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27 JANUARY 2017

RECOGNISING THE LINK BETWEEN TRAUMA AND HOMELESSNESS

Introduction

It is increasingly recognized that many people who are at risk of or are experiencing long term homelessness have been exposed to trauma. However, service systems are not always equipped with the necessary tools or the right responses to help people who have a history of trauma. Often this lack of consideration or understanding of how central the experience of trauma can be for people with whom we work can prevent diverse homeless services from being effective. This paper explores the relationship between trauma and homelessness, and aims to improve our understanding of trauma experiences among people who are homeless. It also presents two approaches to delivering homelessness services – Trauma Informed Care (TIC) and Psychologically Informed Environments (PIE) - that have been found to help meet the needs of people affected by trauma.

Background

The homeless population is diverse[1] and includes people with different level of support needs. Most people who become homeless due to housing shortage or job loss need little support and can quickly return to housing. Those who become homeless for different reasons, often due to system failures, such as leaving state care or prison etc. usually stay homeless for a longer period and have greater and interrelated support needs. Those who are long –term (or chronic) homeless and cycle between street, psychiatry, criminal justice services and temporary accommodation have the greatest support needs and are the most likely to have been exposed to trauma. There are particularly vulnerable subgroups of people who are homeless which include but are not limited to young homeless people, women, migrants, drug users and those with mental health issues.

Homelessness is caused by the interaction of structural problems at macro level such as the lack of affordable housing or long term unemployment and individual causes such as debt, family breakdown, or poor health. This paper attempts to look at the pathway to, and the experience of,

[1] it includes: people sleeping rough and living in public spaces, people using homeless day or night shelters or staying in temporary accommodation, as well as people currently living in state care, hospitals, in prison without adequate housing to return to, and people living in insecure or inadequate accommodation that may be unfit for habitation, overcrowded or that they may not have a legal title to.

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homelessness through the individual's traumatic experience. While we know that the different factors interact with each other and it is impossible to identify a single cause of or pathway to homelessness, it is important to look at how an individual factor such as trauma experience can play a defining role in why one person becomes homeless. Indeed, trauma seems to be a very common experience for people who are experiencing homelessness. We can see that trauma and homelessness are so deeply interlinked that we can assume that any strategy addressing homelessness can only be effective if trauma considerations are integrated within it. It is important to acknowledge these intersections and to make service adaptations to better address the needs of trauma survivors.

The terms PTSD (Post Traumatic Stress Disorder) and PD (Personality Disorder) are intentionally not used in this paper. PTSD and PD are psychiatric classifications that have their place and can be important diagnoses, but they are medical terms which highlight pathology and can be stigmatizing. The purpose of this paper is not to explore the medical concept of trauma, but to look at trauma from a biopsychosocial perspective which takes into account the complexities of a person's life and their social context.

Trauma Informed Care (TIC) and Psychologically Informed Environments (PIE) do not rely on either diagnosis or formal therapy, rather they provide a framework that emphasizes the impact of trauma and encourages the development of strategies for better responding to the needs of trauma survivors. At the very least the overt and conscious aim is to "do no harm and to avoid retraumatisation or blaming clients for their efforts to manage their traumatic reactions".

How trauma and homelessness are interlinked

Trauma and homelessness are connected in at least three ways.

Firstly, trauma is prevalent in the narrative of many people's pathway to homelessness. Research has shown that people who are homeless are likely to have experienced some form of trauma, often in childhood[2]. 85% of those in touch with criminal justice, substance misuse and homelessness services have experienced trauma as children.[3]

Secondly, trauma often happens during homelessness, for example by being a victim or witness of an attack, sexual assault or any other violent event. People can also be re-traumatised by services that leave them feeling powerless and controlled; for example, if they lack privacy and are being challenged in demanding ways.

[2] E.Sundin and T. Baguley, 2015: Prevalence of childhood abuse among people who are homeless in Western countries: a systematic review and meta-analysis. In: Social Psychiatry and Psychiatric Epidemiology February 2015, Volume 50, Issue 2, pp 183–194

[3] Lankelly Chase Foundation, 2015: Hard Edges: Mapping severe and multiple disadvantage, England, accessed at: http://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

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Thirdly, homelessness itself can be considered a trauma in multiple ways. Often the loss of a home together with loss of family connections and social roles can be traumatic. This is because "like other traumas, becoming homeless frequently renders people unable to control their daily lives".[4] Social exclusion activates the same neurological systems as physical trauma, with a similar impact on people.[5] Added to this, homelessness can be such an additional stress in the life of a person that it can erode the person's coping mechanisms and the stress that it causes can rise to a level of trauma.

Defining trauma

Trauma in general refers to experiences or events that by definition are out of the ordinary in terms of their overwhelming nature.[6] They also more than stressful – they are also, shocking, terrifying and devastating to the trauma survivor and often result in feelings of terror, fear, shame, helplessness and powerlessness. There are two types of trauma.

Type 1 trauma occurs at a particular time and place, and is short-lived, such as serious accident, sudden loss of parent or a single sexual assault.

Type 2 trauma refers to events which are typically chronic, begin in early childhood and occur within family or social environment. They are usually repetitive and prolonged, involve direct or indirect (witnessing) harm or neglect by caregivers or other entrusted adults in an environment where escape is impossible.

Many homeless people have experience of both Type 1 and Type 2 trauma: this is called 'compound' or 'complex' trauma.[7]

Adverse childhood experiences (ACE)

Compound or complex trauma very often results from adverse childhood experiences. ACEs refer to experiences during childhood that are considered maltreatment, for instance sexual, physical or

[4] Goodman, Lisa A.; Saxe, Leonard; Harvey, Mary,1991: Homelessness as psychological trauma. Broadening perspectives. In: American Psychologist, Vol 46(11), Nov 1991, 1219-1225.
[5] Eisenberger et al, 2003: Does rejection hurt? An fmri study of social exclusion' in Science Vol 302, p290-292, accessed at www.sciencemag.org and Kross et al, 2011, 'Social rejection shares somatosensory responses with physical pain', in PNAS Vol 8;15, p6270-6275, accessed at www.pnas.org/cgi/doi/10.1073/pnas.1102693108

[6] Such events are neither ordinary, nor uncommon. Destructive events, such as natural disasters, are easier to accept than atrocities committed by fellow human beings. There is a lot of denial, repression both at societal level and at the individual level about traumatic events.
[7] Maguire, N.J., Johnson, R., Vostanis, P., Keats, H. and Remington, R.E., 2009: Homelessness and complex trauma: a review of the literature. Southampton, UK, University of Southampton, accessed at: http://eprints.soton.ac.uk/69749/

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emotional abuse or neglect. ACEs can also stem from living with an adult with mental illness, substance abuse problems or criminality or if domestic violence is committed in the household. These ACEs have long lasting impact, especially because they happen in a developmentally vulnerable period in one's life. The earlier in life trauma occurs, the more damaging the consequences are likely to be. It can disrupt children's basic biological regulatory systems and their normal attachment systems, especially if the perpetrator is a person whom they trusted and had strong emotional ties with. Insecure attachment strongly impacts upon the ability to have healthy social relationships in adulthood.[8]

The impact of trauma: recognizing symptoms as adaptation to the impact of trauma

The impact of trauma is life-altering. Symptoms continue into adulthood and reflect neurological adaptations to the impact of the trauma. Research shows that complex trauma and ACEs, in particular, have long term health consequences into adulthood.[9]

Many of the psychological symptoms fall into three categories: hyperarousal, intrusion and constriction. Hyperarousal reflects a "persistent expectation of danger". The body and mind stay in a permanent alert mode as if the danger could return at any minute. In this state, the person is easily startled, reacts irritably to small provocations, and sleeps poorly. Intrusion reflects an indelible imprint of the traumatic moment. In this state the traumatized person relives the event as though it continues to recur in the present and even small insignificant reminders can evoke these memories. Constriction is the numbing response to surrender. In this state, the traumatized person escapes their situation by altering their state of consciousness. This often happens with the feeling of indifference, emotional detachment or passivity.

Trauma overwhelms a person's resources for coping and impacts upon the person's sense of safety, ability to self-regulate, sense of self, perception of control and interpersonal relationships.

Trauma experienced by people who are long-term homeless

[8] Bessel A. van der Kolk, 2014: The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma, Viking Books, New York.

[9] ACEs increase the risk of poor health and premature mortality. Not only are survivors more likely to die at a young age than those who have not experienced ACEs, but they are more likely to suffer from a range of illnesses – including cancer, heart and lung disease, stroke, hypertension etc. ACEs also increase the risk of mental ill health. The WHO estimates that thirty percent of adult mental illness could be attributed to ACEs. ACEs also impact upon health outcomes through an increase of health-harming behaviours, such as drug use.

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The path to homelessness often begins in childhood. Studies report high prevalence of adverse childhood experiences for homeless people. Herman's comparison of homeless and non-homeless adults found that ACEs were significantly higher in the homelessness population. Others found that rates of ACEs are not only higher, they are contributing risk factors in homelessness. Herman found that the lack of parental care and abuse was associated with a "'dramatically elevated risk of adult homelessness".[10]

Clearly, there is a strong link between homelessness and trauma in early childhood. Poorly addressed complex trauma is a major risk factor of long term homelessness and poor mental health outcomes.[11]

Homeless people are also at increased risk of further victimization during homelessness because they are particularly vulnerable to injury, accident and assault. Crisis found that two-thirds of homeless people have been abused or insulted publicly while sleeping rough.[12]

Overlapping needs: make the connections across sectors

We have seen that trauma has a significant impact on mental health. There is a clear link between traumatic experience and maladaptive behaviours such as: problematic drug and alcohol use, personality disorders, taking sexual risks, high levels of actual and attempted suicide, etc.

It is important therefore to address the reasons behind the disengagement that prevents people from having their needs met.[13] We know that often unresolved trauma histories lie behind the engagement problem. We have seen that exposure to traumatic events can result in complex mental health problems, difficulty in regulating emotional responses and negative views of oneself and the world. As a result, people have problems maintaining social relationships and demonstrate challenging behaviours as a coping mechanism. Instead of concentrating on the complexity of needs or labeling people as 'hard to reach groups', more focus should be on the underlying roots of the disengagement. What we learn from the impact of trauma shows how important it is to look at psychological problems in their social context.

[10] Herman, D. B., Susser, E. S., Struening, E. L., & Link, B. L.,1997: Adverse childhood experiences: Are they risk factors for adult homelessness? American Journal of Public Health, 87(2), 249-255.
[11] Maguire, N.J., Johnson, R., Vostanis, P., Keats, H. and Remington, R.E. (2009) Homelessness and complex trauma: a review of the literature. Southampton, UK, University of Southampton, accessed at: http://eprints.soton.ac.uk/69749/
[12] Living in Fear: violence and victimization in the lives of single homeless people accessed at: http://www.crisis.org.uk/data/files/publications/LivingInFear_full.pdf

[13] We know that homelessness is often the tip of the iceberg, the visible form of a complex disadvantage (multiple exclusion) with different layers of unmet needs. While there is a lot of discussion on the complex needs homeless people have, we know that fundamental human needs are the same for everyone, some people are for some reason less able to have these needs met. In: Macias Balda,2016: Complex Needs or Simplistic Approaches? Homelessness Services and People with Complex Needs in Edinburgh, accessed at: http://www.cogitatiopress.com/socialinclusion/article/view/596

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A trauma-informed service addresses root symptoms and behaviours, considering them 'normal responses to abnormal stress'[14] instead of looking at them as deviances or failures. According to Herman, the core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based on the empowerment of the survivor and the creation of new connections. Recovery can only take place within the context of relationships, it cannot occur in isolation. Establishment of trust is the first stage of recovery of trauma.[15] Service providers have an important role in creating an environment where clients can establish trust first which can be a foundation for engagement with others. An environment where someone feels emotionally safe and where relationships are consciously prioritized and worked with and within is likely to provide the best opportunity for recovery for someone who has experienced compound or complex trauma.[16]

Why is it important in the homelessness sector?

From the above we see that there is a vicious circle between trauma and homelessness. Trauma drives homelessness and homelessness can increase traumatic exposure. Trauma drives social difficulties and mental health problems which can cause homelessness. Homelessness services have an important role in addressing the long-lasting effects of trauma and also in preventing further trauma.

It is important that services recognize the significance of violence and trauma exposure in understanding their clients' problems and address them successfully by developing trauma-informed approaches.

Trauma from the experience of homelessness reflects a failure of services to provide housing and support, and at worst re-traumatisation as a result of punitive power structures and punitive responses to the behaviours arising from the experience of compound trauma. The bigger the delay in getting the person into housing, the more psychological barriers are created by the experience of homelessness. To prevent a vicious cycle, housing should be obtained as quickly as possible to minimize the potential of additional traumatic experiences.

Two approaches to working with people who have experienced trauma and compound trauma:

1) Trauma Informed Care (TIC)

[14] Bloom, SL. 2000: Creating sanctuary: healing from systematic abuses of power. In: Therapeutic Communities: the International Journal for Therapeutic and Supportive Organizations 21(2):67-91
[15] Hermann, J., 1992, Trauma and Recovery: The Aftermath of Violence - From Domestic Abuse to Political Terror, published by Basic Books, New York.
[16] Cockersell, P.: 'Homelessness, complex trauma and recovery' in Johnson R & Haigh R, eds,2012: Complex Trauma and Its Effects, Hove: Pavilion Publishing

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TIC provides a broad approach to engaging with service users which considers behaviours from a trauma perspective and creates an environment for recovery. The consensus-based definition of TIC developed by Hopper, Bassuk and Oliver is the following:

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

The four important themes in this definition are the following:

Trauma awareness:

A trauma informed service incorporates an understanding of trauma in its work. This also means that the providers and staff become aware how various symptoms and behaviours represent adaptations to traumatic experiences. This should include staff training and organisational changes, such as routine screening for traumatic histories and an assessment of safety. Self- care of staff is also an essential element of trauma informed services.

Emphasis on safety:

Trauma survivors often feel unsafe and may actually be in danger, TIC works towards building physical and emotional safety for both service users and providers. Organisations should also be aware of potential triggers for their clients and strive to avoid retraumatisation.

Opportunities to rebuild control:

Control is often taken away in traumatic situations, and homelessness itself is disempowering, therefore TIC emphasizes the importance of choice for service users. Trauma informed services create predictable environments and allow individuals to rebuild a sense of efficacy and personal control over their lives. This includes involving consumers in the design and evaluation of services.

Strengths-based approach:

TIC is strengths-based, rather than deficit-oriented. Service settings assist clients to identify their own strengths and develop their own coping skills. TIC service settings are focused on the future and utilize skills-building to further develop resilience.

2) Psychologically Informed Environments (PIE)

The PIE approach was developed by a group of homelessness service providers, psychotherapists and psychologists, and the national advisor on rough sleeping in Britain, specifically in recognition that homelessness services and the staff working in them work with large numbers of people who have long experiences of compound or complex trauma. The purpose was to publish guidance (published

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2011) on how services could work effectively, and support their staff in working effectively, with homeless people who have histories of compound or complex trauma.[17]

The PIE approach has been implemented by a range of homelessness services in Britain and Ireland for over six years, in hostels, day centres, street outreach, and for client groups including homeless people, rough sleepers, women-specific services (including services for women involved in drugs and prostitution), services for homeless people with psychiatric diagnoses including schizophrenia and dual diagnosis, and services for children and young adults. There is evidence for its effectiveness in terms of housing outcomes, improved mental health, and staff wellbeing.[18]

There are five principles outlined in the PIE guidance:

Social Spaces

The built environment can be designed, re-designed, re-configured or simply redecorated and re-populated in such a way as to support positive social messages and social interactions, either in groups or in one-to-one or small gathering spaces. Buildings can increase or decrease people's sense of self-worth and sense of emotional value and safety.

Managing relationships

Relationships are key to recovery and to healing trauma. Staff are encouraged to focus on using their relationships with clients to support and encourage self-development and recovery, and to enable clients to feel able to lead their own journey out of homelessness. Many of the techniques of managing relationships are already well-known to homelessness staff, who are often very skilled in this area. Managing relationships goes hand in hand with client involvement and client participation, though these are not specifically addressed in the original guidance (but are likely to be addressed in the second edition).

Psychological framework

The aim of this is to enable a shared understanding among the staff of key concepts about how trauma impacts upon people, how it affects behaviours, how the staff's behaviour might impact upon a person who has experienced compound trauma, and the mechanisms of important human processes such as attachment and self-change. It is not about providing psychology labels, pathologizing, or turning staff into lay psychologists or counsellors.

Staff support

The guidance recognises the tremendous work that homelessness staff do, and that working with people who have experienced trauma (and who often have behaviours that challenge the systems of care and support) is a difficult job. It also recognizes that staff need support in doing this. The PIE approach recommends training on aspects of trauma, behaviour, change, regular supervision; and

[17] The guidance is available here:
http://www.rjaconsultancy.org.uk/6454%20CLG%20PIE%20operational%20document%20AW-1.pdf
[18] Cockersell, P., 2016: "PIEs five years on", Mental Health and Social Inclusion, Vol. 20 Iss: 4, pp.221 - 230

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regular reflective practice groups, where the staff team can build on its understanding of the impacts of trauma and how this affects their work with their clients, increase its own team spirit, and share learning and practice.

Evaluation

If we do not measure the impact of what we do, then we will not know which methods are most effective in which circumstances, and which methods are not so effective, as well as not learning from our working experience. Part of the aim of the PIE approach is to create an environment in which positive learning and positive change can happen for everyone, staff and clients alike; evaluation and outcome measurement is part of this.

Conclusion

Trauma can be pervasive in the lives of homeless people both prior to and during homelessness, it has to be integrated into service delivery for homeless people.

Trauma informed care and the PIE approach align with the goals of the homelessness sector. They can be effective without increased cost and organizational burden as they require a change in the way of working and the attitude towards the work rather than the deployment of significant new resources. There is an ongoing shift taking place in the homelessness sector, a move away from reactions to crisis such as providing shelter, food and clothes, to long term solutions with permanent housing and support around the individual's needs. Trauma-related support should be part of any solution to ending homelessness.

Recommendations:

Create a physical environment that is safe

Develop services based on the assumption that the service user will be managing the effects of trauma

Minimize barriers to service (low threshold and harm reduction)

Ensure that services do not retraumatise service users, e.g. by too strict or authoritarian rules etc.

Ensure a gendered approach (trauma affects men and women differently)

Establish services that offer caring, long-term relationships

Provide training on trauma informed care and therapeutic relationships

Make services client-driven

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Focus on strengths (not deficits)

Support staff with emotional stress to avoid burnout