Trauma and Homelessness

By Dalma Fabian, FEANTSA Policy Officer

Trauma is widely recognised as one of the most pressing public health issues. From neuroscience to developmental psychology, what we have learnt about trauma and its long-lasting effects allows us to better understand how trauma impacts on emotions and behaviours, and it opens up new opportunities to work with people who have often been rejected by services because of their complex needs or behaviour. We can now understand behaviour as a response to the effects of trauma and consider them as ‘normal responses to abnormal stress,’ rather than as deviances or failures. It is often described as asking the question what happened to the person rather than what is wrong with them.

Trauma is very prevalent in the lives of those who are at risk of or are experiencing long term homelessness. In their article, Nicoletta Theodorou and Sarah Johnsen show that trauma often results from adverse childhood experiences (ACEs), the incidence of which is very high among users of health systems, substance use and homelessness services. They conclude that the significant link between trauma and homelessness has implications for systems, substance use and homelessness services. In their article, Nikoletta Theodorou and Sarah Johnsen show that trauma often results from adverse childhood experiences (ACEs), the incidence of which is very high among users of health systems, substance use and homelessness services. They conclude that the significant link between trauma and homelessness has implications for systems, substance use and homelessness services.

Relationships are essential to healing trauma. As Adam Burley puts it in his article, relationships are the psychological equivalent of breathing and the relational element of care can drive change and recovery. In a Psychologically Informed Environment, 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.

Control is often taken away in traumatic situations, and homelessness itself is disempowering and isolating. One of the key elements of Trauma Informed Care, as described in Silvia Samsa’s article, is the opportunity to rebuild autonomy and control by giving a voice and choice to service users. Safe and predictable environments are also vital, as well as allowing individuals to rebuild a sense of efficacy and personal control over their lives. The article shares the experience of developing a whole organisational approach to delivering trauma informed care, which essentially means doing everything through the lens of trauma.

Providing a Psychologically Informed Environment is another approach to delivering homelessness services for people affected by trauma. This approach described by Peter Cocksell has also brought additional benefits for organisations that have implemented it. It reduces staff burnout and turnover, it increases staff motivation and satisfaction, it improves staff/management relationships, it stimulates a learning approach throughout the organisation, not just at service delivery levels.

Trauma produces multiple vulnerabilities which strengthens the case for embedding sensitivity to trauma in the whole system of care. It is clear that the principles of trauma-based approaches are transferable to any service, be it in a psychiatric hospital, in Housing First teams or prisons. This is because it is not so much a model but a recognition of the primacy of trauma which guides the work. The example of Philadelphia as a trauma informed city in Cath Gilliver’s article shows how critical it is to integrate an understanding of trauma throughout the system of care, so that whichever service the person is accessing, they will receive services that are sensitive to the impact of trauma.

This recognition of trauma in the homelessness sector is very important, as pointed out by Boróka Feher and Andrea Szabó. It brings recognition to many lives which have suffered the impact of traumatic experiences in silence. If services are equipped with the right responses to help people with trauma histories, it can remove the shame and stigma that often prevents people from seeking help in the first place. In their article they show that complex trauma manifests differently in women and men and conclude that it is critical to have a gendered approach in service design and delivery and to tailor services to the different needs of women and men.
At the very least, the overt and conscious aim of trauma-sensitive service is to “do no harm and to avoid re-traumatisation or blaming clients for their efforts to manage their traumatic reactions”. It is crucial therefore to eliminate practices that can potentially re-traumatise people e.g. unnecessary rules or coercion into treatment that control the individual, mimic powerlessness and can trigger emotional or psychological responses similar to the original trauma and coping strategies to ease the symptoms e.g. drug use or self-harm etc. This is very well illustrated by the case study shared in the article by Emilie Labeyre and Aurelie Tinland which also shows that uniformed, inadequate services can be traumatising and harmful as well and makes the case for personalised care which empowers people by letting the person to draw up their own care plan.

The idea behind dedicating a Magazine to the issue of trauma was to bring it in the forefront. The costs of ignoring trauma is high. It can take a huge toll on people’s lives and result in people cycling in and out of prisons, hospitals, street and homelessness services. Developing trauma-sensitive services does not require enormous resources, but requires change in the way organisations work.

A bit of caution before concluding. Although it should be clear from the articles, we would like to stress that by focusing on trauma we do not want to over-emphasise mental health problems at the expense of the socioeconomic factors that underlie homelessness. We certainly do not want to pathologise individuals or create new labels, categories or stigma. We have to be cautious that trauma is not just the new buzzword, but an opportunity to engage with service users so that behaviour is seen from a trauma perspective and to create a safe environment for recovery.

For more information on FEANTSA’s work on the link between trauma and homelessness, please read our position paper on this subject.

If you know of a good practice, please contact us at dalma.fabian@feantsa.org.

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KEY STEPS TO DEVELOP TRAUMA-SENSITIVE SERVICES:

- Create a physical environment that is safe
- Develop services based on the assumption that the service user will manage the effects of trauma
- Minimize barriers to service (low threshold and harm reduction)
- Ensure that services do not re-traumatise service users, e.g. by being 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
- Focus on strengths (not deficits)
- Support staff with emotional stress to avoid burnout
Extensive evidence demonstrates that traumatic experiences in childhood are strong predictors of poor mental and physical health in adulthood. Homelessness is one of the numerous negative effects that have been associated with Adverse Childhood Experience (ACE). Research has increasingly drawn attention to an overrepresentation of ACE amongst homeless populations; so too significant correlations between ACE and the risk of homelessness. This paper provides a brief overview of literature on the links between homelessness and ACE. It begins by offering a definition and examples of ACE, before outlining the findings of key studies on the prevalence and impacts of ACE amongst homeless adults. It concludes by reviewing evidence regarding the nature and effectiveness of policy responses.

DEFINITION

The term ACE encompasses multiple forms of childhood emotional and physical abuse, neglect and household dysfunction. Examples of emotional and physical abuse include actions such as being insulted, put down, threatened, pushed, grabbed, or hit by an adult living in the child’s home. Emotional neglect involves things such as not feeling loved or protected by parents (or another caregiver), whilst physical neglect refers to not being provided with basic necessities such as adequate food, clothing and shelter or necessary medical care. Examples of household dysfunction may include: living with an adult with mental illness and/or substance misuse issues, experience of parental separation and/or loss, or incarceration of a close adult, as well as witnessing violence inside and outside of the home environment (for a full list see World Health Organisation, 2006).

Research has consistently shown that exposure to such traumatic and stressful psychological conditions in early life can have pervasive effects in adulthood, given that they occur in early developmental stages (and often within the family of origin). In particular, ACEs have been strongly associated with negative outcomes that persist over time on both mental and physical health, including amongst others: problem-atic substance misuse, depression and higher suicide rates, obesity, heart disease and even premature mortality (Felliti, 1998; Anda et al., 2006; Dube et al., 2001; 2003).

Key studies also point to the interrelated nature of ACEs. Notably, individuals who report one ACE are between 2 and 18 times more likely to have experienced at least one other ACE than are those who have experienced none (Felliti, 1998). At the same time, individuals that have experienced four or more ACEs have a two-fold increased risk of adult physical illness and 4- to 12-fold increased risk of behavioural and mental health problems (Felliti, 1998).

PREVALENCE AND IMPACTS

To date, much of the research on the links between ACE and homelessness derives from the USA, albeit that the subject is garnering increasing research interest in Europe (and the UK, in particular). This evidence suggests that childhood adversity features disproportionately in the life histories of homeless individuals (see Sundin, 2015 for a review). This has been most clearly illustrated in the UK by recent statistical analyses that profile the extent and nature of severe and multiple disadvantage (Bramley et al., 2015; Fitzpatrick et al., 2013). Specifically, Fitzpatrick et al.’s (2013) study of multiple exclusion homelessness indicated that childhood abuse and neglect are prevalent in the biographies of people using low threshold support services in the UK. Only a very small minority of the 452 extended interview participants reported not having experienced any ACE, whilst reports of sexual abuse and physical abuse were reported by 23% and 22% respectively, and not having enough to eat by 15% (see Table 1). Even greater numbers reported witnessing violence between their parents/carers (27%) or that one or more parent/carer had a drug or alcohol problem (24%) (Table 1). In addition, the analysis indicated that experience of childhood adversity was a significant risk factor for homelessness before or shortly after the age of 16 (Bramley et al., 2015; Fitzpatrick et al., 2013).
Table 1. Experiences in Childhood (under 16 years old) * Multiple responses were possible

<table>
<thead>
<tr>
<th>EXPERIENCE</th>
<th>PERCENT</th>
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<tbody>
<tr>
<td>Truanted from school a lot</td>
<td>50%</td>
</tr>
<tr>
<td>Suspended, excluded or expelled from school at least once</td>
<td>36%</td>
</tr>
<tr>
<td>Ran away from home and stayed away for at least one night</td>
<td>34%</td>
</tr>
<tr>
<td>Didn’t get along with parent(s)/step-parent/carer(s)</td>
<td>29%</td>
</tr>
<tr>
<td>Violence between parents/carers</td>
<td>27%</td>
</tr>
<tr>
<td>Parent(s)/step-parent/carer(s) had a drug or alcohol problem</td>
<td>24%</td>
</tr>
<tr>
<td>Sexually abused</td>
<td>23%</td>
</tr>
<tr>
<td>Badly bullied by other children</td>
<td>22%</td>
</tr>
<tr>
<td>Physically abused at home</td>
<td>22%</td>
</tr>
<tr>
<td>Brought up in a workless household</td>
<td>21%</td>
</tr>
<tr>
<td>Family was homeless</td>
<td>16%</td>
</tr>
<tr>
<td>Spent time in local authority care</td>
<td>16%</td>
</tr>
<tr>
<td>There was sometimes not enough to eat at home</td>
<td>15%</td>
</tr>
<tr>
<td>Neglected</td>
<td>15%</td>
</tr>
<tr>
<td>Parent(s)/ste-parent/carer(s) had a mental health problem</td>
<td>15%</td>
</tr>
<tr>
<td>Base</td>
<td>451</td>
</tr>
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Source: (Fitzpatrick et al., 2012, p.44)

Additional evidence from research conducted in the UK highlights a strong association between family poverty and an increased prevalence of child abuse and neglect (for a full review see Bywaters et al., 2016). The more acute the socio-demographic circumstances of the families, the greater the likelihood (and severity) of experiencing multiple ACEs. This relationship has been attributed either to the direct impact of lacking material goods or the indirect one through parental stress and/or through the physical environment (i.e. living in a deprived area) (Bywaters et al., 2016). The association between childhood deprivation of various forms (e.g. not having enough to eat at home) and trauma in early life has also been highlighted as a strong predictor of extreme exclusion within homeless populations (Fitzpatrick et al., 2013).

Several studies have also found a strong association between current victimization and childhood maltreatment. Findings suggest that having experienced a number of ACEs severely increases the risk for running away from home, which places one at greater risk for re-victimization, engagement in risky behaviours and poor mental health (Tyler and Johnson, 2006). According to this risk amplification model, experiences on the streets tend to exacerbate early traumatic experiences, which in most cases are poorly addressed (Whitbeck et al., 1999). These create an additive risk for further exposure to abuse and violence while being on the streets (Whitbeck et al., 1999).

The relationship between different forms of childhood adversity and homelessness has also received some attention (Roos, 2013; Mar, 2014). Evidence suggests that physical abuse, physical neglect and general household dysfunction are the most prevalent childhood adversities reported by members of homeless populations. The survey data derived from a large nationally representative sample (34,653 participants) in the US. A few studies have also looked into links between gender, ethnicity, age of first homelessness episode and childhood maltreatment. Experience of sexual abuse was found to be higher among homeless women regardless of age and ethnicity, while being a victim of physical abuse was more likely to be reported by white males (see Sundin et al., 2015 for a review). In parallel, studies that used older samples of homeless individuals found that the rates of physical abuse in early childhood were lower when compared to younger samples (Koegel et al., 1995). Additionally, based on a growing body of research, age of first homelessness has been identified as being strongly associated with increased numbers of experiences of physical/emotional abuse and neglect (Mar et al., 2014; Kim et al., 2009). It has been suggested that reporting 4 or more of different ACEs severely affects the age of first experiencing homelessness, in that homelessness is more likely to occur at a young age (Mar et al., 2014).
It is now widely accepted that traumatic experiences can have a direct impact on an individual’s ability to regulate emotions, cope with later challenges and sustain supportive relationships with others (Maguire et al., 2009). Experience of multiple ACEs has also been noted to have a cumulative effect on drug and alcohol misuse (Dube et al., 2002; 2003). For these reasons, ACEs not only contribute to homelessness but can also create barriers to recovery.

RESPONSE AND PREVENTION

In recognition of the long-lasting effects of violence and trauma in the context of homelessness, two main practice approaches have been developed: Psychologically Informed Environments (PIE) and Trauma Informed Care (TIC). Both approaches aim to address the psychological needs and improve the emotional well-being of their service users by working with (and sometimes through) the interpersonal challenges that are associated with previous trauma so that the individual is better able to rebuild a sense of control and empowerment (Hopper et al., 2010; Johnson et al., 2011). This is based on evidence suggesting that secure attachments and social support can determine the nature and extent of one’s reaction to trauma (Herman, 1992). Evidence on the effectiveness of those approaches in the context of homelessness is limited in terms of quantity, but shows very promising outcomes. For instance, a recent review on PIEs in UK and Ireland has reported better housing outcomes, improved mental health and reduced social exclusion (Cockersell, 2016).

Given the compelling evidence regarding the links between ACE and homelessness reviewed above, it is clear that priority should also be placed in developing ACE-preventing interventions. This is, of course, outwith the remit of much of homelessness policy and provision; but, stakeholders in the homelessness sector might valuably lend their support to associated campaigns and the promotion of good practice in this area. Notably, The World Health Organization has issued a number of publications such as the European report on preventing child maltreatment (WHO, 2013) and a report on key types of child maltreatment prevention programmes (WHO, 2015) to address this need. Those programmes can be understood as a means to reduce the long-term negative effects of ACE, and potentially decrease rates of homelessness.

CONCLUSION

Existing research indicates that ACE is a common feature in the biographies of homeless people. It is clear that socioeconomic disadvantage in conjunction with trauma in early life can have a detrimental effect on later psychosocial functioning and physical health. Further to this, the experience of homelessness in itself can exacerbate previous symptoms of early trauma and increase the risk of re-victimization. There is a clear imperative for further investment in preventive programmes, and reason to be optimistic about the potential benefits of psychologically and trauma informed interventions for this vulnerable group.

REFERENCES


Choking Up.
Relationships, Multiple Exclusion Homelessness, and Psychologically-Informed Environments.

By Adam Burley, Consultant Clinical Psychologist, Edinburgh, NHS Scotland

TAKE A DEEP BREATH.....

Just as breathing is essential for physical life, human relationships are essential to psychological development and well-being. As with breathing, relationships tend to run along in the backgrounds of our day to day lives, out of our attention, and, for the most part, unconscious. It is not, perhaps, until we start choking, then we begin to notice just how fundamental breathing is to our well-being. What was an automatic process that we had not given much consideration to suddenly becomes the sole focus of our attention, and the rising panic we feel tells us something about how central to life this mundane process is. The same is true of relationships. Nevertheless, they provide the absolute fundament to our psychological and social functioning, providing the medium through which we develop attachments and connections, that in turn allow us to do things such as develop friendships and families, raise children, secure occupation and meet our emotional needs.

When these relationships ‘choke’ we start to become aware of just how central to our lives these invisible processes are. For example, if all our relationships were to choke, we could quickly find ourselves becoming friendless, jobless, penniless, emotionally distraught and, perhaps, homeless.

The literature, life stories and research surrounding a population often referred to as the ‘multiply excluded homeless’ routinely tells a story of lives that began in adversity, and developed in circumstances where traumatic, neglectful and depriving experiences were commonplace. Studies have repeatedly shown that the reported levels of abuse, neglect and other forms of severe adversity are extremely high in this population, and this has led researchers to describe the homeless aspect of the presentation as being a late emerging symptom in lives that have been marred by distressing and troubling experiences from the very outset. From this perspective, homelessness is but one symptom of a developmental pathway influenced by a range of known and predictable variables, rather than the random accident it is often portrayed to be. Multiple exclusion homelessness does not just ‘happen to anyone’.

Extreme levels of adversity can have profound and long lasting effects on the individuals who have experienced them. Over and above the plethora of neurological disturbances that trauma and neglect can have on the developing brain, the psycho-social consequences of developmental adversity can be devastating and hugely life-limiting. In particular, childhood adversity can seriously impact upon an individual’s developing sense of how they relate to others, and how others relate to them. This kind of history can give rise to serious disturbances in the capacity to form trusting and anxiety-free relationships with others, and so limit the degree to which an individual can develop both psychologically and emotionally. It can make intimacy and secure attachment difficult, if not impossible. As a consequence of these disturbances the capacity of an individual to connect with the world and the people in it can be severely damaged. In short, it can lead to a serious ‘chocking’ in relationships. At the severe end of the scale it can lead to the deep level of social exclusion so often seen in this population. The impact this can have on the life expectancy of an individual is catastrophic; A Recent review of the average age of death of multiply excluded homeless patients accessing a dedicated health centre in Scotland was 42 years of age. Choking kills, as does choking in relationships.

All health and social care is fundamentally relational. It involves one group of people (patients, service users, clients etc.) coming into contact with another group of people (support workers, doctors, social workers, psychologists, nurses etc.) in a relational dynamic that centres around the need for and provision of care. Without taking notice of the relational elements of care when working with people from very adverse backgrounds, health and social care providers can often become caught up in the relational choking described above, and find themselves (unconsciously) re-enacting some of the neglecting, excluding and abusive experiences so common in the histories of the people they are trying to serve.

Service providers often use words such as ‘engagement’ to describe how they feel someone is relating to them, or, perhaps more commonly ‘non-engagement’ to describe relationships where the service user is not relating to the service in the way that the service would like them to. It is when services then act upon these feelings by doing such things as discharging or excluding a patient that relational damage is replicated. When people who have experienced high levels of distress communicate their history by behaving in distressing ways it is understandable that services might use phrases like ‘non-engagement’ as a way of getting rid of the distressing behaviour, but in doing so they may well exacerbate the life problem as they re-enact an excluding and rejecting dynamic.

By
Adam Burley,
Consultant Clinical Psychologist, Edinburgh, NHS Scotland

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Health and social care typically operates from a relational model that is rarely articulated, but assumes all users can make use of care in a straightforward and anxiety-free way. Policies and procedures that determine inclusion and exclusion from the care relationship are then derived from this basic assumption. This somewhat institutionally-autistic idea can prove very problematic for those whose responses are, by virtue of trauma and adversity they have experienced in their developmental experiences of care, very far from straightforward. Trauma, disturbance and adversity in the earliest experiences of others can lead to later care relationships that appear complicated, ambivalent, and even destructive. A failure of the service to understand, bear or tolerate the way in which the service user is actually relating to care, can easily lead to excluding and limiting responses. The relationship choking and the service user has another experience of being excluded, which typically serves to increase their anxiety about future contacts with care.

For those individuals who have experienced high levels of anxiety, pain and suffering in their early experiences of care, then the relationship that the individual has with care itself can become the life-limiting problem. The difficulties that the person has in the formation and maintenance of life-giving relationships in their general life can be intensified when they are in contact with a service specifically organised around care. A horrible dilemma can occur for the individual whereby their need for care increases as they struggle to get those care needs met, but their phobia of the care relationship and the subsequent choking dynamic means they cannot get the care they need. The trauma and adversity they have experienced has left them understandably extremely ambivalent about relationships, and in particular about relationships that are built around an offer of care. As described above, most services do not respond well to ambivalence. Instead, they demand (sometime overtly, sometimes more subtly) that service users engage (relate) to the services being offered in the way that those who designed the service dictate. Other atypical and challenging ways of relating can lead to excluding responses such as discharge, service bans, and treatment refusals.

A psychologically-informed approach places an interest and analysis of the relational elements of care at the heart of its operation. It acknowledges the psychological and emotional needs of the individuals it finds itself in relationship to, and attempts to organise itself around a sound and grounded understanding of those needs. It recognises the relationship between itself and those with whom it works as the central vehicle for care and change, acknowledging that the psycho-social background of the individual may have impacted upon the ways in which they relate to themselves and others. It seeks to provide a physical environment that feels safe and secure and aims to be informed by a coherent and evidence-based psychological framework. Recognising that the relational dynamics of the work may not always be straightforward, a reflective practice process for service providers is a central component of the approach. This provides a regular and protected forum in which staff can speak honestly about their relational experiences, and through reflection try and use their experiences to inform future care in a way that aims to maximise the well being of both staff and service user. At its most simple level a psychologically-informed service attempts to take full account of the psychological and emotional developments of those who seek care from it, and works hard to ensure that it does not re-enact the adverse relational dynamics that may have left the service user in need of them in the first place.

The literature on adverse childhood experiences is clear about the protective nature of having at least one secure and trustworthy relationship in childhood. This data highlights the importance of secure relationships in the development of good mental and physical well being, and provides evidence as to why and how a psychologically-informed approach views relationships as the key component of enabling change. The approach can serve to validate and legitimise the development and maintenance of relationships as being an important, if not fundamental, part of the work. The care relationship is often de-emphasised in mainstream care provision in contrast to the elevated place specific treatments and interventions are afforded. This can often leave care staff with an idea that all of the good stuff is being done elsewhere and by other people, for example by highly trained professionals in specialist clinics to which individuals are referred as part of their care. The psychologically-informed approach challenges this perception, and with proper reflective practice processes in place, demonstrates that a good psychological understanding can be owned and shared by everyone, and that good psychological care may be provided by staff and service providers at all levels.
In sum, relationships might be regarded as the psychological equivalent of breathing. We all have multiple and complex psychological needs, but thankfully for most of us we can get those needs met through the basic processes of relating, something we do as naturally and effortlessly as breathing in a friendly, oxygen-rich atmosphere. However, there are those for whom the basic processes are not straightforward, and it is only through the analysis of relationships that repeatedly choke, and the continued provision of relationships that carry the potential for health, that the levels of exclusion and health inequality experienced by some of the most vulnerable members of our communities will ever be addressed.

**CASE EXAMPLE**

John is a 35 year old man who was brought up in care from the age of five after it was recognised that his home environment was not physically or psychologically safe. He had experienced physical abuse and neglect by the time he went into care, and experienced further abuse whilst in care. As he aged he began to communicate his experiences through abusive behaviours toward those he perceived to be either a threat to him, or in a position of power. This included most people, and these interactions led to regular contact with the criminal justice services and periods of time in prison for violence related crimes. He began rough sleeping, and using drugs and alcohol from around the age of sixteen, and continued to cycle in and out of homeless, health and criminal justice services for the rest of his teens and twenties. These relationships, like those he had in his personal life, seemed to oscillate between high demand of others, and aggressive rebuttals of any service that attempted to meet those demands. He would engage with services through not attending offered appointments, and then becoming angry when those services discharged him in response to his non-attendance. This meant that through the 19 years that he had been known to services he had never managed to complete a single treatment regime, or remain in relationship with a service (outside of prison) for longer than three months. Relationships with housing and care providers would typically end in exclusion, discharge or eviction due to ‘non-engagement’.

A psychological formulation described a severe ambivalence at the heart of understanding John’s emotional and psychological needs. His demands for care were seen as a genuine request for assistance, while his rejection of care was viewed as being a defensive response to the anxiety that being in need of others evoked in him. This understanding was embedded in what was known about John’s developmental history, and rather than seeing his non-attendance as non-engagement it was viewed as an extreme form of ambivalent attachment. John appeared to simultaneously be both desperate for help, and desperate to avoid it in equal measure. While John was residing within a hostel that was attempting to develop a psychologically informed approach to care, this formulation was used to influence how the staff and service positioned themselves in relation to John. The informed plan was not complicated in nature, being organised around a simple approach of responding to John’s ambivalent ways of relating by continuing to provide the opportunity for care past the point where mainstream services had typically pulled the plug. Support meetings were offered in a committed way independent of whether John attended or not, and importantly John’s tenure in the accommodation was not contingent upon him engaging with support in a pre-determined way. Through this simple approach being provided consistently and coherently, and with staff support in place, John was able to sustain the supported accommodation for 34 months to date, attend support meetings on a regular basis, and begin to think about his future. This period of accommodation is the longest that John has ever been securely housed in his life, and the longest period he has ever gone without rough sleeping. He is able to report that there are members of staff that he trusts. Many of his difficulties remain, but it does feel as if he is starting to breathe a bit more easily.
Women’s Habitat – taking a trauma-informed approach to helping survivors of violence

By Silvia Samsa, Executive Director of Women’s Habitat

Women’s Habitat operates a 25 bed shelter for women and children who are survivors of violence. We offer safe shelter, advocacy and supportive counselling using a trauma informed approach, but what is trauma-informed and how do we take a term that is often used in our sector and put it into practice in every aspect of our service delivery? Since our shelter opened in 1978 we have served thousands of women who share they are harmed or re-traumatized by uninformed, inadequate social systems, including women’s shelters.

The process to undertake a trauma informed perspective involves staff and management. Training is essential and we all enrolled in a six day trauma training course. This training was essential for all of staff to understand that the women we work with had experienced trauma due to their abuse and some of the behavior was a direct result of the trauma. It is from this place that we changed our ways of working, not only by revising policies and procedures, but by creating a space where women can feel safe and empowered to challenge us.

Our first step on journey to create trauma informed relationships with our clients was to redesign our physical space. We provided in-room safe’s that allowed control and autonomy over medications/valuables. We recognized abuse included control over food access, where food is limited, or food intake is monitored and we responded by providing an open, accessible well stocked kitchen.

Next we eliminated rules that controlled the women (i.e. curfew). Creating rules and policies provided us with control and comfort. Removing rules made us uncomfortable and forced us to follow our client’s instructions, not the instructions of a policy manual. When we enforce rigid rules and guidelines we are mirroring the power and control many women have experienced in violent relationships, re-traumatizing them and breaking their trust in us. The pivot point in eliminating rules was when reading one of the evaluations that women fill out when they are about to leave the shelter for permanent housing: “I do not do my chore and I get a warning, which can lead to me and my family being discharged. How are you any different that my husband who hits me when the supper is not good enough?” To be trauma informed meant that if we wanted to listen to the women we work with, we had to listen to the criticism and ensure that changes were made. A trauma informed approach takes work, challenges our interactions with our clients, other staff and ourselves. Clients need to know that there is an avenue for complaints (as well as positive feedback). Complaints policy posted on an agency’s website and on site signal to the clients that an agency is open and willing to listen to feedback.

We applied an intersectional approach. We recognize that we have been a part of the western feminist movement that has ignored and silenced the voices of marginalized women. Our clients are forced to confront multiple layers of traumatic experiences and when we ignore their unique experience we are denying them the support and service they deserve.

Many of the women we work with deal with their trauma in ways that staff find challenging. We recognize that the ‘nice, abused woman’ is the client of preference. The impact of trauma on the women we work with affects their coping skills and relationships with others. Staff job’s is to support and model behaviors that are positive.

We collaborated. We understand that in order to provide holistic care we must create meaningful partnerships with organizations that share our commitment to trauma-informed practices and are skilled service providers. By doing so we can ensure we are making thoughtful referrals and strengthening our own service delivery.

We committed to continuous learning. We invest the time and resources to train staff, volunteers and board members. We provide current, relevant trauma training and workshops on harm reduction. We ensure these trainings are taught by or informed by women with lived experience. Our staff team is diverse and we build their skills based on their individual needs.

We committed to public policy advocacy. Traditionally our clients have a limited voice in the policy process. We use our platform to provide opportunities for survivors to be involved in matters that are important to them by hosting community forums, providing opportunities for them to depute at City Hall and providing them with the support and resources to do so. We consult them when we are creating media campaigns, educating the public, advocating, researching and reporting on issues that affect them.

We expect the women we work with to change and yet find change a challenge for ourselves. We support staff in their struggle to work in a new way, individually in supervision and in staff meetings. We recognize vicarious trauma experienced by our staff if left undressed can limit their effectiveness and cause mental and emotional harm.

Being trauma informed is constantly evolving and changing your ways of working. Just as we must continuously check our power and privilege, we must challenge our practices and each other. We cannot constrict ourselves with rigid policies and procedures and we need to push back at funders and stakeholders who require us to do so.

In the anti-violence against women sector we often call ourselves the experts of this work. We do this because violence against women is often reported on in the media in insensitive and harmful ways without our consultation. However we are only the experts because our clients supply us with the knowledge. Being trauma informed is continuously seeking that knowledge. It is not their job to teach us, but it is our job to learn, and it is a job we are privileged to have. They are the experts of their trauma and they must always guide our work.
Anybody who has worked with long-term rough sleepers and the chronically homeless knows that a large proportion of them have experienced very difficult lives, often starting with early childhood experiences of abuse, neglect, parental separation, death or alcoholism, often followed by difficult school histories, maybe trouble with the police, with violence, or drugs, or alcohol, or mental health problems (often undefined), and sometimes with all these things. They then in adult life face social exclusion and the dangers and challenges of rough sleeping. This understanding among homelessness workers of the clear link between compound trauma and long-term or repeat homelessness has been confirmed by a range of academic studies in Britain, Europe, and across the world (Maguire et al, 2009; Cockersell, 2011).

Psychologically Informed Environments (PIE) is an approach to working with homeless people that takes into account the psychological and emotional impact of exposure to trauma and social exclusion, and the effect that this has on behaviours, and it also supports staff in working more effectively to enable this group of people to move sustainably out of homelessness.

It was developed by a working group chaired by Helen Keats, who was at the time the Rough Sleeping Special Advisor to Britain’s Department of Communities and Local Government, the government agency responsible for homelessness, and consisting of social workers, psychologists, psychotherapists, and providers of services for homeless people. The concept of the Psychologically Informed Environment arose from the experience of the providers in piloting similar concepts, from the tradition of therapeutic communities, and from initiatives in mental health and criminal justice services such as Enabling Environments and Psychologically Informed Planned Environments. The idea was not to pathologise the homeless, nor to psychologise homelessness services, but to use the understandings and some of the techniques derived from psychology to enable better support for staff and more insightful interactions with the clients that would be more likely to lead to sustained life changes.

In 2012 the group published guidance on developing PIEs (Keats et al, 2012), which is available at www.Pielink.net, which set out five principles that underpin a psychologically informed approach. The principles are:

1. **Psychological framework:** which essentially means a way of understanding behaviour and how interactions affect behaviour, and how trauma influences behaviours and motivational systems

2. **Social spaces:** which is about the impact the environment has on social relations, and on enabling people to embark on their personal recovery journey

3. **Managing relationships:** this focuses on understanding the importance of the relationship between staff members and clients, and how to use these relationships as the key to effect positive change (and avoid negative outcomes)

4. **Staff support:** two key elements of staff support were identified, which were relevant and regular training on various aspects of behaviour, the processes of change, the impact of trauma, ways of motivating, involving and supporting people; and regular (at least monthly) formal reflective practice sessions, usually externally facilitated often by a psychologically-trained professional (a psychologist or psychotherapist)

5. **Evaluation:** gathering information on the effectiveness of the approach, to use to develop more effective service delivery and to support funding for homelessness services working in this way

Since the publication of the guidance, many homelessness agencies have adopted PIE as an approach, and a number of local authorities have specified the PIE approach in commissioning homelessness services. There are now PIEs working in hostels, day centres, outreach teams, night shelters, and accommodation services for people with mental health problems, women fleeing domestic abuse, women involved in prostitution, children in need of care, ex-offenders, people with dual diagnosis of mental health and substance dependency problems, and of course rough sleepers.

Because the PIE approach has now been implemented in so many services working with such a range of clients, and in so many homelessness agencies across several countries, there has been a demand for an updated version of the guidance, and more supportive materials, examples of practice in different settings, information on psychological frameworks, systems of evaluation and so on.
The new guidance for the PIE approach to be published in 2018 will add two more principles, as well as refining and redefining the original five in the light of experience. The two additional principles are:

6. **Client involvement**: the idea of client involvement runs through the original guidance but it was not made explicit and this was a mistake and an oversight. Client involvement, leading to client participation and eventually co-production, has been shown to be a powerful tool for enabling recovery. It is also right — the redistribution of some power and responsibility to those who have been socially excluded is an act of social justice as well as good for effective homelessness services.

7. **Access to psychotherapy**: this is a slightly different principle, in that it is not a requirement of the service, but something the service should seek to establish if possible. Access to psychotherapy enables people with histories of trauma to work through some of the impacts in a way that untrained staff cannot safely or easily contain, and to explore some issues in greater depth than is possible with busy hostel staff, and it also protects homelessness staff from too much exposure to the risk of vicarious trauma.

Evidence for the effectiveness of PIE from the first five years of operations suggests that there is:

- a significant reduction in the number of incidents in services using this approach compared to similar services following more traditional approaches
- a significant reduction in evictions
- increased positive move-on and sustained move-on
- an increase in take-up of other services including employment and training and drug and alcohol treatment services
- a clinically significant reduction in mental illness
- and improved staff retention and morale

(Cockersell, 2016)

There are many ways of working with people who have experience compound trauma and social exclusion: the PIE approach is one of them with proven effectiveness in the field of rough sleeping and homelessness, and in an increasing number of other fields. Organisations that have implemented the PIE approach have found not only that they are more effective in helping the homeless people they work with, but also that PIE brings additional benefits — it is not expensive to introduce, as it is an approach rather than a model; it reduces staff turnover and absenteeism, and improves staff motivation and satisfaction; it improves staff/management relationships; it stimulates a learning organisation approach throughout the organisation, not just at service delivery levels; it triggers greater participation by clients in a range of other aspects and activities provided by the organisation or others in the environment, so it has a wider impact than just on the service itself; and it is valued by the clients. Organisations have also learned that, as it is an approach, they benefit most by adapting it to fit their own particular client group, their own organisational strengths, and their own situation: PIE is not the same in a service for homeless families in Cork, or a day centre for rough sleepers in Bristol, or a home for disturbed children in Birmingham, or a psychiatric hospital in Luxembourg.

Implementing the PIE approach is a creative process in any organisation that adopts it, and it stimulates the creativity of the whole organisation and of the staff and clients who live and work within it. The evidence suggests that it also improves the outcomes for homeless people.

Cockersell P (2011) Homelessness and mental health: adding clinical mental health interventions to existing social ones can greatly enhance positive outcomes, in Journal of Public Mental Health, 10:2, 88-98


Philadelphia: a trauma informed city

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INTRODUCTION
In 2016 I spent 4 weeks in the States to research policy and practice in relation to the trauma informed care approach with particular reference to its use within homelessness services. Of the four cities I visited, (New York, Detroit, Boston and Philadelphia), while I found examples of good practice in all of them, Philadelphia stood out due to its commitment to becoming a trauma informed city with trauma informed principles embedded across its Human Services.

THE BACKGROUND TO THE DEVELOPMENT OF THE TRAUMA INFORMED MODEL IN THE UNITED STATES
In 1997 a large and ground breaking research study in the US, commissioned by Kaiser Permanente, demonstrated both the prevalence of Adverse Childhood Experiences (ACEs) and the causal relationship between these and mental and physical ill health in adulthood; as a result, as well as the more expected correlations between negative childhood experiences and mental illness or substance misuse in adult life, researchers discovered a strong link with physical disease such as heart and lung disease.

The result was both an emphasis on prevention and early intervention in childhood and adolescence and national attention on how to work with the adult survivors of ACEs in order to promote healing and avoid retraumatisation; this led to the development of the trauma informed model and its promotion by the US government’s Substance Abuse and Mental Health Services Administration (SAMHSA).

PHILADELPHIA’S CHALLENGES AND THE CITY’S RESPONSES
Philadelphia, 94 miles south west of New York, is the sixth biggest US city in terms of population, (1.6 million), but also the poorest US city with over 12% of its population in deep poverty, (defined as living at 50% or below of the national poverty line). There is a seasonal fluctuation in the street homeless population as people go south to escape the harsh winters, but a January 2016 ‘Point in Time’ survey found 705 unsheltered homeless individuals while 15,000 people (including families) accessed the City’s shelters last year.

Contributing factors to homelessness include the disparity between housing costs and Social Security or the minimum wage, a shortfall in shelter places, affordable housing, transportation and healthcare, along with the prevalence of domestic violence and the relative lack of accessible mental health and substance misuse support; like most rural and urban areas of the US, Philadelphia is experiencing the opioid epidemic with a 58% rise in drug-related deaths between the first six months of 2016 and the same period this year.

In response to these challenges Philadelphia has been at the forefront of developing and implementing a city-wide trauma informed model, largely due to the strong leadership provided by its Public Health Department, DBHIDS, (the Department of Behavioral Health and Intellectual Disability Services), which has influenced and directly changed practice across Children and Family Services, Emergency Services and schools as well as in relation homelessness and substance misuse. In addition to a number of inspirational individuals with a long term commitment to DBHIDS, the interplay between national and State government and the City, (at that time in late 2016), seemed to allow for a considerable degree of autonomy in developing robust and coherent systems and long term planning with positive support and funding available from national agencies such as SAMHSA and the US Department of Housing and Urban Development (HUD).

The strategies to realise this have included requiring a trauma informed care approach in cross sector commissioning, rolling out free training on the model along with complementary tools and programmes, such as Mental Health First Aid and Critical Intervention training, and setting up multi agency networks in partnership with Drexel University to share good practice in relation to ACEs and trauma informed care. This has resulted in the development of a shared language and belief system, particularly in work with disadvantaged groups, that has led to a high level of communication and collaboration across diverse sectors and services.

However, one of the most visible and, (for me), high impact initiatives is Porchlight, part of Philadelphia’s wider Mural Arts programme, which employs artists to work alongside disadvantaged groups and communities to create largescale murals across the city depicting community history and the challenges faced by, (for example), homeless groups or areas struggling with high levels of violence and suicide. This public art programme is also mirrored within many individual services, in that all the agencies I visited used art as an important tool to build skills and confidence and as a means to divert people from issues such as crime or substance misuse, while many services also consciously use art in the recognition that people who have experienced trauma may find it easier (and safer) to express their feelings non verbally.
Two examples of Philadelphia homeless services I visited which have fully adopted a trauma informed approach are described below:

- **Journey of Hope**
  [http://dbhids.org/about/organization/office-of-addiction-services/recovery-house-initiative/the-journey-of-hope-project/](http://dbhids.org/about/organization/office-of-addiction-services/recovery-house-initiative/the-journey-of-hope-project/) set up in 2007, provides a residential programme for people who have a history of chronic homelessness and substance misuse, as well as mental health problems, with the promise of access to independent housing on successful completion. Contact starts with assertive outreach to people on the streets and, (very unusually in my experience), Senior Managers play an important part in outreach in order to build a relationship with clients from the start to avoid a split between frontline staff and Managers in clients’ perceptions. The six projects include a 10-bedded facility for women, Woman Space, which provides a full programme on therapeutic community lines, maintaining a strong trauma informed and recovery focus, with daily house meetings, individual psychotherapy and art therapy sessions and group activities. Data from the projects defines a positive outcome as move on into independent, semi-independent, or supported independent living with 2010 data showing a variation in positive outcomes from 19% to 65% between projects.

- **Broad Street Ministry**
  [http://www.broadstreetministry.org/](http://www.broadstreetministry.org/) is a Philadelphia Day Shelter run by a Christian community and practising a model called Radical Hospitality which sees the provision of unconditional welcome and immediate practical support as vital in responding to need; and potentially life changing in themselves, but also as prerequisites in enabling people to engage with deeper, longer term change. Their application of a trauma informed model includes the concept of Trauma of Scarcity: - recognition that the experience of homelessness is in itself retraumatising through the difficulty in getting basic needs met; and this concept has had a major influence on the physical design and layout of the building as well as the way that guests are greeted and meals served. For example, the dining room is arranged hotel style with small round tables, flowers and a fruit bowl on each, and an experienced volunteer stationed near the door to welcome people individually. Once they are seated a staff member gives a more formal welcome which includes thanking guests for treating everyone with kindness and respect.

Again, arts are a central feature of the Broad Street Ministry ethos, with art sessions available daily and partnerships in place with the Philadelphia Museum of Art and the Philadelphia Orchestra, among others.

I was particularly interested in this approach due to my then role as Chief Executive of SIFA Fireside, a Birmingham-based homelessness charity, [www.sifafireside.co.uk](http://www.sifafireside.co.uk), which delivers services from a Day Centre base and, similarly, provides open access practical support as a gateway to its more formal services as well as using art, drama and music as recovery tools.

With One Voice, [http://www.with-one-voice.com/](http://www.with-one-voice.com/), an international arts and homelessness movement coordinated by UK-based Streetwise Opera which aims to connect the sector world-wide, published its first North America Review of Arts & Homelessness [http://with-one-voice.com/north-america-country-review](http://with-one-voice.com/north-america-country-review) in April 2017; this showed a passionate and effective but under-resourced and fragmented sector and has resulted in a six day exchange and conference in Montreal in November 2017 for delegates from the US, Canada and the UK to make connections and share good practice.

However, my overall experience in Philadelphia was not one of fragmentation and lack of resources due to the overarching framework and guidance provided by DBHIDS, the synthesising principles of the trauma informed care model, and the symbolic and unmissable public statement delivered by the Porchlight programme. In addition, access to local, national and State funding, along with a strong tradition of philanthropy, meant that many projects were better resourced, particularly in terms of staffing, than they would have been in the UK.

**FURTHER READING**

- Calm through creativity: how arts can aid trauma recovery; Family & Youth Services Bureau; web article 2015
- Innovations in recovery management for people experiencing prolonged homelessness in the city of Philadelphia; Maguire Sheahan & White; Alcoholism Treatment Quarterly 2012
- Mural arts@30; Golden and Updike; Temple University Press 2014
- Using trauma informed care to provide therapeutic support to homeless people with complex needs; Jo Prestidge; Housing Care & Support Vol 17 Issue 4 pp 208-14.

Philadelphia has been at the forefront of developing and implementing a city-wide trauma informed model.
Signs of Possible PTSD among Homeless People

By Boróka Fehér – Andrea Szabó, BMSZKI, Hungary

In both quantitative and qualitative research in Hungary, homelessness is seen as “a loss of a thing, person or status … which can be experienced as traumatic” (La Capra, 1999). Even though many homeless people come from underprivileged, impoverished households (see Győri, 2017), “the loss of family, friends and neighbours; health and beauty; toes, or even whole feet or limbs; jobs, skills and income; homes, daily routines and social status or a place in society can all be traumatic experiences” (Fehér, 2011). While traumatic experiences might surface during talking with homeless people directly, or they might be “absent but implicit” (White, 2000), the February 3rd working group tried to quantify the possible signs of trauma among homeless people in its annual survey.

Every year since 1999, the February 3rd Survey takes place in Hungary on the night of 3 February. The survey does not claim to be a census and offers results for all homeless people in Hungary. Nevertheless, it reaches about 10 000 homeless people each year, with the involvement of 60 to 70 percent of homeless service providers. Each year we ask a set of the same questions (ranging from their demographic situation, to where they were sleeping one year earlier, what kind of income they have and how much money they had received the month before,) and, also depending on the theme, questions differing from year to year (one year we would focus more on employment and the barrier people face, other years their satisfaction with the services they access and the support workers they encounter, or the substance abuse issues they face). In 2014, the survey also contained ten statements that could possibly indicate PTSD.

We decided to adopt the ten questions from the PROTECT Questionnaire, which has been developed as a simple and practical tool to identify signs and symptoms of PTSD and depression among asylum seekers. While the original PROTECT Questionnaire is used by highly trained staff in an interview setting, in our survey for homeless people the ten questions were only a small part of the whole survey, and did not serve as a base for further treatment or services. The questions of the PROTECT Questionnaire were translated into statements, which people could agree with, not agree with, or choose not to answer.

There are everyday things that we usually express in a simple sentence. Would you say the following statements are true for you?

1. I often sleep unwell.
2. I often have nightmares.
3. I often suffer from headaches.
4. I often suffer from physical pains (apart from headaches).
5. I easily get angry.
6. I often think about painful past events.
7. I often feel scared or frightened.
8. I often forget things in my daily life.
9. I often find myself losing interest in things.
10. I often have trouble concentrating.

People were then assessed for the level of risk of traumatization: people who score between 0-3 are at a low risk, those scoring between 4-7 are medium risk, and those with 8-10 yes answers are considered people with a high risk.

8155 homeless people responded to all the 10 questions.

### The Statements, Ordered by Most "Yes" Responses

<table>
<thead>
<tr>
<th>Statement</th>
<th>Number of Yes Responses</th>
<th>Rate of Yes Responses (Among All Respondents)</th>
<th>Rate of Yes Responses (Among Respondents to the Statement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I often sleep unwell.</td>
<td>5463</td>
<td>52.4%</td>
<td>54.3%</td>
</tr>
<tr>
<td>I often suffer from physical pains (apart from headaches).</td>
<td>4663</td>
<td>44.7%</td>
<td>47.4%</td>
</tr>
<tr>
<td>I often think about painful past events.</td>
<td>6430</td>
<td>44.4%</td>
<td>47%</td>
</tr>
<tr>
<td>I often find myself losing interest in things.</td>
<td>3943</td>
<td>37.8%</td>
<td>40.1%</td>
</tr>
<tr>
<td>I often suffer from headaches.</td>
<td>507</td>
<td>33.6%</td>
<td>36%</td>
</tr>
<tr>
<td>I often forget things in my daily life.</td>
<td>475</td>
<td>33.3%</td>
<td>35.6%</td>
</tr>
<tr>
<td>I often have trouble concentrating.</td>
<td>395</td>
<td>32.5%</td>
<td>34.8%</td>
</tr>
<tr>
<td>I easily get angry.</td>
<td>337</td>
<td>32.3%</td>
<td>34.6%</td>
</tr>
<tr>
<td>I often feel scared or frightened.</td>
<td>971</td>
<td>18.9%</td>
<td>20.4%</td>
</tr>
<tr>
<td>I often have nightmares.</td>
<td>937</td>
<td>18.6%</td>
<td>20%</td>
</tr>
</tbody>
</table>

1. It is an anonymized voluntary survey asking homeless people a range of questions in the place where they sleep on the night of February 3rd in shelters, hostels or on the street. The distribution of the survey takes place with the involvement of support workers at homeless services, who also take part voluntarily.
2. PROTECT: Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment, coordinated by Jerome Boillat and Bertrand Camouton.
3. The data from the February 3rd database is based on Andrea Szabó’s analysis and presentation: “Háborús állapotok – Poszttraumás zavarra utaló jelek” (Warlike Situations – Signs Indicating Posttraumatic Stress Disorder in the Survey Results of the February 3rd Research) at the National Conference of Homeless Service Providers in Hungary at Balatonföldvár, August 29th, 2014.
While (surprisingly) homeless people sleeping at shelters/hostels sleep just as unwell as those sleeping rough, some answers were more frequent in shelters/hostels than on the streets and vice versa. People sleeping at a homeless service mentioned more painful past events, while people sleeping rough complained more of having trouble concentrating, getting angry easily, often feeling scared or frightened and having nightmares.

Younger people (20–49) got angry more easily, were frightened more and mentioned nightmares more often. They also thought about painful past events a bit more. Older people suffered more from pain (although headaches are similarly frequent for all age groups) and forgot things more often in their daily life.

The longer people have been homeless, the worse they sleep, the more pain (including headaches) they have, the less interest they show and the more forgetful they are. People who have been homeless for less than a year think of past painful events the most, and they complain of fear more than those homeless between one and five years. This might suggest that there can be traumatic experiences leading to becoming homeless (or that events leading to homelessness can be traumatic to people), but also that being homeless itself is a traumatizing experience!

Women are much more likely to suffer from all the symptoms. They responded with yes 10.8% more on average than homeless men. Certain problems, especially headaches, fear and past painful memories, torture women even more.

When looking at data from only the respondents of all ten questions, 50% (4200 individuals) can be considered to be of low risk, 38% (3 084 people) of medium risk, and 11% (871 people) of high risk. When looking at the same data according to gender, we see that 18% of women can be considered to belong to the highest risk group, as opposed to "only" 8% of homeless men, and 44% of women belong to the medium risk category, as opposed to 36% of homeless men. Women sleeping on the street or in shelters are more vulnerable than women sleeping in hostels. Women with less than eight grades of education are the highest risk population, as well as women begging as a way to make a living.

Income also seems to be linked to the level of risk: people in the medium and high risk groups tend to have a lower income and could spend less money, while those with an income from work – both men and women - were more likely to be in the group of low risk people.

4 Shelters in the Hungarian context are services that can be accessed only for the night, and have to be abandoned in the morning. In general, there is no secure tenure, people arriving first get accommodated, so late-comers might not have a place the following night. People do not have to pay for the use of the service. Hostels, on the other hand, receive people for a fixed duration of time (4–6-12-24 months), and people have a fix place for this duration. They have to pay a fee for using the service.
Péter Györi (2008) connects signs of trauma and shame, arguing that the shame (and trauma) connected to becoming homeless, and being a homeless person (“a bum, a voluntary bum, a human wretch, a miserable being, a zero, a victim of the system, a socially vulnerable person, a sad learnt individual, excluded from society, a hopeless case”) with the unwillingness to turn to others, whether these are people from their informal networks or social agencies or services, for help. It is thus vital that social services try to reach out to those in need, who might be reluctant to use their services, and look beyond the physical and psychological symptoms people suffer from (Katz, 2009) – where they might find the implicit trauma, which should be the base of support from that moment onwards.

**BIBLIOGRAPHY:**


A Recovery Approach to Addressing Trauma

By Emile Labeyre and Aurelie Tinland, Rough Sleeper Mental Health Outreach Team, Marseille, France

The Rough Sleeper Mental Health Outreach Team (EMPP) is a mental health service provided on the street. The team meets homeless people who have serious mental health problems and are excluded from the mainstream health and social care system. Its two guiding principles are “reaching out” and working in partnership with the social sector.

This way of working, out on the street itself, is a new mental health practice in France. It allows us to get a better grip on the actual conditions people are living in, we can meet their needs more effectively and we can better understand their ways of thinking. In its role as bridge between health and social care services, the EMPP meets its users where they are, so as to create a space for dialogue in the setting the users themselves have chosen.

The EMPP is part of the MARSS (Movement for Health and Social Recovery). Reflection is an integral part of the movement’s identity. In parallel with the launch of its street-based clinical practice, the programme set up an action research project, designed with the principles of clinical psychopathology in mind. The EMPP sets up experimental projects that bear witness to the reality on the ground and the dead-end situations the users of mental health services find themselves in. This opens up dialogue on public policy.

Through its collection of quantitative and qualitative data, the EMPP can identify the difficulties and obstacles that stop people accessing the existing care services in the Marseilles area. This allows it to spot vectors for action likely to make service provision to these very vulnerable groups work better, in physical and mental health care.

It also offers innovative solutions based on national and international experiments that it studies to work out what conditions are needed to make them possible. These are experiments like the mutual support group Les nomades Celestes, the Housing First programme, the Work First programme, advance directive programmes, the COFOR (Centre for Recovery Training), etc.

Lastly, it sets up ways to evaluate these experiments and public health policy more generally in order to improve or modify them.

When the asylums were closed, the aim of setting up community health care projects that allowed people to integrate into mainstream life was only partially achieved. And instead of the goal of including people to integrate into mainstream life was only partially achieved. And instead of the goal of including people to integrate into mainstream life being achieved, outpatient services created exclusion by trapping people in street homelessness. As they did not fit any of the eligibility criteria for service provision, patients went from pillar to post, from institution to institution. It seems madness is no longer to be found in mental health services. So where is it, then? In migration? In social and economic insecurity? In segregation? In social exclusion? In prisons?

Changing outpatient services for the better and overhauling sectoral divisions in hospital services that do not work for this very specific population group is one of the drivers of the team’s work.

Marseille is a town with a large migratory presence and a “transit” location for migrants. There is a large population of newly-arrived migrants whose life stories are complex and painful. Their unstable housing situation and living conditions that are unfit for human habitation, the legal limbo they find themselves in and their inability to understand the language or culture can also worsen pre-existing mental health conditions they may have or be part of triggering new mental health problems.

Providing psychological trauma services is a complex issue and one that our clinic comes up against daily. Mental health problems and addictions disproportionately manifest themselves around - and tag onto - previous trauma. Life on the streets also produces new trauma, combined with a long history of rough sleeping and homelessness and an ever-widening gulf between individuals and their families.

Living on the street can potentially generate and worsen certain conditions, but certain conditions can in turn put people at risk of losing their home. This is particularly true of conditions that can cause behavioural problems. And that brings about new trauma. That’s why the EMPP does street outreach and encourages care services to work together. It provides a support and care pathway to people that takes account of their own pathway through life.

The EMPP draws upon theories of more personalised practice. It focuses on developing people’s psychosocial skills, working on self-esteem, the sense of responsibility, emotional intelligence, empathy, resilience and managing stress.

Goals are agreed with the service user and then worked towards: having a fulfilling life, being a citizen like everyone else, belonging in the community, being better able to manage their life, taking part in social activities, redefining themselves and rebuilding a sense of self, etc.

This introspective work includes putting in place benchmarks such as hope, the ability to take action, wellbeing, happiness, independence, etc.
The main focus of the service is aiming to improve the person’s mental and social wellbeing in order to give them a better place and status in society, so they can regain a recognised role in society. This is a mental health service that is closer to reflecting the service user’s voice and what they have to say about their psychological suffering in the social context. It’s about giving people time and space to speak through their actions or through the chaotic confusion that they are feeling. This doesn’t mean there cannot be clinical work around capacity and mental health treatment, such as assessing symptoms or prescribing drug therapy, moving towards hospitalisation.

But we work with the person at the centre and move towards self-determination and self-management. We use a holistic approach, focused on the body, the spirit and the community, aiming at reflexive practice on service provision as a whole. Mental health problems are not seen as deficiencies. The unique relationship with the person’s world is contemplated in the here and now.

For that to work, we must take an active role in the relationship.

Our work is about reassuring the person and emphasising their right to choose. It is a process towards empowerment. It is a strength-based approach which recognises the existential dimension of psychotic episodes, so as to make sense of what the users are feeling.

From the outset, what is important in building trust is starting by meeting the person’s basic needs: food, sleep, hygiene, safety. It’s about creating a relationship dynamic where you listen attentively. The person might ask for help with health or social care once this is established. We have to think of the person as a subject with needs and wants - and more - instead of a thing to be thrown away like society labels them. That comes about through providing outreach mental and physical health care: diagnoses, conversations with doctors, treatment, prevention, harm reduction.

We give people back their social rights. We go with people to healthcare appointments (consultations with specialists, hospitalisations) as part of getting them to take control of their life but also provide care at home or in their temporary accommodation.

When recent or past psychological trauma is not treated or addressed, it is a real obstacle to the person’s personal growth and self-fulfilment. Often, when faced with the distress brought about by post-traumatic stress disorder, people turn to a type of “self-medication” to manage the anxiety caused by the trauma: using alcohol, drugs, violence, etc. People need support so they can build resilience.

To treat complex phenomena like these, the EMPP also uses specialist psychotherapies like Eye Movement Desensitisation Reprocessing (EMDR) or structural psychotherapies that tackle cross-cultural issues.

When doing this intensive clinical work, it is important to understand that for this specific client group, accessing the care system is an additional risk factor for trauma.

This was evident when we met Barbara. During an outreach session in 2013, the EMPP met a 49-year-old lady who had been rough sleeping for more than 20 years. She hates the mental health care system that forced her to be sectioned three times. What’s more, the diagnosis of schizophrenia they gave her means nothing to her and does not adequately represent what she really experiences in terms of her mental health. She has thought disorders but they do not bother her. She does not see the need to be looked after by social workers all the time. Unaware of what is happening, she has mood swings and significantly accelerated thought and movement patterns. She is often extremely aggressive and has very invasive auditory and visual hallucinations that have the effect of greatly disrupting her thoughts.

Right from when we first met her, we suggested she move into a Housing First programme. She refused this vehemently. She was then accommodated in a Housing First programme in Paris. We will take this forward. Standing by the person and supporting them in the life experiences they go through: that, too, is care provision.
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Cover image 'Untitled' by Elsa Maria Mateus Ramirez

Mateus says this painting doesn’t have a name as a description limits the whole idea of it. She originally trained as a lawyer in Colombia but had to leave, becoming a refugee in the UK. She is now housed in north London. She connects with Cafe Art (www.cafeart.org.uk) through her beautiful paintings.