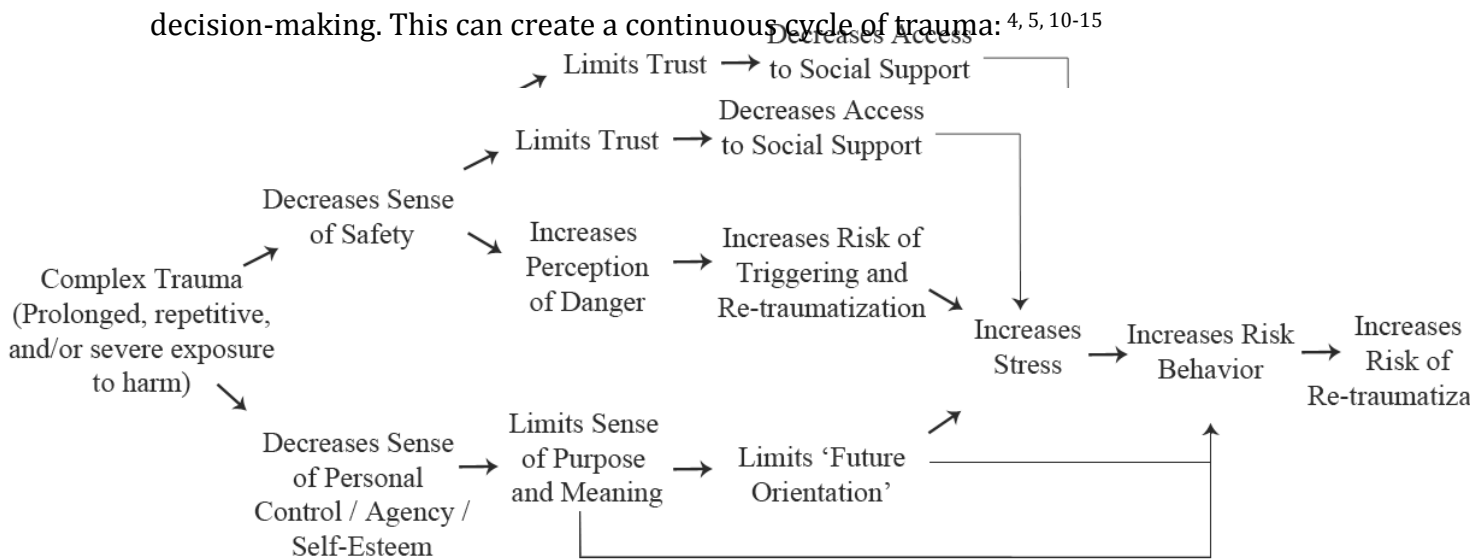
Trauma Informed Care (TIC)

Trauma Informed Care is an umbrella approach that addresses the impact of trauma on clients and staff. [22, 26, 43] Trauma-informed organizations attempt to create environments, policies, and programs to directly counter the effects of trauma. When engaging with clients, the primary goals of TIC involve: [23, 24, 30]

1. Decreasing the clients' risk of triggering and re-traumatization by enhancing their sense of safety and predictability within the organization

2. Enhancing opportunities to effectively address clients' trauma, in part by increasing their perceived control in their services, the agency and society.

<u>Wraparound Care</u>

'Wraparound' describes a style of healthcare that incorporates a holistic and individualized design. The basic idea is to create a collaborative and coordinated team of providers and stakeholders (physical, mental, behavioral health providers; client) to develop strengths-based, measurable, and tailored objectives for enhancing the client's wellbeing. [114]

This model originally emerged in the 1980s and 90s as a plan for addressing children with behavioral and emotional problems. It provided an alternative for children who might otherwise end up in residential treatment. Over the years since its original inception, the US National Wraparound Initiative has standardized 10 principles that collectively define a 'wraparound' structure: [115, 116]

1. Client / Family Voice and Choice

2. Team Based

3. Natural Supports

4. Collaboration

5. Community Based

6. Culturally Competent

7. Individualized

8. Strengths Based

9. Persistence

10. Outcome Based

Evaluative studies have found promising results. Research suggests that programs, which adhere closely to these principles, can significantly improve child behavior and functioning. They yield higher patient satisfaction than traditional and residential treatment models. [115, 117, 118]

As 'wraparound' continues to evolve as a popular model to assist children, its foundational principles are expanding into other areas of healthcare. The patient centered medical home (PCMH) is an emerging style of primary care that incorporates much of the 'wraparound' design.

PCMH carries over the basic philosophy of collaborative and individualized care. Healthcare providers adopt a holistic approach that considers the comprehensive needs of the patient. A team of providers, who represent different healthcare disciplines, take on the same case. These providers attempt to create a coordinated response that tailors to the needs of each patient. [119-122]

As with the research that supports wraparound programs for children, studies have found positive results in PCMH. Evaluations indicate that this style of primary care can improve patient experience, lower rates of clinician burnout, and enhance quality. PCMH clinics also bring lower or similar costs to non-PCMH clinics. [119-122]

Purpose of this article: Exploring the impact of a 'wraparound' approach on clients who experience homelessness and trauma

Within this paper, I explore the idea that a wraparound structure can enhance an agency's ability to practice Trauma-Informed Care. I draw from the perspectives of people in homelessness, who receive healthcare from a clinic that incorporates a PCMH design. Across a series of in-depth interviews, these participants describe how the clinics' wraparound structure has enhanced their sense of safety and predictability within the organization. They explain how it has improved the ability of providers to effectively address their trauma.

METHODS

The study site is a comprehensive health clinic that provides care for people in homelessness. The agency offers a range of services including primary care, mental health, addictions treatment, care management, and peer groups. In 2013, I partnered with an internal committee of staff and clients. Its purpose was to bring Trauma Informed Care to the clinic.

I came on to the project to assist with an agency-wide assessment. Our goal was to identify strengths, needs, barriers, and opportunities for improvement. [63, 64] We wanted to identify the ways in which the clinic's programming, policies and environments are currently trauma-informed. We were already interested in ways through which the clinic can improve its preparedness and sensitivity to the trauma impacting clients and staff.

While the overall project incorporated staff feedback, my role focused on the client perception. Clients have the most intimate knowledge regarding the clinics' features that enhance or detract from their sense of comfort and safety. Their perspective became especially valuable to the goals of the assessment.

I selected interviews as my primary strategy for data collection. This method encourages in-depth exploration and high levels of engagement between the researchers and participants.

Participants / Recruitment

I conducted all recruitment on site. My inclusion criteria required participants to have received at least one service from the clinic in the past calendar year, to be over 18 years old, and to demonstrate the cognitive ability for voluntary consent. The majority of participants (24) volunteered after hearing announcements in peer groups. Another 5 came into the project through a referral from a service provider. The last client learned about the opportunity through a posted flyer in one of the waiting areas.

A total of 30 clients successfully completed an interview. (4 had more to share after one session, and so participated in a 2nd session.) All participants reported histories of traumatic exposure and unstable housing. Many carried mental health diagnoses – primarily depression and anxiety. Some struggled with substance use. Their final demographic distribution closely matched the client population in age, gender and ethnicity:

	African American male	African American female	Caucasian male	Caucasian female	Native American male	Native American female	Total (age)
20s	3	1	0	0	0	0	4
30s	2	3	0	0	1	1	7
40s	4	2	1	0	0	0	7
50s	2	0	1	2	0	0	5
60s	4	0	3	0	0	0	7
Total (ethnicity)	15	6	5	2	1	1	30

Interview Content and Structure

Having acquired IRB approval from the Johns Hopkins Bloomberg School of Public Health, I collected data between November 2013 and January 2014. I personally facilitated interviews with 26 participants (both 1st and 2nd sessions), while a Research Assistant (RA) interviewed the remaining 4. All sessions occurred in a private room in the clinic (either an exam / interview room or a small conference room). Before asking questions, I went over the verbal consent process.

Once I began the interview, I inquired about the agency's performance in Trauma-Informed Care. My question guide concentrated on the following four categories:

9. Trauma awareness and preparedness
10. Establishing safety
11. Opportunities for clients to develop healthy relationships
12. Opportunities for clients to gain a sense of personal control and confidence [29, 30, 95-100]

While I made sure to review these topics, I was flexible in my interview style. I wanted the participants to largely set the direction of the discussion. In order to match the flow of the conversation, I mixed the order of my conversation prompts, removed redundant questions, and added appropriate probes. This made for rich dialogue, ranging from 35 to 115 minutes (with the average interview lasting 72 minutes).

Data Analysis

My initial codebook included a list of 'trauma informed' factors (e.g. how safe clients feel in the agency), followed by sub-codes that specified the client's perspective (e.g. safe; unsafe). I began data analysis by assigning these sub-codes to appropriate sections of text. [101]

As I continued this analysis, I adopted a more inductive and iterative approach. Based on the interview content, I adjusted and added codes. With every new and adjusted code, I added a definition to clarify the meaning. I also reviewed the linkages and overlaps between codes. This helped to develop my overall understanding of the data, while identifying major themes and patterns. [101]

Once I went through the majority of interviews, I shared my developed codebook with the RA. After I explained each code, she used this tool to analyze her 4 interviews. We then merged the transcripts to make a complete data set.

Member Checking / Peer Debriefing

Throughout this process of data analysis, I shared emerging themes and patterns with teams of clients and staff. Even though this audience mostly did not include interview participants, they offered a valuable perspective. Clients shared when they experienced or noticed similar things in the clinic. Staff shared when they saw similar patterns with their clients. All of the below results received support from clients, staff, or both. [102]

RESULTS

Overview

Interview themes illustrate the complex circumstances that can occur for people in homelessness. The majority of participants report multiple threats to their wellbeing. They explain that a lack of reliable housing has exacerbated their physical health problems. Many describe how a history of traumatic events has contributed to a range of mental health issues, including anxiety and post-traumatic stress, as well as a general sense of disorganization and strained attachment in their lives. They relay how their trauma might also have stimulated risk behavior, including substance abuse, violence, and risky sex.

Study themes indicate that the wraparound model could be a successful strategy for addressing this range of issues. The interviews identify three potentially beneficial aspects of this approach. Patterns suggest that the first two can enhance the clients' sense of accessibility, predictability, and safety when receiving services. The third can enhance the ability of providers to more effectively address the clients' trauma:

(1) Multi-disciplinary clinicians physically come together under one roof to create a 'one stop shop' of healthcare.

(2) Clients work consistently with the same provider(s).

(3) Practitioners invite the client to collaborate as a holistic team, in which all parties are equal. This team then creates a healthcare plan that brings the clients into a decision-making role and tailors to their needs.

It's worth noting that several models beyond wraparound incorporate some of these features. The goal of this paper is to represent why **all** three elements may be useful.

How does the 'one stop shop' enhance the accessibility and predictability of services?

Multiple interviews reveal the distance between needing care and receiving care that can exist for people in homelessness. Several participants describe three contributing factors:

(1) People might need services, but not know what services exist.

(2) People might know about services, but not know how to access them.

(3) People might initially enroll in services, but drop out before they begin to see improvement or build supportive relationships.

The majority of respondents assert that bringing multi-disciplinary providers together can help to close these gaps. Study patterns illustrate five ways in which the 'one stop shop' can make it easier for people to initially enroll in care and then remain engaged over the long-term.

1. Introducing clients to new services

Most of the interviews suggest that the 'all in one' structure can increase clients' awareness and interest in services that they had not previously considered. Many participants originally arrived at the clinic with particular interventions in mind – most often primary care. But, once engaged in the initial services, their providers recognized and recommended different types of care that could be useful.

Multiple respondents enrolled in additional services once they received this education. Others decided to 'try out' an intervention, simply because of its availability in the agency.

These participants describe how the 'one stop shop' eased the process of adding a new type of care. Rather than navigating through an alien set of procedures, guidelines, and schedules at another organization, they benefited from their familiarity with the agency and its enrollment process.

Some respondents cite additional advantages, including the ability to turn to current providers for guidance. With everybody working under one structure, clinicians have enhanced knowledge on how to guide their clients into additional care. Multiple participants offer examples where employees have directed them to appropriate staff, walked them through procedures, made internal referrals, or advocated for other departments to take on their case. They applaud this system as more effective and efficient than isolated services, which rely on external referrals across different organizations.

Several respondents express that these added services have played a large (and, in some cases, primary) role in improving their wellbeing. They convey that, without education from staff and the relative ease of enrollment, they would never have obtained this additional care by themselves.

2. Streamlining enrollment

Study patterns indicate that complex enrollment procedures can create a barrier between consumers and comprehensive care. A few participants describe their frustrations at the idea of 'starting over' (i.e. repeating the enrollment process) when they wish to include an additional service. These respondents have felt overwhelmed with the experience of added waits and repeated sets of identical

questions. They explain how this frustration can keep people from registering with more than one type of care.

The 'one stop shop' offers an opportunity to streamline this enrollment process. A couple of participants recommend for multi-disciplinary departments to adopt one standardized set of questions. As clients enroll in different services, providers can then build upon this foundational information by asking questions that relate to the specific discipline. But, the decreased repetition overall might ease the frustrations of adding a new type of care. Respondents assert that this could potentially increase a client's willingness to sign up for multiple services.

3. Overcoming challenges with mobility

Study patterns illustrate how limited mobility can threaten a person's ability to travel to a clinic. Several respondents describe how a large proportion of individuals in homelessness have little (if any) access to transportation. Many are physically restricted by illness or physical disability.

> *"I've been having all these issues with my legs. I'm able to walk about two blocks before I'm in serious pain. So, I maybe would be able to make it a bus. Then I have to sit down for a while. But if I have to stand on a bus, it puts more stress on my legs. It's ironic. Because I have this health problem that really needs medical attention. But the health problem itself is what's keeping me from getting to places where I can receive medical attention."*

Some interviews suggest that this problem can intensify when consumers require multiple types of care. (Most participants describe needing multiple services.) But, with different services scattered across a city, clients can struggle to travel between all of them. Before discovering the comprehensive clinic, many

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respondents gave up on their efforts to engage in more than one form of healthcare

– either preemptively, or after trying and experiencing too much difficulty.

> *"I like when they got everything in one building. I don't have to go across town over there. Across town over there. Across town over there. All in one building is good. I can get to know a few people; I get to know the staff. I see people coming and going. A couple of years ago, I had my mental health area over on the east side of [the city]. And my primary care doctor was on the west side. And there have been clashes of appointments. You know. Clashes of appointments have been scheduled, and I just couldn't – I couldn't do it. I could not do it. So, I had to admit to myself, I was unable to keep that up. Then I managed to get into here where everything was in the same place."*

The majority of participants report a drop in anxiety after enrolling in the

'one stop shop.' They describe the relief from no longer having to move across long

distances. For one client, the clinic takes her an hour to get to by bus. She explains

that her situation would be overwhelming, if not impossible, if she had to make

multiple trips to different locations. But, the 'all in one' structure allows her to

create a manageable schedule.

> *"I got to get 3 buses. I have to get - when I leave here today, I got to get 1 bus to go to the subway. Then I get the subway. And when I get off the subway, I get on a bus. So that's 3 different transportation that I have to get. It's time consuming. But at least I can come to one place for everything I need. Cause I just wouldn't be able to get to multiple places. Plus here, I can try to set all my appointments and groups for the same day. So I only have to make the trip once a week. It makes it a lot more manageable."*

4. **Helping clients keep track of appointments**

While many participants describe themselves as organized, several others

outline factors that can challenge their ability to maintain a reliable schedule:

mental health problems; substance addiction; feeling overwhelmed by their current

state of homelessness. Even in scenarios where travel is feasible, some respondents

admit to missing appointments because of subsequent struggles with organization.

These participants explain that their tendency to forget appointments can increase when they receive services across different agencies. According to the interviews, their schedules can become overwhelming when they have to keep track of multiple timetables across multiple organizations across multiple locations. They describe how appointments in one agency often end up interfering or overlapping with services at another.

The interviews illustrate how the 'one stop shop' can simplify this process. The majority of respondents describe the advantages of having only one agency and one location to keep track of. They can enter all of their services into one time card, which can then remind them of every upcoming session.

The repeated act of coming to the same place can also help clients to establish a predictable routine. Several participants explain that they are more likely to forget appointments when they encounter long gaps between services (for instance, with monthly sessions). But enrollment in multiple services can keep them in the habit of regularly coming to the agency. These respondents describe how, once this routine begins to stick, their reliability of arriving for any one service tends to increase.

5. Enhancing comfort

Interview patterns suggest that consumers can struggle with anxiety when they don't know their surrounding environment. By engaging with multiple services, people expose themselves consistently to the same physical space. They also have regular opportunities to develop relationships with both staff and other clients.

Many participants explain how this enhanced familiarity can decrease their stress and increase their enthusiasm about services.

Some respondents compare this to settings where they only receive one service. Since their visits are not as regular, they are not as quick to become familiar with the space. This seems to prolong the stress they experience when visiting these sites.

How does continuing with the same provider enhance the clients' sense of safety and comfort in services?

Interview patterns indicate that there is a strong connection between the quality of the provider-client relationship and the clients' overall satisfaction with services. The participants, who report having a positive and trusting connection with a clinician, tend to also report high satisfaction, high optimism, and high levels of engagement.

Several respondents compare this with services, where they have not developed a trusting relationship with a provider. In these contexts, most participants express relatively low satisfaction, low confidence levels, and limited investment in care. This pattern holds true across all disciplines: primary care; mental health; case management.

Study themes identify two factors that seem to most heavily influence a client's ability to create a strong relationship with staff:

(1) The empathy and trust-building skills of the individual employee(s)

(2) Repeated interaction between the client and the same employee(s)

While relationships do vary by individual provider, the practice of assigning clients to specific clinician(s) seems to enhance the opportunity for a strong connection. Several respondents describe how their repeated interactions with the same providers have helped them to build a valuable sense of familiarity. The interviews outline five positive outcomes that can develop from this enhanced familiarity.

1. **Reduces the risk of triggering**

Many respondents report a sense of perpetual anxiety within clinics and emergency rooms that do not assign clients to specific clinicians. They explain how, even after multiple visits, their experience remains unpredictable. They see someone new every time.

Their discomfort seems to increase during sensitive questioning and sensitive examinations. Multiple participants explain that short-term encounters only allow limited time for rapport building. In these contexts, clients must relay difficult, negative, or embarrassing information with employees they just met.

Several participants describe their anxiety that develops when they reveal this kind of sensitive information to new providers. They explain how this structure of service delivery can build up their stress rather than relieve it.

> *"We're talking about people in vulnerable situations. They want help. But nobody really wants to come here. There's a shame associated with this kind of stuff. Being in recovery… it's very emotional. And very stressful. And very depressing. And very untrusting. And everything else.*
>
> *So when you've got someone you don't know asking you all these personal questions… I know they need to get that information. But sometimes you're just not ready to share. You're not ready to put yourself out there right away. It's*

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just not a relaxing situation. So you end up feeling worse than if you had never gone in at all."

The practice of assigning clients to specific clinicians can help to combat this problem. This structure can give the consumer room to establish a foundation of comfort, before delving into more vulnerable topics. After getting to know the staff, most participants report much less anxiety in discussing sensitive materials and engaging in sensitive examinations. A few respondents further explain that providers might also use the time to learn about specific trauma-related triggers. This can help to minimize the possibility of re-traumatization.

> *"I questioned, when I first started, getting involved in this process with my doctors. I have a lot of stuff in my past that I don't like to share with just anyone. And there are a lot of people who can set me off, especially when I'm feeling vulnerable. So, when I started coming here, I wasn't sure what to make expect.*
>
> *But the more I came, the more comfortable I was talking to them. I got to know them. They got to know me. They learned how to keep me comfortable. How to not push my buttons. It got easy towards where I'm at now. It got a lot easier."*

2. Decreases frustration

Several interviews indicate that, when clients aren't assigned to specific providers, clinicians must spend extra time gathering information that picks up where the earlier appointment left off. Multiple participants describe these sessions as a consistent game of 'catch up.' They express frustration with the resulting potential for delays and confusion.

> *"It's really important for me to keep seeing my same doctor. I feel a lot more comfortable now. It got a lot easier, once I got to know him. I wasn't comfortable at first. It's like… I have to get to know you before information's flying.*
>
> *I'd rather see one person instead of seeing 5, 4 other people for this and that… I like it because he already knows everything about me. You know. Instead of seeing 7 or 8 other people – "who wrote this up? I don't know this." No…*

I went to this one clinic. And every time I went, I saw a different doctor. I'm like - well how in the world are they supposed to find out what they said – "well what do you need it for?" 'It's on the paper. Right there on the paper. You can see it.' So... you know, then 'well, what happened the last time you was here? What did the doctor write? What did the doctor do?' 'It's on the paper!'

You know, I'm like, "you asking me? You're the one taking over. So you the one who should know what I'm here for." But with one doctor, he remember what I'm here for. Or, when they say 'oh! ok, he already know what the problem is.'"

When visits involve sensitive information, this repetition can become harmful. One respondent describes the negative impact of repeatedly reviewing his history with new people.

"I don't like going to clinics where they keep transferring you to new people. Once I share information with one person, I don't want to go into it with somebody new.

Even if that new person might have the right answers, it brings back your wounds. Then you have to deal with it again and everything. "Oh I gotta go back and deal with this.' And that's not helpful. To me. That's not helpful to me. Keep going back. I want to move on from the state that I was in. Not keep going back."

Study patterns indicate that assignment to the same provider can help to resolve these issues. Clients are able pick up right where they left off, without backtracking or feeling stuck.

3. **Establishes a foundation of trust**

The majority of participants describe their relief once they have established a trusting relationship with a provider. The interviews indicate that 'trust' is a difficult but valuable factor for people in homelessness. Several respondents explain that their history of trauma has contributed to a tendency of hyper-vigilance and mistrust. But, at the same time, they convey a strong desire for safe relationships.

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"I don't trust a lot of people. But I got a lot of issues. I gotta talk to somebody. I'll feel more secure, knowing I've got my mental health in place. Cause I need a therapist. I need it. I need somebody to talk to and let some garbage out. I seen a lot of killings. I have nightmares about that.

But to open up my - and you know, the trust. Cause I don't talk to people about my life. You know. I'm ashamed - I'm ashamed of having hurt my family. Going to prison all those years. But that's some of the stuff I have to talk about. I have to get it out. I have to get it out."

The interviews illustrate how provider-client relationships can create a foundation of confidence and dignity. Many participants describe this relationship as the first time in a long time where they have not felt invisible.

"I was pretty beaten down. But when I got here, I started getting a glimmer of hope. Since the time that I've been coming to them, this place has always been about their business. That's getting you care, taking care –taking care of your well-being, seeing to it that you are – that you're goal-oriented and all that – you know, all the things – that you're a person again.

They're doing that to make you become a person all over again. 'Cause when you're – 'cause a lot of things – when you become homeless, you end up losing your dignity – you might lose your personality.

But you come in here and you start to feel visible again. And you find yourself again. There's some dignity back.

Just knowing that they take the time to recognize you as a person. To help you recognize yourself again as a person… I mean, I know it's their job. But then, at the same time, a few of these staff members really take time to get to know you. At that, to me, that's ok. It's all right. It's all right."

4. **Allows for Long-term planning / Tracking Progress**

Multiple participants explain that their assigned providers are helping them to develop long-term healthcare plans. Clients and practitioners mutually decide upon goals and map out incremental steps.

Several respondents contrast this experience with single encounters, which generally focus on immediate problems. The interviews suggest that, without an ongoing relationship, providers and clients only have room to tackle crisis issues.

Short-term visits tend to focus on plugging the emergency, without addressing underlying problems. In these contexts, the participants describe cycles of one crisis after another.

> *"I've been homeless for some time now. And I have all these problems that kept sending me to the emergency room. But all me and the doctors were doing was focusing on the crisis. Just handling the immediate problems. Trying to stop them from getting worse. But it never really solved the problem. Didn't end it or cure it.*
>
> *When you're doing that, you're really just managing the challenges. One after the other. It's too simplistic. It just keeps everything to a certain level. Maybe not getting worse. But not getting better either. So, from the healthcare side of things, what you really need to do is to build up a person by working with them over time. Figure out what they need, and set progressive goals for making it better. That way, maybe you can end the homelessness. Cure it."*

Most respondents agree that continuous care can enhance the ability of clinicians to guide clients out of this spiral. They illustrate how the conversation moves quickly beyond a problem-focused / emergency approach. Clients and clinicians can work together to identify strengths, set goals, and develop preventative and sustainable solutions.

Several respondents further explain that this approach can help consumers to recognize and track their progress. According to the interviews, providers and clients are able to observe and acknowledge both large and small successes. This tracking can potentially increase the motivation of both the consumer and clinician.

What to do when a provider leaves?

In systems that assign clients to specific clinicians, a change of providers can still occur for a variety of reasons – leaving the organization; changing positions; etc. In these circumstances, consumers typically switch to another practitioner.

Several participants describe how provider changeover can disrupt their progress, especially after a trustworthy relationship has developed. Leading up to termination, clients might panic or disengage, because they know the relationship is ending. When starting with new providers, multiple respondents express frustration at the idea of having to establish trust all over again.

> *"Depending on what the services is, or what's going on, I have trust issues. To open up and trust... In order to talk, you gotta trust the person you're talking to. Ok. If that's not there, I won't talk. My therapist at [another agency], I talk to her some. But I only go 50 yards. Because I know it ain't gonna last. They're cutting me off after January.*
>
> *So that's why I want to start with a counselor here. And once I develop a certain bond, I don't want to change to anybody else. I'd rather talk to someone that I can communicate with, and I can trust, rather than anybody else."*

To smooth out this transition, some participants recommend a strategy that temporarily overlaps the two providers. Clinicians can share a set number of sessions. This can allow the client to establish a new relationship while still in the comfort of the old one. It might also allow the entering provider to gather information that picks up where the exiting provider leaves off.

How does a multi-disciplinary / holistic / client-centered approach enhance the ability of providers to effectively address the clients' trauma?

Multiple respondents advocate for a structure in which multi-disciplinary practitioners work as a team. They highlight four advantages to the holistic approach – generally asserting that the 'whole is greater than the sum of its parts.'

1. **Increasing Comfort**

Study patterns indicate that clients tend to feel more comfortable when working with a team of coordinated individuals. Several participants assert that the team effort can create more positive outcomes than working with isolated clinicians. Even when participants are receiving multi-disciplinary services, they describe having more comfort and motivation when these services merge into a united effort.

> *"They're a team. It feels like somebody is looking out for me. You know, not only do I have one in my corner. I've got 4 in my corner. And we're all working towards the same thing. So you better believe I'm going to do my part."*

2. Increased Coordination

Most respondents describe how they entered services with a relatively high level of confusion and disorganization in their lives. Several applaud the team approach for helping to center them. One participant explains how the level of coordination among his providers directly has directly influenced his personal sense of coordination.

> *"It's amazing how they somehow intertwine them all together. But my whole team - they was all on the same page which unfortunately when you got two or three or four people working, sometimes they're not all on the same page which –but all of them seemed to be on the page. And the process was moving toward the same thing. Like I came in here, and I had no sense of where I was going or what I was doing. And I had all of this stuff in me.*
>
> *But I was able to work with all of that stuff that I had with me. But I was also given a goal, you know, that I could start to achieve in the beginning with the treatment plan*
>
> *When I was working as a drug counselor at this other hospital, I worked on the team. And it was like three or four different teams and there was like four or five. And sometimes one didn't know what the other was doing and so the client is confused because we're all confused. But I never felt that way with my team here. I never felt that with them."*

3. Increased Efficiency

The interviews suggest that the holistic approach can increase efficiency. By working together, multi-disciplinary providers may be more efficient in addressing preventative, emergency, and long-term health concerns for clients.

"One day I had an appointment with [my counselor] and my leg had gotten swollen. It swelled and it wasn't going down overnight. So I didn't have an appointment with my primary care doctor for another two or three weeks. So [my counselor] called on the medical side and a nurse came and they were able to get me in at the end of my doctor's day. So she looked at my leg and said, "This isn't going down. It doesn't look good." And she wrote a voucher for a cab to go to [the hospital] and to get me into the emergency department. That visit put me in the hospital for two days and out of that, I was able to get [appointments with different surgeons and specialists]

[...]I hadn't had a mammogram in a while and I hadn't had a colonoscopy and I hadn't had the GYN services. So [my primary care doctor here] was able to schedule all of that and the help in scheduling the colonoscopy was something I'm forever indebted to her because they found a polyp and they were pre-cancer cells, slow-growing pre-cancer cells and polyps and they just snipped it out.

There's some new computer system. Here, [my counselor] can send notes to [my psychiatrist], so he can be aware of some things from the mental health perspective. And [my primary care doctor has access through a computer system that the doctors have at [the hospital]. Because there was another concern because I had blood clots that there might be something more going on. And I had inflamed lymph nodes, so she was able to get a referral to the [specialist] and different doctors down there.

The main thing for me and I keep telling people that this is an odd thing to say that it was kind of a blessing in disguise being homeless because I would have never been able to coordinate all the services that I've had here on my own."

4. Addresses the Complexity of Trauma

The majority of participants highlight the impact of trauma on their physical, mental, and behavioral health. The interviews illustrate how these issues can be tangled and complex. Several respondents describe situations where one problem flows into another.

"I had a trauma happen to me when I was five years old -sexual abuse, and I've never dealt with it; from a family member, which was my sister. I've never dealt with it. I always used the drugs. I feel as I got older, I used the drugs to like just erase it.

I really want to come off the drugs. Cause they're the reason I'm homeless. But right now, my living condition, me being homeless, really not knowing where I'm going to stay at night -not stable, I'm scared. Like some days I get real depressed. The psychiatrist talked to me about the depression. I've got to see her in two weeks. Some days I get real depressed and that's been my pattern in life. When I get real scared or real depressed, I used the drug as a crutch."

Study patterns indicate that individual providers might only have a snapshot of the overall situation when they address these issues separately. A number of participants assert that this approach can fall short of its intended goal to create sustainable solutions. They explain how it can create a scenario where providers are constantly trouble-shooting.

"I think it would be pretty important that my different providers talk to each other. You know for them to know where the individual is at. Because of course the physical ailments really affects your mental health. I have sight issues, teeth issues, and diabetes. That stuff works on your mind. And you've got to relate the services. Because this physical stuff is on my brain.

Or let's say that you injured your foot because you were upset and kicked a wall? Even if someone fixed your foot, it might get broken again. Because you didn't address the mental health issue.

You've got to talk to each other and seeing where the person is actually at. You've got to tie the physical, mental, emotional health type of things together in order to really know the person - you know really where they're at and what needs to be done."

Many respondents explain that multi-disciplinary collaboration can offer providers a greater understanding of the situation. By working together, clinicians are able to craft a big picture, rather than operating with only a fraction of information. This can enhance the team's ability to develop long-term sustainable and prevention-based solutions.

5. **Builds confidence among clients by bringing them into a decision-making role**

Several interviews illustrate how wraparound model encourages collaborative partnership between clients and providers. Within this structure, staff members educate clients to help them create feasible objectives. They provide guidance to break down larger goals into manageable steps. But ultimately, it is the client who determines direction of treatment or therapy.

Study patterns indicate that this strategy can build confidence among consumers. The majority of participants express satisfaction when they perceive that their providers respect their skills and knowledge. They feel more confident, because clinicians acknowledge them as experts over their own lives.

Some respondents also describe how their provider has given them more and more responsibility to complete healthcare goals. These participants explain how this strategy has increased their ownership over the process – thereby increasing their enthusiasm and adherence to healthcare guidelines.

DISCUSSION

Study patterns illustrate several ways in which a wraparound design can help agencies maintain a trauma-informed approach with clients. The interviews outline points at which 'wraparound' and 'Trauma-Informed Care' overlap:

- A comprehensive care structure can increase clients' access to services, while enhancing their sense of predictability and safety.

- Continuous care with the same providers introduces a valuable opportunity for relationship-building

    o This can reduce the risk of triggering and discomfort for clients who disclose sensitive information.

    o It can also increase the provider's opportunity to create a long-term, sustainable, and preventative plan to enhance the client's wellbeing.

- Enhanced communication and coordination between providers can increase understanding of the client's complex trauma

- Collaborative partnership between providers and clients can increased adherence, empowerment, and a sense of ownership among clients

These observations demonstrate an important note about Trauma-Informed Care (TIC). The literature clarifies a distinction between TIC (an agency-wide approach) and Trauma-Sensitive Services (clinical intervention). This emerges as a point of confusion for agencies that mistakenly isolate TIC to a demand for clinical interventions to address trauma (Cognitive Behavioral Therapy; Eye Movement Desensitization and Reprocessing). While TIC supports the use of these therapies, it has a broader scope. The goal is to consider the entire culture within an organization. TIC aims to create structures that enhance overall trauma preparedness and sensitivity. In this light, wraparound becomes a prominent option for agencies that aim to integrate TIC into their overall design.

This brings up interesting implications for direct service agencies, policy makers, and funders. For true multi-disciplinary collaboration to exist, these systems must first consider some barriers and limitations:

- Much of our current system (physical health, mental health, social service) exists in siloes. Funding and payer structures trend to support one service / program at a time. This often means that, instead of creating a streamlined structure, organizations must sustain separate billing. This creates the potential for heavy administrative overhead.

- Historically, physical health has received priority over mental health needs. Only recently has research indicated a link between the two – calling for more equal attention to both physical and mental health. However, the historical preference towards physical health continues to display itself in service structures. Even the PCMH specifies a 'physician-led team' that inherently prioritizes the physical professional over the remaining team. True collaboration would involve the equal treatment of all parties – allowing for more of a holistic approach.

- When considering the issue of homelessness, wraparound does not offer a sufficient replacement for housing. While clients would benefit from integration of wraparound services as a supplement to 'Housing First' policy, wraparound cannot stand alone as an all-encompassing solution to homelessness.

For a wraparound model to establish itself firmly as a mainstream model in healthcare delivery, decision-makers must consider these obstacles and limitations. This might result in tweaks to devise streamlined billing across funding and payer structures to encourage collaborative and holistic care. It might require hospitals to raise the status of mental health practitioners as equal players in determining a

patient's needs. It might require cities to support 'Housing First' policy in addition to wraparound services. Overall, this article suggests a need for substantial restructuring of our current healthcare and social systems to best support a client-centered, holistic, and wraparound approach for people in homelessness.

While this recommendation introduces an interesting debate for the future of healthcare, there are some limitations to consider when interpreting these study results and conclusions. Although interviews create an opportunity for in-depth research, they do not bring the breadth that surveys allow. A group of 30 participants might not represent the entire clinic population. The client population of the clinic also might not represent the total population of those who have experienced trauma.

As a counterpoint, the study site provides services to a population that has experienced multiple forms of trauma. The literature demonstrates how people in homelessness report high rates of childhood abuse, physical assault, domestic violence, incarceration, and military-related violence. [78, 81-86, 123] This overlap suggests that the clinic population likely shares similarities with clients at other agencies that work with vulnerable and trauma-impacted populations – indicating that results might generalize to outside organizations.

Another detail of the study design brings both a benefit and limitation to the research. The high level of engagement between researcher and participant can help participants feel more connected to the study and to share more in-depth detail. But it introduces the possibility of response / social acceptability bias. Client might not want to disappoint the researcher. They might provide feedback that exclusively

makes the organization look good. Study results included a mixture of positive feedback and criticism – suggesting that participants were not biased in their review. But this does not discount the bias that might develop from the researcher's heavy influence on the data. Another facilitator might elicit different responses from participants. Another data analyst might interpret different patterns and themes from the data. This project has included some strategies to offset these concerns – inclusion of an RA who facilitated and analyzed a small proportion of interviews (and came away with similar patterns and themes); member checking with staff and clients.

But, even with these efforts in place, this study's conclusions would benefit from validation in further research. Future projects might explore the impact of a wraparound structure in other agencies that address clients with trauma. Studies could take on an observational design, or – if given the opportunity – even a pre / post-test design. Their findings could help to confirm or deny the results presented in this article.

CONCLUSION

Overall, this research suggests promising conclusions. As agencies increasingly understand *why* they might consider a trauma-informed approach, they are looking for sustainable and structural strategies to best engage with clients. Research has already established 'wraparound' as a model that enhances the overall patient experience and wellbeing. This study indicates that wraparound's benefits might also improve clients' perception of safety, as well as their opportunity for

trauma recovery. Leaders can therefore consider this model of healthcare as a concrete strategy for operationalizing 'Trauma Informed Care.'

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ARTICLE 3:

THE VALUE OF 'CLIENT EMPOWERMENT' AS A STRATEGY FOR ENHANCING RESILIENCE AND TRAUMA RECOVERY

INTRODUCTION

In recent years, researchers, policy-makers, and direct service organizations have developed an emerging awareness of psychological trauma and its impact on health, wellbeing, and behavior. As practitioners and programs adapt to this knowledge, there is demand for interventions that effectively address trauma. Much of the research has focused on clinical individual therapies, such as Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR), as potential treatment for individuals who have encountered harmful events. [124, 125]

This article expands beyond specific clinical models. I review the concept of 'client empowerment' as a general strategy for enhancing resilience and promoting trauma recovery. The literature defines 'empowerment' as the process through which individuals, groups, and communities gain control of their surroundings. [126, 127] I use the term 'client empowerment' to describe interventions that encourage people to take on active roles within agencies. Rather than strictly receiving services, clients can pursue tasks and responsibilities to improve both their situation and that of others.

This type of intervention can include clinical relationships that encourage clients to adopt leading roles in improving their personal wellbeing. It can also refer to non-clinical settings where people look beyond their individual situations and assume more interactive, 'helping,' and task-oriented roles. Such opportunities

might involve peer groups, peer mentorship, engagement in agency-growth initiatives, and participation in advocacy / community mobilization efforts.

This paper explores how these interventions, which emphasize 'client empowerment,' can enhance a participant's resilience against trauma. It reviews perspectives from people in homelessness, who receive services at a comprehensive health clinic. Across a series of interviews, participants identify 'client empowerment' as a consistent theme among the interventions that have most effectively assisted their recovery from trauma.

Trauma

Trauma is a stress reaction that can occur after an event, which involves the threat of death, physical harm, and / or sexual assault. The literature identifies two kinds of traumatic exposure – acute and chronic. Acute events are typically short-lived. They involve one-time incidents, occurring at specific times and places. These include public shootings, natural disasters, vehicular accidents, and isolated physical and sexual assault. [4]

By contrast, complex trauma results from events occur repeatedly over a long period of time. [4] In some cases, acute trauma can trigger behavioral change that eventually leads to complex trauma. Events include child abuse and neglect, intimate partner violence, prolonged exposure to community violence, slavery, and war. [4] This perpetual exposure to violence tends to bring the most extreme and long-lasting consequences, with problems even spanning across generations. [5-8]

Impact of Complex Trauma

Several articles have documented the impact of 'complex trauma' on a person's self-worth and sense of value. Feelings of self-blame, shame, guilt, and low self-esteem are common. Many people begin to view the world as an unsafe place that they feel powerless to control. They can struggle to feel hopeful, generally perceiving themselves as 'damaged.' Impacted individuals often live from moment-to-moment. Many remain in a crisis state, without optimism or even consideration for the future. [10, 11]

This helps to explain why high risk-behaviors are relatively prevalent among individuals who have experienced complex trauma. As an attempt at coping, people often engage in self-harm and substance abuse. The lack of 'future orientation' can promote unsafe sex, violent interactions, and illegal behavior. Feelings of 'powerlessness' can also increase the risk of re-victimization. [10, 11]

The below chart provides an illustration of trauma's cyclical pattern. For some people, this trend eventually leads to a state of homelessness:
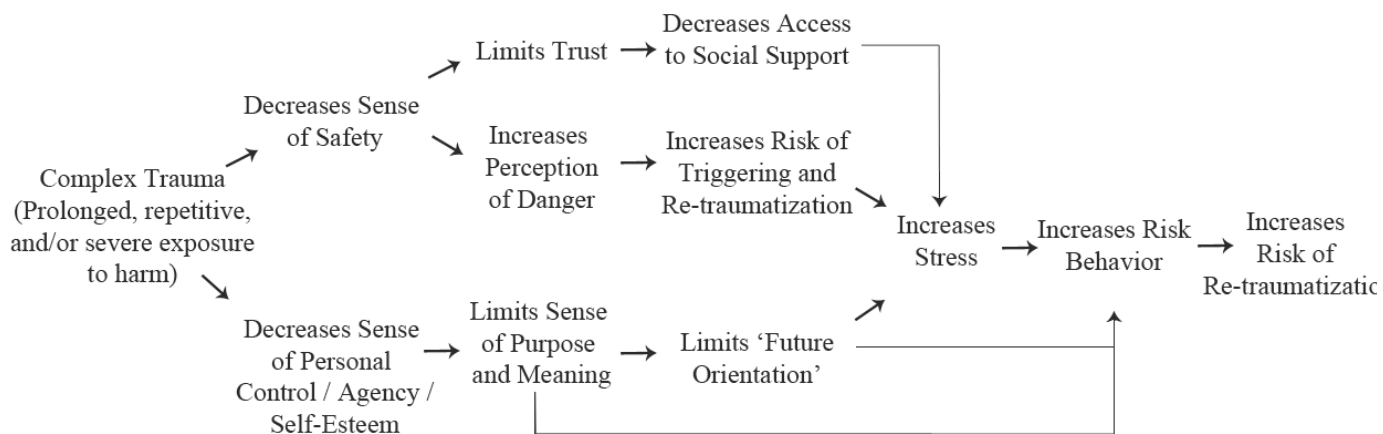
Trauma as a Precedent to Homelessness

People in homelessness report substantial trauma across their histories – often starting because of childhood abuse and neglect. [77] Research documents high

rates of caretaker abuse (physical; sexual; emotional) among run-away youth. [78, 79]

Women commonly describe how childhood adversity, followed by intimate partner

violence, has contributed to their homelessness. [80] Childhood trauma is also

associated with higher rates of mental health problems among men in homelessness.
[81]

These findings complement the results of the Adverse Childhood Events

(ACE) study – one of the first projects to document the impact of childhood stress on

long-term health and wellbeing. In a partnership between the CDC and Kaiser

Permanente, researchers surveyed 17,000 members of the HMO. Participants

answered 10 'yes or no' questions about their early exposure to abuse, neglect,

poverty, parental separation, witnessing intimate partner violence, and household

members with a history of mental illness, substance abuse, or incarceration.

Participants who responded 'yes' to 4 or more questions reported significantly

higher health risks in adulthood. When compared to peers who responded 'no' to all

questions, these individuals were:

- 2x more likely to smoke

- 2x more likely to have a cancer diagnosis

- 2x more likely to have heart disease

- 4x more likely to have emphysema or chronic bronchitis

- 6x more likely to report sex before age 15

- 7x more likely to have alcoholism

- 10x more likely to have injected street drugs

- 12x more likely to have attempted suicide [9]

This association between early trauma and future wellbeing offers context to explain the high rates of childhood adversity that exist for people in homelessness.

Exposure to violence in adulthood is also a contributing factor. Research has documented high rates of homelessness, particularly among veterans. Female veterans, for instance, are nearly four times more likely than non-veteran women to end up homeless. [84, 128] Vets point to childhood adversity, military-related trauma, post-military abuse and adversity, and post-military mental health concerns as the primary reasons for their vulnerability. [128]

Trauma as a Result of Homelessness

Once people enter homelessness, their risk of violence, abuse, and neglect increases significantly. The literature estimates that between ¼ to over ½ of individuals have experienced victimization after losing stable housing. This compares to 2% of the general population. [85] Women and girls are particularly vulnerable to sexual assault and exploitation. [87] One New York based study found that women in a shelter were "106 times more likely to be raped, 41 times more likely to be robbed, and 15 times more likely to be assaulted than housed African American women." [86]

Homelessness itself is a traumatic experience. Circumstances typically involve a lack of safety, stability, and control. People might be uncertain of where they will sleep or eat. They become exposed to dangerous and drug-prevalent environments. These factors, combined with isolation and stigma, can exacerbate

mental health and addiction issues. The result is a cyclical relationship (Trauma →

Homelessness → Trauma) that often requires intervention to break. [30]

Resilience

But, what accounts for the people who don't experience trauma after a

dangerous event? What explains the evidence of strength and recovery that is

apparent among many who have experienced or currently experience trauma? An

increasing amount of literature is exploring 'resilience' as a key component in

protection and healing. [18]

When understanding resilience, it's helpful to remember that 'trauma' is the

psychological reaction to a harmful event – not the event itself. [4] This distinction is

important, because not every person who encounters violence will necessarily

experience trauma. Psychological consequences can vary in severity and longevity.

Although some people experience harsh and long-lasting problems, others recover

healthfully without much long-term impact. [19, 20]

'Resilience' helps to explain this difference. The term refers to a person's

ability to protect their mental health through potentially traumatic events. [20, 21]

Current evidence identifies four factors that can influence resilience:

↑ Level of Exposure to Danger • Severity and repetition of a violent event • Lifetime load of harmful events	↓ resilience
Demographic Factors • ↓ Age of initial harmful exposure • ↓ Income / SES	↓ resilience

• ↓ Education	
↑ Social Support and resources • Connection, bonding, and social interaction with family, community, and fellow survivors • Positive emotion and humor / laughter • Knowledge and use of protective coping skills	↑ resilience
↑ Hardiness • Self-esteem and self-confidence • Belief that one can influence one's surroundings • Having a meaningful purpose in life • Belief that one can learn and grow from positive and negative experiences • Ability to make meaning from the harmful experience and life afterwards	↑ resilience

19, 20

Research has linked these 'resilient' characteristics to a reduced risk of the short and long term problems that can follow a dangerous event (depression, anxiety, PTSD-related symptoms, etc.). [21] This helps to explain why some people display few symptoms while others experience continuous crisis. It also sheds light on potential pathways of recovery for those who have encountered violence.

'Client empowerment' as a strategy for increasing resilience?

The primary purpose of this article is to illustrate what programs can look like when their goal is to enhance clients' resilience against trauma. Agencies have no control over clients' past exposure to violence, or their demographic

characteristics at the time of their traumatic experience. But, there might be opportunities to influence social support and 'hardiness.' So, what kinds of programming could be effective at enhancing these two areas? What is feasible in an outpatient setting? And what is the ultimate impact of these strategies on clients' resilience against current and future trauma?

Four Vehicles for 'Client Empowerment'

Within this article, I explore the idea of 'empowerment' as a central tool for trauma intervention. Prominent organizations, such as the National Center for Trauma Informed Care, have long promoted this concept as a key strategy for building resilience. [103] But even with this support, there is a gap in research studies and empirical evidence.

At best, the literature identifies specific treatment models that intertwine the idea of empowerment. [100, 129, 130] While these models have promising results, many organizations would prefer to design their own programs to ensure that they are both feasible and appropriate to the setting. So, where does this leave an organization that is interested in the idea of empowerment, but unable or unwilling to adopt a prescribed treatment model?

The goal of this article is to identify a variety of strategies that are specific enough to provide practical guidance, but general enough to allow for tailoring and adaptation. A second goal is then to explore the impact of each intervention on the clients' sense of resilience.

Within this article, I identify four categories of intervention that prioritize the idea of empowerment:

(1) 'Empowerment with individual providers'	This first area has received attention as a promising approach in physical and mental health care. 'Patient-centered care' is a model of healthcare that encourages empathetic and collaborative partnerships between clinicians and clients. While clinicians provide guidance, clients set the direction of therapy. Multiple articles illustrate how this style of treatment improves client satisfaction, adherence, and outcomes. [131-134]
(2) 'Empowerment among peers'	Peer groups have long been a staple intervention across physical, mental, and behavioral health agencies. Most of the literature promotes peer work as effective at providing social support, enhancing hope and optimism, and increasing self-esteem. [135, 136]
(3) 'Empowerment within the agency'	The literature around 'Community Based Participatory Research' (CBPR) provides a foundation of support for this third strategy. CBPR emphasizes a partnership approach to research. Impacted communities adopt a primary role in the determining the study design, data collection, and recommendations. [137] This method can enhance the relevance and quality of data, reduce gaps of power between communities and researchers, and improve the health and wellbeing of participants. [138] While CBPR has more prominence in academia, agencies can consider this model for practical purposes. Strategies include the use of Client Advisory Boards (CABs), staff-client task forces, client membership on Boards of Directors, and internal evaluations that incorporate client feedback (surveys; focus groups; interviews). [139-141]
(4) 'Empowerment with society'	According to the 'empowerment' literature, people can enhance their personal wellbeing by becoming involved in the larger social and political environment. [126, 127] This theory translates successfully into practice, particularly in the area of female empowerment. In the 1990s, women's empowerment programs began developing across the globe. These interventions have focused largely on community mobilization, advocacy, and micro-finance. [142]

While the available literature provides a convincing amount of support for all four interventions, only a few articles explore these strategies from the perspective of trauma recovery. The goal of this article is to review the impact of each intervention on resilience.

I draw my evidence directly from the perspectives of people who have experienced severe trauma. Study participants are clients involved in one (or more) of the four 'empowerment' interventions at a homeless health clinic. They describe how these experiences have enhanced their perceived levels of social support, hardiness, and overall resilience against current and future trauma.

METHODS

Study Site

The study site is a healthcare clinic that serves people in homelessness. This clinic offers comprehensive services including primary care, mental health therapy, addiction treatment, dentistry, case management, and peer groups.

Organizational Assessment

In 2013, I partnered with an internal committee of staff and clients. Their purpose was to enhance the clinic's awareness, sensitivity, and responsiveness to the traumas that impact both staff and clients.

I joined project to assist in the design and facilitation of an organizational assessment. The goal was to discover, map out, and address current strengths and needs within the agency. [63, 64] More specifically, the committee wanted to know:

(1) How well is the clinic currently equipped to respond to and protect against

staff and client trauma?

(2) In what ways can the clinic strengthen and improve its approach to trauma?

By answering these questions, stakeholders could develop strategies to overcome

barriers and expand positive practices within the clinic.[63, 64]

Qualitative Methods: In-Depth Interviews

A primary component of this assessment involved gathering the clients'

perspective. Clients have the most intimate knowledge of both their trauma and the

ways in which the agency has exacerbated and/or mitigated this stress. Their

viewpoint was therefore critical to the success of this project.

I selected in-depth interviews as my primary strategy for data collection.

This method allows for rich exploration of the clients' perspective, with a level of

depth that is not feasible in a survey.[74] Considering the low literacy rates that can

exist for people in homelessness, it was also helpful to select a method that didn't

require reading.[90]

One of the biggest advantages to this design was that it gave the participants

a voice in determining the topics that were most valuable to them. Surveys are

limited to the questions that the researchers deem important. By contrast,

interviews use open-ended questions to allow participants to direct the

conversation.[74] Rather than solely giving feedback to current programming,

participants had the opportunity to brainstorm changes and improvements to the

agency. This use of the client voice embraces the empowerment perspective, which

is central to this article.[70]

Participants / Recruitment

Considering that transience is common among people in homelessness, I used convenience sampling with a set list of inclusion / exclusion criteria. [94] All participants had to have received at least one service from the clinic within the past year. To ensure voluntary consent, I did not include minors (under 18 years old). I also required that participants had the cognitive ability to agree to the interview.

Because all participants were active clients of the clinic, I conducted recruitment on site. Twenty-four participants volunteered through announcements that I made in peer groups. One came on board after seeing a flyer in the waiting area. Another five volunteered through a direct referral from an individual provider. By the end of data collection, a total of thirty participants had successfully completed an interview. Four of these respondents completed a second interview (primarily because they wanted to talk more after the first session).

The below table represents the distribution of ethnicity, age, and gender among the participants. Even though I used convenience sampling, this final distribution closely matches the demographics of the clinic population:

	African American male	African American female	Caucasian male	Caucasian female	Native American male	Native American female	Total (age)
20s	3	1	0	0	0	0	4
30s	2	3	0	0	1	1	7
40s	4	2	1	0	0	0	7
50s	2	0	1	2	0	0	5
60s	4	0	3	0	0	0	7
Total (ethnicity)	15	6	5	2	1	1	30

Data Collection

After acquiring IRB approval, I collected data between November 2013 and January 2014. I facilitated 26 of the first-interviews, as well the 4 second-interviews. A research assistant (RA) recruited and facilitated sessions with the remaining 4 participants.

All interviews occurred in a private room at the clinic. Before beginning each session, I walked the participants through a consent form that described the purpose of the research, their right to confidentiality, and the voluntary nature of the study. I also clarified that participants would not receive payment or material incentive. To maximize anonymity, I gathered verbal instead of signed consent. As a final step in this process, I offered to answer questions and requested permission to audio record.

Interview Content / Structure

I developed my interview guide after reading articles, which provide guidance to organizations that are attempting to be trauma-informed. [24, 25, 30] Based on this literature, my questions inquired primarily about the agency's performance around:

13. Trauma awareness and preparedness

14. Establishing safety

15. Opportunities for clients to develop healthy relationships

16. Opportunities for clients to gain a sense of personal control and confidence [24, 25, 30]

Because I wanted the participants to direct the conversation, I was flexible with my interview style. While I made sure to cover the primary topics, I tailored my questions to match the flow of each discussion. I mixed the order of my questions, removed redundant questions, and added appropriate probes. The result made for a richer discussion than would have occurred in a firmly structured session. Interviews ranged from 35 to 115 minutes, with the average lasting 72 minutes.

Data Analysis

Before reviewing the data, I used the 'trauma-informed' literature to develop my original codebook. I designed these initial codes to locate interview patterns that suggested how the agency was performing. The original coding structure included a list of factors that the literature has deemed relevant to a trauma-informed approach (e.g. how safe the client feels in the agency), followed by sub-codes that specified the client's perspective (e.g. safe; unsafe). [24, 25, 30] I then assigned these sub-codes to the appropriate segments of texts. [101]

Although I began my analysis in this deductive manner, I adopted a more inductive and iterative strategy as I continued my review of the data. [143] I tailored my original codes and added themes that emerged directly from the interviews. With each new and altered code, I created a short description to clarify its meaning and relevance to the data. As a final step in the analysis, I reviewed the linkages and overlap between the emerging themes. This process helped to identify larger patterns within the data. [101]

Once I had reviewed the majority of my interviews (and had sufficiently developed and tailored my codes), I discussed my codebook with the RA. She then

used this tool to analyze her 4 interviews. We then brought our codes together for the complete data set.

Member Checking / Peer Debriefing

Throughout this process of analysis, I discussed the emerging results with groups of staff, clients, and former clients. Although most of the clients and former clients were non-participants, their feedback was especially valuable. They expressed when they felt that my findings provided an accurate description of the reality. Staff members also had an opportunity to share if they noticed similar patterns / heard similar things from clients. This audience agreed with all of the patterns and themes presented in this article. [102]

RESULTS

Overview

Interview patterns suggest that client empowerment could indeed be a valuable tool in trauma recovery. The majority of participants explain that their homelessness, often combined with other stressful events, has contributed to several risks in their physical, mental, and behavioral health. They describe how these experiences have disrupted their confidence, self-esteem, and sense of identity. Most respondents recount their struggles with re-traumatization and cyclical crises.

To combat this situation, the majority of interviews illustrate the benefits of helping clients enhance their perceived control both over their personal lives and their surrounding environments. In many ways, this approach is the opposite of trauma. The results illustrate how 'client empowerment' interventions can help

clients improve their perceived levels of strength, meaning, and purpose in their lives.

Most participants explain how these opportunities have helped them to improve their sense of identity and break their cycle of trauma. As a result, they've learned to adopt healthy coping skills, sustain protective behaviors, and build personal resources of emotional support.

This article breaks down the participants' perspectives on the four different levels of empowerment – with individual providers; with peers; with the agency; and with society. It outlines the potential benefits of each approach.

Empowerment with Individual Providers: Relationship-Based Care and Collaborative Partnership

When discussing one-on-one interventions, almost half of participants emphasize their appreciation for their providers' effort to build collaborative relationships. They advocate for this kind of 'team' approach. While clinicians offer support, education, and advocacy, they also tailor services to the consumer's preferences, desires, and expertise. Clients, in turn, adopt an increasing level of responsibility in identifying their goals and performing tasks to achieve each step.

Multiple participants assert that this strategy has encouraged them to develop a sense of ownership over their healthcare. These respondents describe the sense of accomplishment they feel when they successfully achieve goals. They convey how this experience has increased their adherence to health plans, as well their optimism about their future wellbeing.

> *"When I first came in here, I was a mess. I really didn't feel like I could get control of any part of my life. But my team here… they were great. Worked with me step by step.*

Really helped me break down goals that seemed overwhelming at first. They helped me see the steps that I could just take into one at a time. It's not like they were just telling me what to do. It was my decisions. My goals. My actions. They were my guides. My advocates. But the responsibility was mine. Like training for a race or something, and they were the coaches. They didn't do it for me. You gotta do it for yourself. But they provided the structure, education and motivation to make at all manageable. Now I just feel a lot more confident. A lot more optimistic about my future. A lot more in control. I feel like I'm gonna be ok for the first time in a long time."

Empowerment among Peers: Groups

Half of the respondents highlight the role of groups as a valuable opportunity to take initiative in their surroundings. These interviews identify nine primary benefits that can emerge from group settings:

1. **Increases Structure – 'Something to fill the day.'**

Several participants define 'boredom' as a major stressor in homelessness. They explain that a lack of activity can trigger anxiety, as well as unhealthy coping. Some clients describe how boredom alone can contribute to substance abuse.

According to the interviews, limited activity can also exacerbate a general sense of disorganization for individuals. Without a set structure, people have few markers on which to track the day.

Multiple participants outline the advantages of being able to fill these empty hours with regularly scheduled groups. They illustrate how sessions can provide an escape from the boredom and fatigue of homelessness. Having something to do can distract from unhealthy attempts at coping.

Some participants explain that groups can also help to build a level of structure in their lives. They describe how their schedules become more predictable

as they participate in more sessions. This can create a level of stability, which can help to decrease stress.

> *"The consistent schedule of the groups is real good. Because when you're out –when you're living in the street or you're homeless, you have very little to no structure except, you know, "At this time of day I gotta be back standing at this shelter if I want a bed." But the rest of your day is completely unstructured. So to know, "Okay, I'm going to [the agency] at 10:00, I got this group at 12:00, I have lunch at 1:00, I have this group." That structure really helps."*

2. Relieves Isolation

Study patterns identify isolation as another key stressor of homelessness. Multiple participants describe their sense of separation from community. They define groups as an opportunity to actively (and regularly) engage with others who have experienced similar situations. According to the interviews, this can help to enhance feelings of 'belongingness,' while relieving feelings of isolation and invisibility in society.

> *"At one time, I was… I was kind of like a sick, quiet kind of person. You know what I mean? And then once I came in here, I got to running my mouth, you know. [laughter] You know, it used to take alcohol for me to start running my mouth and opening up and everything. But once I got here around my peers then I don't need alcohol to open and run my mouth and say what I got to say and just be who I am, you know what I mean. So that's what helps me right there. Being in touch with, um, sober people and being in touch with good people, you know what I mean. These people up here got in touch with people who been through the same thing you been through, you know. And finding out that people aren't that bad.*
>
> *I didn't feel alone in my endeavor. You know? I had other people around me and other people with the same problems and we got to talking about it and then I wasn't alone anymore. And that's a good thing to have someone to endure things with you."*

3. Opportunity to Receive Support from Others

Around half of the interviews illustrate the positive impact of peer support. Participants describe how they have received education and emotional comfort

from group members. For many, this support has provided relief during periods of acute stress.

Building a Supportive Community for Stigmatized and Discriminated Individuals

In this light, a few respondents promote peer support groups, specifically for stigmatized minorities. The interviews identify three populations, who might benefit from a peer community / group:

(1) Lesbian / Gay / Bisexual / Queer

(2) Transgender

(3) Commercial Sex Workers

Some participants point out that people with marginalized identities have unique experiences that are distinct from the 'mainstream' homeless population. Affected individuals might not find the level of support that others appreciate in regular groups. But by creating peer groups, people can find the opportunity to connect with others who have a similar minority status.

A couple of participants suggest that hosting a 'minority' group can also promote the organization as an accepting and welcoming environment. This can help to convey an expectation of non-discrimination and non-stigmatization within the agency. This could potentially influence the behavior of both minority and non-minority clients. As in, non-minority clients can understand that bullying and stigmatizing behavior is not acceptable. And, minority clients can feel more welcome within the overall setting.*

*When describing how groups may help to shift norms and expectations in the general environment, respondents are specifically referring to LGBTQ. One participant is careful to point out that commercial sex workers would benefit most from a closed, unadvertised group. He cautions that an open group could increase the danger to participants. Members might be vulnerable to unwelcome solicitation from other clients. This could sabotage the group's intent to create a supportive and protective environment.

> *"I'd like to see and I know they got all kinds of groups and stuff now… but a place… a trauma group just for clients specifically that have just focused on client trauma. And the reason for that is unfortunately a lot of the female clients who have been traumatized through prostitution and abuse.*
>
> *But if she discusses it in another group, people will talk. 'She's the prostitute…' And then she'll go outside and get all of these unwanted offers. I've seen it happen like that before. Where somebody self-discloses and then they go out the door and everybody is sort of propositioning them.*
>
> *I'm not sure if people talk about it in the women's group. It may be a safer environment. But if you had a group specifically for people who had been through trauma, I think it alleviates outside poison because everybody in there is the ones who are affected.*
>
> *Because these are people who are treated as nothing. Just an f'ing prostitute on the street. They're mistreated by everybody from the police to the pimp. It's really terrible psychological abuse. So they left in the cycle of once they – once they do get locked up or something and have to go into some type of treatment program, they already – they already have little to no self-esteem at all. […]*
>
> *And – and the thing is is it's not just women. It's the males that prostitutes too that unfortunately get beat up or something like that. And I lived on the part of St. Paul Street and I seen the same kind of abuse from the male pimps toward the male prostitutes that the women get beat, slapped, kicked, you know. Where does a male go, you know, for those in transition… Where do they go? They're already ostracized and then to say I'm a prostitute too? Where do they go?"*

4. Provides Examples of Others' Success

Study patterns indicate that witnessing others' success can be highly motivating for an individual. When watching peers overcome the same challenges

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that they face, several participants explain how they become more optimistic about their own lives.

> *"When I have a down, the group just helped me cause I know that I ain't gonna stand there. I'm gonna get back up. We get knocked down but we get back up. They helped me with that part. Because you can sit there or you can see just one person that, 'wow, they were so down when they came in and now, wow, they up.' That's pretty normal to see. I was down today and a girl brought me back up when she shared, 'I got my house. My house is coming through and I'm turning around.'*

5. **Opportunity to Help Others**

A majority of respondents emphasize their desire to help others. They describe how they have experienced a lot of struggle. The act of 'giving back' can help them to make meaning out of this struggle and their overall lives. Opportunities to educate or assist others can enhance their sense of purpose.

> *"When I was in prison, I tried to help the kids. I took a lot of time helping kids when I was in prison. And I gain their trust, and they talk to me. And I just share my experience with them. And the one thing I always think for them kids was I built their confidence up.*
>
> *And surprisingly a few of them - I heard back from a few of them. They're doing good. You know, which I'm really glad I was able to help them. One was saying that, if it wasn't for me, he would be lost. That made me feel good. Made me feel like I did some good justice.*
>
> *It made me feel wonderful about myself. I felt good. It's a blessing to be able to help other people. To know that, even though I messed up most of my life, I was able to help somebody."*

Several participants explain that 'helping others' can increase their personal motivation to improve their wellbeing. Their desire to serve as a positive example can keep them moving forward with their own goals.

Many participants have adopted informal 'helper roles' through the natural connections they have developed with other clients. In terms of more formal opportunities, several respondents promote the 'small group' structure. They

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explain how these sessions offer regular changes for people to educate and support others. In addition to the small group, participants recommend peer mentoring and volunteer activities as potential strategies for formal 'helping.'

- Peer Mentoring: "*The big thing that helped me was peer-to-peer support. I got a lot of support from other clients. It wouldn't be a bad idea to have peer counselors.*"

- Volunteer Activities: "*I wouldn't mind actually volunteering somewhere. I love helping other people. Even part of, you know, making sandwiches. So if we had the time, yes, because I wouldn't mind… where we have a spot where we can go work go work at a food bank. I want to do that….*"

6. Opportunity for Positive Emotions and Humor

While most define the 'peer group' as an avenue for emotional support, some respondents point out that these sessions also offer an opportunity for humor. They explain that laughter can be a welcome escape, especially considering that levity can be rare for people in homelessness.

"*The conversations and stuff in group are nice because you can get a little laugh and laughing is always good for the body. I love to laugh. It's nice and if somebody says something a little humorous and when the class is going through it everybody is blending. And when the class is over… sometimes you hate when the class is over because you're having such a good time in class.*"

7. Opportunity for Creativity

A few respondents identify several benefits that can emerge from groups that are structured around a creative activity (art; writing; etc.):

Emotional Outlet

Multiple participants describe the therapeutic advantages of having a creative outlet. They explain how these sessions allow them to express and ventilate their feelings through art and writing.

"*Writing group. Awesome. Art group. Awesome. […] I got a chance to express myself. I*

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didn't know I was good at anything. I'm actually not good at drawing. But I'm very artistic. I do collages. I like glitter. Me and glitter have a kinship. (laughing) I did something the other day. I'm like 'I feel like doing this. I need glitter. Do we have glitter?' She's like 'Yeah, we got a whole thing of glitter.' I was like 'I'm joking.' She's like 'No. You're doing something with glitter.' Boom. Big thing of glitter. I'm like 'woah. So many colors.' (laughing) [...] It gives me an outlet. This is what I always joke about.

I had to be serious when I was out on the street. I had to play this serious, hard core role all the time. And I've always had to be serious. Like I was a crew chief in the military. So it's like, now I get a chance to actually go back to what I really love. I get to express myself. I get to be emotional. I get to not have to worry about what people think about me. I'm a geek at heart. I don't care anymore. It's alright. I like being a nerd. It's so much fun. It really is. I like laughing at corny stuff."

Skill-building

Many participants point out that people can use creative groups to recognize and develop their skills and strengths. This can be especially beneficial for people who struggle with homelessness and trauma.

Several respondents describe how they feel overwhelmed by challenges. They report rare opportunities to build upon something they enjoy. Creative groups can offer a chance for clients to shift their attention away from this stress and instead focus on a positive goal.

> *"I'm trying to get into this writers group. Cause I like to write. Because for real for real, my goal and one of my main things, once I get my housing - well, I'm not gonna say once I get my housing situation... One of my goals has always been to write a book. Yeah. That's one of my main goals."*

Feeling a Sense of Accomplishment

The interviews suggest that positive feelings of accomplishment can be relatively rare for people in homelessness. A few respondents explain how groups offer them the opportunity to create and share something they are proud of.

> *"I bring a lot of skills to the table. Because with all the groups and stuff like that, that's where I get all my skills from. I use them. We just had an art show. And somebody bought my art. A man that bought it called me up. I told him about the picture. It made me feel happy."*

8. **Tokens of Accomplishment**

Such feelings of accomplishment are not exclusive to creative groups. Multiple participants express their satisfaction with general groups that formally acknowledge when clients have accomplished their goals. They describe their feelings of validation from awards or celebrations within group settings.

> *"Well, for the substance abuse, they have the little diplomas and the graduation. So that kind of makes you feel pretty good that you're doing it. I'm sure - cause of what I've seen of people out on the street, that really makes a difference to them. Cause a lot of times, people - you've got to figure in homelessness, they more than likely don't have a lot of support groups, or a lot of family to support them, and this type of thing. So when you get a little bit of acknowledgement of where you're going, what you're doing, it helps. You get to celebrate something. It helps you move on. Move forward."*

9. **Develops Leadership Skills**

Multiple participants explain that groups can also help members build leadership and teamwork skills. Especially when working on task-oriented projects, clients can learn how to become active members within a team – facilitating discussions; dividing roles; setting agendas; supporting one another. Some respondents describe how this helps to increase confidence among members.

As a means of formalizing this leadership development, a couple of participants advocate for programs that prepare clients to co-facilitate groups. This could occur once a consumer has developed sufficient skills and received appropriate training. These respondents specifically recommend co-facilitation, which offers a balance between leading and receiving support from a trained employee.

Empowerment within the Agency: Opportunities for feedback and input

The majority of respondents relay a desire to have a voice within the agency (beyond just a group setting). When discussing this concept, participants distinguish between 'helping clients find their voice in the agency' and 'encouraging clients to support the agency's voice.'

This latter strategy can be common in development initiatives. Client stories often contribute to grant applications and donor solicitation. While some participants express willingness to assist agencies in funding their programs, a few respondents caution that this process is different (both in design and purpose) from programs that help clients to build their own voice.

> *"[This agency asked me to participate in an effort to improve programming.] I appreciated that a lot more than this other time. I was at [a different agency], and they asked for speakers to talk specifically about what the program did for them. It was associated with funding. But that didn't really feel like it was to give us a voice. More just so donors could hear about the program and give money.*
>
> *But over here, it felt much more like the staff was genuinely interested in our opinion on how to better serve the population. Really giving us a voice. I liked that a lot better."*

Feedback

Multiple participants emphasize their appreciation for feedback opportunities. They explain that, by asking for client perspectives on current programming, agencies can express their genuine concern for the consumer experience.

Several respondents specifically advocate for anonymous feedback strategies – e.g. confidential surveys or interviews that inquire about groups, providers, and general services. Without this confidentiality, they express concern that critical comments could lead to negative repercussions for consumers.

Input

Several participants describe the respect and dignity they feel when asked to contribute recommendations for the future direction of the organization. They support the idea of a 'Client Advisory Board,' as well as task groups where staff and clients collaborate on agency initiatives.

> *"I was invited to take an active role in an agency initiative. And that's the best part. To go from feeling like I had nothing to seeing some progress and then to be asked to be a part of something is... you know.... It's just – I sit in there and I look at the people on all different kind of professional levels, you know from running programs and directing programs to direct client care to all these different levels of people. And they all seem to say, "You have something to say." What it does self-esteem wise and just knowing they care about my opinion – especially since it's something I'm passionate about – it really just makes so much difference."*

Empowerment within Society: Advocacy and Community Mobilization

Several participants express a desire to carry their voice into larger society. More specifically, they appreciate opportunities to take part in advocacy groups and community mobilizing efforts that support people in homelessness. These initiatives can take on a number of different forms – public speaking; writing editorials; lobbying with government officials and policy makers.

Multiple participants explain that advocacy-related experiences can be highly rewarding. They describe how this involvement can help them feel that they are making a difference in the world.

In many ways, this kind of empowerment is a key strategy to combat the effects of trauma. Most respondents explain that their trauma has contributed to a general sense of disempowerment – i.e. a lack of control over their lives and their environments. Study patterns suggest an association between this perceived lack of control and the risk of stress, aggression, and harmful survival strategies (e.g. substance abuse).

The interviews illustrate how, when people adopt an advocacy role, they can move into a position of increased control. Many participants feel like they are working to improve society, while combating the same forces that have contributed to their homelessness. As a result, several respondents describe an increased sense of purpose and satisfaction.

The study indicates that, as clients feel more control in their surrounding environment, they feel more control in their personal lives as well. In this way, involvement in advocacy groups might actually help clients to directly combat the personal effects of trauma.

> *"If you're firing a gun at passerby's, you're completely out of control. But if you're actually talking to council people, state senators and congress persons, you are in control. If you're actually having positive interactions with the cops on the street, you're in control. Whereas if you're getting handcuffed and smacked on the group, you're obviously out of control. [...] Instead of going out in the street corner and pulling out a gun and shooting passerby's because you're pissed off, you get to go down to city hall and express why this law should be changed in this way about drivers. It gives you an appropriate outlet. If people cannot empower themselves, then they are still gonna be lost.*
>
> *The other point is that advocacy also makes me feel more contributory. More like I'm actually not only helping myself. But I'm also helping the organization and thereby helping other clients as well. It impacts me a lot of help people beyond myself."*

The Role of the Provider / Agency?

While they advocate for the chance to take on an active role in their recovery, the majority of participants are careful to acknowledge the value of the provider and the agency. Most describe how the clinic has set up the pathways through which they have built their knowledge, skills, and confidence. This support and guidance has helped them to gain a heightened sense of control over their lives and surrounding communities. Many express that they would have struggled to make such progress on their own. This suggests that, even with 'client empowerment' as a

principle value within an organization, the agency and its employees still have substantial roles to play.

DISCUSSION

Within this study, participants offer multiple examples of interventions that have improved their perceived level of emotional support, their sense of purpose, and their optimism for the future. The underlying thread across each program is a commitment to enhance the clients' sense of control and their voice – whether in individual treatment, in groups, in the agency, or in society as a whole.

In their discussion of trauma, evidence-based articles tend to focus on clinical interventions as the primary tools of recovery. This study does not discount the value of clinical intervention. But it expands the evidence-base to support more general, agency-wide practices and policies that guide clients out of a traumatic cycle. It moves the conversation beyond a question of what particular treatment a provider should choose. These results suggest that an intervention's ability to build resilience among clients hinges primarily on the clients' perceived level of control, agency, and support within the service (i.e. their sense of 'empowerment').

This introduces a valuable opportunity for agencies that are interested in trauma-recovery. Organizations can consider both clinical and non-clinical strategies to enhance resilience – relationship-based care; peer groups; client/staff committees; advocacy initiatives.

This variety of interventions expands the options for clients who might not pursue clinical treatment for a number of reasons – lack of interest; schedule conflicts; lack of financial ability / insurance. In the world of managed care and

limited non-profit resources, clients might also be restricted to a limited number of therapy sessions. Many individuals are still in need of support, once they reach the end of treatment.[29]

When agencies support a variety of strategies to keep clients engaged in the agency (through peer groups, client/staff committees, and advocacy efforts), clients have multiple options to remain connected to a supportive environment. Sustaining this link can (1) provide a layer of continuing protection to those who might still feel vulnerable after concluding clinical treatment; (2) allow the agency to preemptively intervene with clients who might otherwise return to crisis; (3) prevent vicarious trauma among staff, by allowing employees to follow the 'success stories' of those who have sustainably improved their wellbeing.[144]

This conversation represents a valuable paradigm shift, as agencies move away from a crisis-oriented model (which responds to emergencies) and towards a prevention model (which works to protect clients from future crisis).[30] Research illustrates how the long-term damage of trauma can keep an individual in a constant state of crisis. Given this situation, there is a risk that agencies will remain in a constant state of crisis response – particularly if they only address the short-term needs of client.

For many organizations that serve people in homelessness, this can create a revolving door. Even when staff members are working overtime to respond to emergencies, the clients can linger in a condition of perpetual vulnerability. This places substantial strain on agencies that struggle with high demand and low resources.

As knowledge about trauma develops, there is a push is to break out of this short-term response model and move toward a path of long-term and sustainable recovery. 'Client empowerment' fits hand-in-hand with this strategy. It provides tools to for clients to break their cycle of trauma and limit their risk of re-victimization.

It also recognizes the value of 'advocacy as clinical intervention.' To date, we have measured the success of advocacy initiatives purely by their influence on policy and public awareness. But this is an incomplete metric. It fails to acknowledge that the individuals and groups most impacted by advocacy initiatives are the advocates themselves. Participation in change-efforts (whether to assist peers, improve an agency, or improve society) can generate a positive level of purpose and meaning. The impacted individual moves from 'client' to 'advocate,' bringing an identity shift that is both rewarding and protective.

Emphasizing the advocacy component also introduces an opportunity for organizations to expand their outreach and community-based interventions. Research already supports the use of peer educators and peer-led groups as effective strategies for harm-reduction and behavior change.[145] Similar patterns might also apply to trauma recovery interventions. Training clients to lead resilience-building efforts could not only relieve burden from overwhelmed agencies, but it could also expand interventions into hard-to-reach populations.

While these results are optimistic, there are a few caveats to consider. Client empowerment initiatives cannot take the place of other needed interventions for people in homelessness – for instance, treatment for the severely mentally ill or the

expanded availability of housing. Training peer mentors and advocates also requires

awareness of the power dynamics that can emerge among the clients themselves.

Conscientious training programs can prepare clients to take on increasingly

empowered roles, without overshadowing the voices of others or creating

unintended harms (for instance, a peer mentor whose unreliability creates distress

for another client).

As far as the limitations within this project, it's important to remember that

the facilitator can influence the results of the interview. Another researcher might

have prompted different responses from the participants, based on different style,

tone, order and phrasing of the questions. Interviews also do not provide the

breadth that surveys allow. [113] With a sample size of 30, I cannot conclude for

certain that the participants fully represent the views of the entire client population.

Considering that most recruitment occurred within groups, the results might also

skew towards clients who have more involvement in the agency. The respondents

might differ from less engaged clients, who have limited group interaction. There is

also the possibility that, because the participants are all clients at a single clinic, the

results might not transfer to outside agencies.

A counterpoint to this last limitation is that the study site shares multiple

similarities with other clinics. It also serves a population that has experienced

various forms of trauma. As seen in the research, homelessness overlaps with

childhood abuse, domestic violence, incarceration, and military-related violence.

This overlap suggests that the participants might share similarities with clients at

various agencies that address these different forms of trauma. These commonalities

in structure and clientele indicate that the results can generalize beyond the study site.

Even so, future research would be valuable to verify this study's conclusion that 'empowerment' is a key component in the effort to build resilience. As a next step, studies might consider exploring the impact of 'empowerment' initiatives at other organizations that address trauma. Similar results from outside agencies could help to confirm the conclusions from this project.

CONCLUSION

The results from this study introduce an exciting time for agencies. Organizations that are grappling to adjust to the idea of trauma can consider the idea of 'client empowerment' as a general strategy to enhance resilience.

The value of this approach is that it is not restricted to any one context. It works at the individual level, group level, agency level, and societal level. This means that organizations have many opportunities to improve the mental health outcomes of clients, who are grappling with trauma.

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DISCUSSION

SUMMARY OF RESULTS

<u>Ten strategies</u>

The interviews identify ten strategies – each one helping to fulfill one of the four areas that I inquired about in the TIC assessment: [29, 30, 95-100]

1. Trauma awareness

2. Establishing safety

3. Opportunities for members of the agency (including clients and staff) to develop and sustain healthy relationships

4. Opportunities for members of the agency (including clients and staff) to gain a sense of personal control and confidence

Organizations can consider these recommendations when providing outpatient services to people who experience trauma and homelessness.

Objective 1: Trauma awareness (i.e. ensuring that the agency is aware and prepared to address trauma, as well as its impact on health and behavior)

1. Training to Enhance Staff Awareness and Competency in Addressing Trauma (for all staff, including clinical and non-clinical)

Study patterns suggest that employees are in a better position to prevent re-traumatization if they themselves fully understand the impact of trauma. Several participants express their appreciation for agency efforts to educate staff on why safety, communication, and trust are so important when working with vulnerable

individuals. Appropriate training can guide employees on how to avoid triggering. It can also prepare them to react appropriately if a consumer does become triggered.

Education can also help staff to understand the impact of trauma on behavior. Some participants predict that this awareness can help to increase patience and relieve frustration for workers. It can improve understanding around why clients might behave in ways that otherwise seem irrational, hypersensitive, or self-sabotaging.

Objective 2: Establishing safety

2. **Welcoming demeanor among lobby staff**

The majority of participants advocate for welcoming and respectful communication among lobby staff. They explain that the perceived 'friendliness' of the employees can influence the likelihood that new clients will successfully enroll in services. It can also impact client satisfaction with the agency, among those who have already enrolled. When lobby staff members succeed at communicating in respectful and comforting ways, this can create numerous benefits for clients.

Participants explain how their homelessness has limited their exposure to friendly interaction and 'warm' settings. They describe their relief when they enter a welcoming environment. This can increase their motivation to invest in services.

3. **Predictability, communication, and clarity**

The interviews outline several positive outcomes when agencies take steps to ensure that the setting is as predictable as possible. Most participants report

lowered stress when they are familiar with their surroundings and when they generally know what to expect.

This means emphasizing communication, especially with new consumers who might feel confused about what the services are and what the process is of accessing them. Once enrolled, agencies can enhance predictability by ensuring that clients will continuously interact with the same providers and / or groups.

Objective 3: Providing opportunities for members of the agency (including clients and staff) to develop and sustain healthy relationships

4. **Establishing structures to ensure that clients interact continuously with the same staff members**

The majority of participants explain that continuous interaction with the same employees can help to establish a foundation of trust. This trust can be effective at minimizing the risk of re-traumatization during sensitive questioning and examination. It also creates a relationship, through which providers and clients can work together on a long-term plan to improve health and wellbeing.

5. **Using groups to build relationships among peers**

Study patterns reflect how peer-to-peer relationships can be just as beneficial as staff-client relationships. Most participants appreciate opportunities to engage with other individuals, who are encountering similar struggles. These connections can help to relieve the isolation that people experience in homelessness. Peer groups often become a primarily avenue through which individuals can build community and 're-enter society.'

Interview themes show how the resulting friendships can also help clients feel comfortable within the agency itself. Participants describe their lowered stress when they arrive for appointments. They feel excited to engage with people they know.

6. **Conscientious staff selection, orientation, and evaluation**

The interviews applaud staff members who come into their positions with a genuine enthusiasm for human service work. Participants describe these employees as passionate and engaged. They treat their tasks as 'not just a job.'

Respondents distinguish passionate workers from those who do not have a personal commitment to the mission. Participants assert that mission-oriented staff members not only provide the best service, but also show the fewest signs of burnout. They recommend for agencies to take this criteria into account when hiring, orienting, and promoting staff.

Objective 4: Providing opportunities for members of the agency (including clients and staff) to gain a sense of personal control and confidence

7. **Collaborative partnership between providers and clients**

Most of the interviews demonstrate how providers can enhance clients' sense of control by inviting them on to the treatment team. The majority of participants appreciate when clinicians recognize their skills, expertise, and perspectives. Within this structure, providers help to guide clients towards manageable objectives, and to break large goals into feasible steps. But the consumer sets the direction of treatment. Respondents describe how this strategy

helps to increase their confidence, motivation, and adherence to healthcare guidelines.

8. **Strengths-Based intervention and goal tracking**

Multiple participants express how clinicians have built their confidence by helping them identify their strengths and assets. In recognizing evidence of their resilience, respondents have experienced improvements to their self-esteem.

The study outlines how this confidence can increase when providers help clients to break large goals into feasible steps. The team can then track and acknowledge each success (both large and small). This can enhance overall optimism and investment in the intervention.

9. **Opportunities for client engagement (in the agency and in society)**

Most participants emphasize the positive benefits they experience when they help other people. Opportunities to not just receive, but give support can be highly motivating for an individual. Respondents explain how this builds their sense of purpose. It can also enhance their incentive to improve their personal wellbeing, because they wish to serve as an example for others.

The majority of participants appreciate opportunities to make a difference – in the lives of others; in the agency; and in society. The interviews outline the personal rewards that consumers can experience when they (1) engage in peer mentorship (both formal and informal); (2) participate in agency initiatives to evaluate and develop programming; and (3) contribute to advocacy efforts in the larger community.

10. **Providing adequate support for staff**

Several respondents acknowledge the challenges for employees who work with people in homelessness. They witness the stressful (and sometimes scary) experiences that staff members encounter. Multiple interviews describe how these stressors can build up over time and potentially lead to burnout, disengagement, and loss of productivity. This can negatively impact clients who depend on a friendly and supportive staff.

These participants advocate for strategies that specifically protect employees. They recommend various approaches including: staff training in trauma and vicarious trauma; therapy sessions for employees; reflective supervision; role rotations in and out of more stressful positions; and a reduction in role overload (i.e. too many tasks that overwhelm the employee).

IMPLICATIONS – A NEW AND EXPANDED MODEL OF TRAUMA INFORMED CARE

These ten strategies collectively create a new and expanded model of Trauma-Informed care. This helps to offer guidance for community-based agencies, as well as fill a gap within the literature.

Current research has so far outlined the impact that trauma can have on health, wellbeing and behavior. [1-3] It has also begun to document the idea of 'resilience.' [10, 11, 18, 19, 21, 146] As organizations become aware of the research and theory around trauma and resilience, there is growing demand for guidance. While the TIC literature provides some basic direction, most articles offer a limited number of specific recommendations. Of the recommendations that are available,

most have limitations in one of three areas. This assessment has helped to expand the concept of TIC into new and more applicable directions:

1. Inpatient treatment centers, versus community-based
2. Clinical therapies, versus agency-wide
3. Theoretical, versus based on evidence

Inpatient treatment → Community-based services

Much of the discussion around Trauma Informed Care (TIC) originally developed out of inpatient (and locked) mental health units. As such, much of the current guidance tailors to these settings. [29, 97, 147] But as TIC expands into outpatient agencies, this creates a new direction for needed research and assessment.

Community-based settings bring a different set of tasks and demands. The recommendations within this dissertation help to provide specific guidance that is appropriate to these outpatient agencies. While this study took place at a single site, the host clinic shares similarities with other health and community-based organizations. Many of the results and recommendations can therefore expand to external settings.

Clinical therapies → Agency-wide

Much of the available literature offers insight into the clinical therapies that can be effective for people who have experienced trauma. But with the emphasis on clinical intervention, there is limited guidance that applies to the agency as a while.

[25-28] Where is the model applies to all environments, programs, policies, and staff members (both clinical and non-clinical)? [27]

Having established that TIC expands beyond the clinician's office, there is need for guidelines that consider the entire organization. [24, 25, 30] This study has attempted to craft several agency-wide suggestions by exploring the client perspective. Organizations can apply these recommendations across the board, rather than restrict them to a clinical context.

Theory → Practice

Much of the current literature rests strictly in theory. Authors have provided extensive discussion and prediction around what creates a trauma-informed environment. However, there is limited data that has originated from real-world environments and that involves the perspectives of staff and clients who directly experience trauma.

This research expands beyond the theory. It provides concrete evidence from a community-based site, and gathers voices from people who intimately understand the difference between a triggering and trauma-sensitive agency. By pulling from these perspectives, this assessment is able to expand the trauma-informed model into evidence-based recommendations for agencies that are interested in TIC.

Caveats with Trauma Informed Care

When considering a TIC approach, it is important to consider a couple of disclaimers. In the first place, this list of recommendations applies primarily to *how* agencies conduct their programs. They are not meant to replace programming. [25, 26, 30] Clinics still require mental health interventions to treat mental illness. Patients

still require physical health treatment to address physical ailments. People in homelessness still require housing as a top priority. Trauma-informed practice does not serve as a substitute for other programming. It simply offers guidance in how agencies can adapt their services to best address the client. [25, 26, 30]

Another important disclaimer is that TIC implementation is not designed to pathologize all clients and staff. In this light, 'Trauma-Informed Care' becomes a misnomer. The purpose is not to place trauma-related diagnoses on all clients. Trauma-informed agencies simply endeavor to establish practices that are positive and protective for every person, regardless of their history, but especially if they have been through trauma.

In fact, the goals of TIC fall largely in contrast to a demand for pathology. Pathology and even diagnoses imply that the respective individual has 'something wrong with them.' This brings an element of blame that does not consider the external factors that impact the person's life. By contrast, a trauma-informed approach encourages agencies to consistently consider the context of a person's behavior – both that of clients and staff members. When considering the influence of environmental and social factors, many behaviors begin to make sense. [2, 3] By acknowledging this, trauma-informed agencies can then think about how to create environments and social relationships within agencies that are protective and non-judgmental for everyone, rather than triggering or harmful. [24, 25, 30]

LIMITATIONS OF THIS STUDY

While the conclusions from this study provide insight into the practice and value of Trauma Informed Care, they come with limitations. With all of the client-

related data deriving from in-depth interviews, there were limited opportunities for triangulation. A more robust and reliable dataset would have involved multiple methods to investigate the client perspective – not only interviews, but also focus groups and observations. This added information would have helped to bring more understanding and nuance to the patterns and themes presented.

While the complete assessment project included additional methods – staff survey; focus groups with front line staff – their results are not presented in this dissertation. Future research articles could perhaps flesh out this data and present it in comparison to the client interviews. This might help to bring a more rounded view of the situation at the clinic. For instance, a quick review of the focus groups with front line staff adds an important supplement to the client interviews. Gathering perspectives from employees in the lobby space especially helps to explain some of the challenges that these staff face within their work – and how this ultimately impacts the client experience. While interview participants reported witness of these challenges, the focus groups help to bring real meaning and understanding to the employee situation in the lobby.

Another area of triangulation that did not receive full utilization within this dissertation was the use of multiple researchers. While a research assistant contributed to data collection and analysis, her time availability prevented me from taking full advantage of her participation. Had she been available to commit increased time to data analysis, we would have each coded the same transcripts. This would have given an opportunity for us to directly compare our codes – thereby checking the reliability of the coding process. As it was, her alternative

commitments, as well as her participation in the survey analysis for the overall assessment, limited her availability.

Even so, her involvement did bring advantage to the project. With her help, I was able to ensure that researchers (beyond myself) could understand and utilize the codebook. As we reviewed the codebook together, I could clarify the meaning of any confusing codes or unclear definition. By sharing my transcripts and then reviewing hers, I could also ensure that another researcher could use the codes as I originally intended. This increases the reliability of this important tool for data analysis.

A final way, in which this research could have been strengthened, would involve expansion of the 'member checking' strategy. This project did involve review of interview patterns and themes to check the validity of the results. As a more accurate method of checking validity, the participants who directly contributed to the study would have had an opportunity to review the results. In this way, these clients could have provided feedback on how closely these interpretations matched their perspectives.

The circumstances of this project – limited time availability of the RA; transience of people in homelessness that restricted the researcher's ability to contact participants for the purposes of member checking – has limited my ability to carry out these optimal methods for checking validity.[94] This introduces a need for future research.

FUTURE RESEARCH

Future research could help to confirm, counter, or expand upon results presented in this article. Ideas for additional study include:

- Continued investigation of the client perspective, using additional methods beyond in-depth interviews (surveys; focus groups; observations)
- Investigation into the perspectives from direct service staff and leadership using in-depth interviews, surveys, focus groups, and/or observation
- Similar assessments at other agencies and clinics that work with vulnerable populations
    - One advantage to this project is that the study site shares multiple similarities with other organizations. Its status as a health clinic offers parallels to various healthcare settings. The overlap between homelessness and many types of trauma – military-related violence; domestic violence; child abuse – also suggests that the participants likely share similarities with clients at external trauma-related agencies. [77-84] That said, an assessment within these organizations could help to expand the applicability of the TIC model.
- Pre / post-tests that measure the impact of 'Trauma-Informed Care' on different variables and outcomes (staff satisfaction; client satisfaction; staff retention; client retention and adherence; client health outcomes)
- Pre / post-tests that measure the impact of some of the recommendations within TIC. This could help to tease out the influence of different pieces.
- Cost-effectiveness studies that compare trauma-informed sites with non-TIC sites

CONCLUSION

Overall, the results of this study provide insight into the details and logistics of what it means to be "trauma informed." This research contributes evidence to the growing conversation of how agencies can practically adjust to their emerging awareness of trauma. Participants describe several concrete examples of features and experiences in the clinic that either enhanced or decreased their perceptions of control, support, and dignity. They explain how these features then influenced their overall sense of safety in agency.

Being trauma-informed means stepping out of the clinician's office and reviewing the entire experience within the agency (from the perspective of both staff and clients). This project can help practitioners, administrators, and researchers alike further think about practical and operational strategies to incorporate Trauma Informed Care into their organizational structures and cultures.

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EDUCATION

PhD in Social and Behavioral Sciences
Expected Spring 2015

- Johns Hopkins Bloomberg School of Public Health
  Department of Health, Behavior and Society

Master of Social Work (MSW)
Expected Summer 2015

- University of Maryland School of Social Work

Master of Public Health (MPH)
Awarded 2010

- Emory University, Rollins School of Public Health

Bachelor of Arts (BA) in Sociology and International Studies
Awarded 2007

- Northwestern University

EXPERIENCE

House of Ruth Maryland (HRM) – Baltimore, MD
Fall 2013 to Present

- Pro Bono – assessment, training and project development for a community-based organization, focused on intimate partner violence (IPV)
  - Developed and conducted an agency-wide needs assessment around Trauma-Informed Care
    - Acquired IRB approval from the Johns Hopkins Bloomberg School of Public Health
    - Designed and analyzed an all-staff survey
    - Designed, recruited, facilitated and analyzed in-depth interviews with clients
    - Wrote internal reports for review by the executive staff
  - Partnered with the HRM Training Institute to develop a 'Story-Telling' Initiative

- Assisted in the design of an intervention to train women to 'tell their stories' in the context of IPV-related advocacy, community education, and peer education / mentorship
- Acquired a grant from Urban Health Institute at Johns Hopkins School of Public Health
  o Assisted in the design of a training to introduce 'Reflective Supervision' to staff as a strategy to protect against vicarious and organizational trauma
  o Designed and facilitated trauma-related trainings
    - All-staff training on 'Trauma Informed Care'
    - Supervisors' training on protecting against vicarious and organizational trauma
    - 'Introduction to trauma' to train child expert witnesses in IPV-related custody cases
- Foundational MSW Field Placement
  o Provided clinical mental health therapy for women, adolescents and children impacted by IPV
  o Assisted in the facilitation of a multi-family group intervention around trauma recovery
  o Answered calls on the crisis hotline to provide crisis counseling and connect callers to resources

Healthcare for the Homeless – Baltimore, MD
Spring 2013 to Present

- PhD Dissertation
  o Partnered with a committee of staff and clients to develop and facilitate an organizational needs assessment around Trauma-Informed Care
    - Acquired IRB approval from the Johns Hopkins Bloomberg School of Public Health
    - Assisted in the design and analysis of an all-staff survey
    - Designed, recruited, facilitated and analyzed in-depth interviews with clients
    - Wrote internal reports for review by the executive staff, as well as 3 research articles for future submission to peer-reviewed journals
    - Conducted a workshop at the National Harm Reduction Conference to share the process
- Advanced MSW Field Placement
  o Provided clinical mental health therapy for people living in homelessness

Adolescent Inpatient Unit, Spring Grove Hospital – Catonsville, MD
Fall 2010 to Winter 2012

- PhD Practicum
  - Provided health education and harm reduction counseling for adolescents, who had received court-orders for inpatient mental health evaluations from the Department of Juvenile Services

The Lighthouse, Johns Hopkins School of Public Health – Baltimore, MD
Fall 2010 to Spring 2012

- Qualitative Research Assistant
  - Facilitated and analyzed in-depth interviews with injection drug users to evaluate the long-term impact of a harm-reduction workshop

Public Health Institute, Global Health Fellows Program– Washington, DC
Summer 2010

- USAID HIV Community Care Program Management Intern
  - Assisted with a close-out evaluation of a capacity building project for HIV-related organizations
    - Participated in the facilitation and analysis of interviews with local staff and clients of grant-recipient organizations in Vietnam
    - Wrote an evaluation report for review by USAID staff
  - Selected for one of 29 GHFP internship positions from an original pool of 1751 applicants.

Scenarios from Africa, Rollins School of Public Health (Emory) – Atlanta, GA
Fall 2008 to Spring 2010

- Qualitative Research Assistant
  - Analyzed stories written by youth across multiple African countries. Reviewed trends to determine how youth consider the HIV epidemic. Compared patterns across different countries and years.

Voluntary Counseling and Testing Center (VCT) – Old Mutare, Zimbabwe
Summer 2009

- MPH Practicum
  - Developed and conducted a community-based assessment to inform a local HIV outreach clinic of the health and wellbeing-related needs of the surrounding client population
    - Designed, recruited, facilitated and analyzed in-depth interviews with clients
    - Wrote a report for review by the funder

'Footsteps In Hope' AIDS Walk/Run – Jackson, MS
Summer 2007 to Spring 2010

- Creator / Coordinator
    - Acquired a grant from the STI / HIV Division in the Mississippi Department of Health
    - Recruited participants from local universities, faith-based organizations, churches, hospitals, health-related organizations, and athletic groups.
    - Managed donations from the event to support programming for multiple HIV organizations in Mississippi, as well as a Voluntary Counseling and Testing Center in Old Mutare, Zimbabwe.

Orphan/Vulnerable Children outreach program – Old Mutare, Zimbabwe
Fall 2005 to Summer 2006

- Outreach Worker
    - Worked with people living with HIV to provide emotional support, supply basic healthcare materials, and liaise with the local healthcare system. The central goal was to enhance clients' access to anti-retroviral medications and treatment of opportunistic infections.

SCHOLARSHIPS

Johns Hopkins Bloomberg School of Public Health (JHSPH)

- Doctoral Dissertation Award – Department of Health, Behavior and Society
- Public Health Training Grant – Health Resources and Services Administration (HRSA)
    - One of 7 annual recipients in the JHSPH student body to receive this public health training grant.

Emory University, Rollins School of Public Health (RSPH)

- Charles and Sue Hardman Scholarship / Ansley Miller Scholarship / RSPH Merit Scholarship
    - One of 15 scholarships awarded within the 2010 Rollins class of over 300 people.
- Global Health Institute (GHI) Individual Field Scholar
    - One of 8 individual GHI scholars in 2009. The original pool of eligible applications for this award included ~100 Rollins proposals, as well as applications across Emory University.