Homeless Link

Being trauma-informed

A practice development framework

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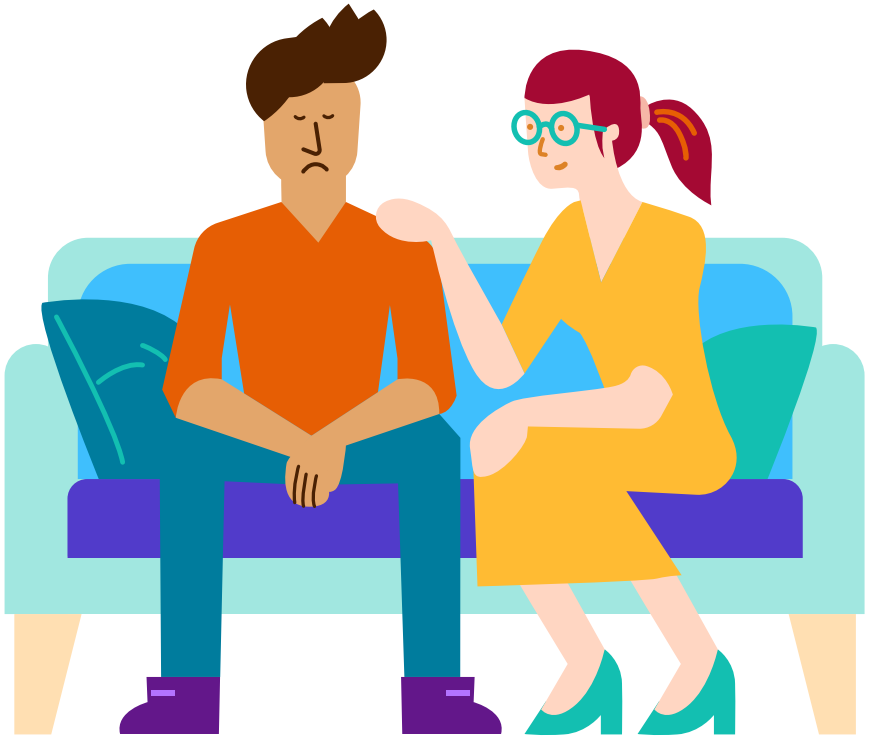


Published
June 2024

Introduction

About this framework

This framework is designed to support voluntary and community organisations (VCS) within the homelessness sector to apply trauma-informed care in practice. The publication is divided into several parts, beginning with an overview of what is meant by trauma-informed care, including the key steps to delivery. The document then outlines in more detail what the steps look like in practice and provides a series of questions to help organisations assess their progress to identify areas for change or future development. Space is provided to write down evidence of how organisations are meeting the indicators and their areas for development.

Being trauma-informed is an ongoing process, which is often described as a journey, not a destination. This involves continual reflection and development by everyone. Trauma-informed care is not a specific intervention, but instead, a way of working or process of change that can be applied across different services and activities.[1] Each organisation will apply the steps in a slightly different way to best fit their ethos and service provision. As such, this framework is not definitive guidance, but a reflective tool to support the process of development towards becoming trauma-informed.

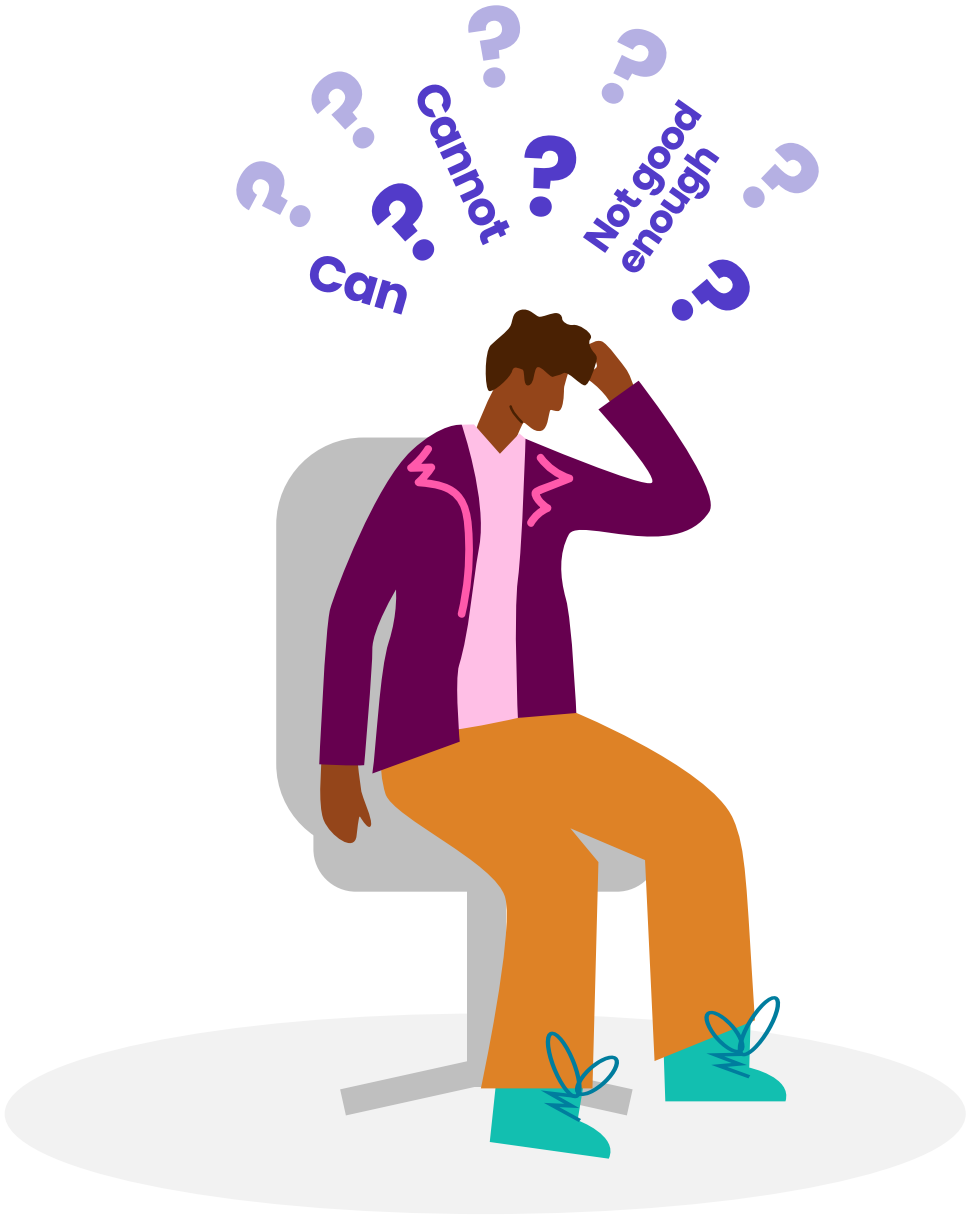
How was this framework developed?

Alongside desk-based research into trauma-informed care, consultation through Community of Practice sessions with homelessness organisations across England and focus groups with people with direct experience of homelessness have fed into the development of this framework. The framework has also been reviewed by trainers and consultants who specialise in trauma-informed care. Thank you to all individuals whose valuable contributions have informed this framework.

Acknowledgement

This framework has been peer reviewed by One Small Thing; an organisation whose work aims to redesign the criminal justice system for women and their children. One Small Thing have a strong track record of facilitating evidence-based trauma informed and gender-responsive training, and benchmark and recognise good practice through their Working with Trauma Quality Mark. We appreciate them sharing this expertise and encourage organisations to visit their website for more information.

1 Changing Futures Programme/DLUHC: Trauma-informed approaches to supporting people experiencing multiple disadvantage: A Rapid Evidence Review. April 2023.



Why do we need this framework?

Homeless Link offers training and consultancy in trauma-informed care. However, through our experience, we know that the sector needs more practical guidance about how to implement and embed trauma-informed care in their organisations. We believe that this framework will be a key tool to support this process.

Adopting a trauma-informed approach has a significant number of benefits to organisations, staff, and people accessing services. These can include, but are not limited to:

- improved outcomes and engagement for people accessing support
- reduction in violent incidents and behaviour
- increased staff retention
- improved prospects for funding opportunities.

Being trauma-informed

Understanding trauma

The Substance Abuse and Mental Health Services Administration's (SAMHSA) definition of trauma is:

> *"Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual wellbeing."*[2]

Complex trauma, first introduced by Judith Herman in the 1990s,[3] refers to a series of varied, repeated, traumatic experiences that take place over a long period of time, often of an invasive, interpersonal nature.

The National Child Traumatic Stress Network defines early childhood complex trauma as:

> *"Complex trauma is when children are exposed to multiple traumatic events. These events are severe and widespread, such as abuse or profound neglect. They usually occur early in life and can disrupt the child's development. Since these events often occur with a caregiver (parent/guardian), they interfere with the child's ability to form a secure attachment. Many aspects of a child's healthy physical and mental development rely on this primary source of safety and stability."* [4]

Adverse Childhood Experiences (ACEs), for example maltreatment, violence, and household or family adversity can negatively affect a person's wellbeing into adulthood.[5] People who have experienced an ACE are more vulnerable to physical, mental and substance use disorders later in life and are at increased risk of repeated trauma exposure.

If a child has experienced trauma from their caregiver, this can directly influence attachment development. Bowlby's (1979) Attachment Theory [6] suggests that when carers are sensitive and responsive to a child's needs, they will develop a secure attachment.[7] However, if a child is exposed to harmful behaviour from their caregiver, they will develop an insecure attachment (avoidant, anxious or disorganised). As a result, this learned attachment style moves forward into adulthood, impacting people's ability to trust others, their self-esteem and emotional regulation.

2 Substance Abuse and Mental Health Services Administration [SAMHSA], Trauma and Justice Strategic Initiative, 2012. Available at: https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf

3 Herman, J (1992), Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. Journal of Traumatic Stress. Volume 5, Issue 3

4 https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma

5 YoungMinds have identified forms of ACE's here: https://www.youngminds.org.uk/media/ojpon1ut/addressing-adversity-infographic-poster.pdf

6 Bowlby J. The making and breaking of affectional bonds. 1979.

7 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4964073

Trauma and complex trauma can impact people differently and can trigger a number of responses:

- An individual may be triggered **emotionally**, such as feeling anger, fear, sadness, or shame.[8] However, not all individuals will be able to identify these feelings, or will instead define their reactions as 'numbness' or a lack of emotions. Some survivors may experience **emotional dysregulation**: often, individuals will either feel a lot of, or very little, emotion.
- A common symptom following a traumatic experience is **hyperarousal**. Hyperarousal symptoms include irritability or aggression, risky or destructive behaviour, hypervigilance, heightened startle reaction, difficulty concentrating, and difficulty sleeping.[9] It is one of the primary diagnostic criteria for PTSD.
- Some individuals may experience an impact in their **physical health**, for example, lasting or latent trauma from events can trigger endocrine and immune problems (that a person may or may not have already been genetically predisposed to). These include chronic autoimmune illnesses, heart attack, diabetes, stroke and even cancer.[10]
- **Cognitive or thought-processing changes** can occur as a result of experiencing trauma, for example, misinterpreting situations, excessive guilt, intrusive thoughts and hallucinations/delusions.
- **Difficulties with building trusting relationships** is a significant impact of trauma. For people who have experienced an ACE, trust has often been breached by a caregiver, and as a result individuals may decide to keep a distance from others as a form of self-protection.

Trauma survivors can often face re-traumatisation in their lives. Trauma can leave a trail of terror, rage, and pain[11] and therefore people can be fundamentally changed when traumatic events happen. For example, if deficit-based language and restrictive policies/procedure are used within a service, an individual may feel triggered due to previous experiences, and experience re-traumatisation.

8 SAMHSA, Trauma-Informed Care in Behavioural Services, TIP 57, 2014

9 https://library.neura.edu.au/category/ptsd-library/signs-and-symptoms-ptsd-library/general-signs-and-symptoms-signs-and-symptoms-ptsd-library/index.html

10 https://www.healthcentral.com/chronic-health/how-trauma-impacts-your-health

11 https://www.homelesshub.ca/resource/avoiding-retraumatization-and-fostering-recovery-among-people-experiencing-homelessness

What is trauma-informed care (TIC)?

TIC is a relationship-based approach that can be adopted by organisations to improve awareness of trauma and its impact, to ensure that the services provided offer effective support and, above all, that they do not re-traumatise those accessing or working in services.[12]

The concept of trauma-informed care was first articulated by Harris and Fallot[13] who made the distinction between 'trauma-specific services' and the culture change referred to as 'trauma-informed care'.[14] Their principles were then developed by the Substance Abuse and Mental Health Services Administration (SAMSHA), the agency within the U.S Department of Health and Human Services that lead public health efforts to improve the lives of individuals living with mental and substance use needs.[15] They stressed that the context in which support was provided played a significant role in the outcomes for survivors. They have developed a comprehensive toolkit around the approach and its implementation.[16]

SAMSHA's concept of trauma-informed care is grounded in four assumptions. These assumptions state that a program, organisation, or system that is trauma-informed:

- **realises** the widespread impact of trauma and understands potential paths for recovery
- **recognises** the signs and symptoms of trauma in people, families, staff, and others involved within the system
- **responds** by fully integrating knowledge about trauma into policies, procedures, and practices
- and seeks to actively **resist re-traumatisation.**

Hopper et al[17] found there to be four key themes shared across homelessness services implementing TIC:

1. **Trauma awareness –** service providers incorporate an understanding of trauma into their work.
2. **Emphasis on safety –** services work to establish physical and emotional safety for clients.
3. **Opportunities to rebuild control –** increasing client choice and providing predictable environments.
4. **Strengths-based approach –** supporting people to identify their strengths and coping mechanisms.

12 The Office for Health Improvement and Disparities published a working definition of trauma informed practice in Nov 2022 which adopts the SAMHSA definition: https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice

13 Harris, Maxine; Fallot, Roger D. (2001). "Envisioning a trauma-informed service system: A vital paradigm shift". New Directions for Mental Health Services. 2001 (89): 3–22

14 https://www.nasmhpd.org/sites/default/files/NCTIC_Marketing_Brochure_FINAL(2).pdf

15 https://www.samhsa.gov/about-us/who-we-are

16 https://store.samhsa.gov/sites/default/files/sma14-4816.pdf

17 Hopper et al. Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings. 2010

Psychologically Informed Environments (PIE)

Psychologically Informed Environments are services that are designed and delivered in a way that takes into account the emotional and psychological needs of the individuals using them.[18] Specific guidance on PIE for homelessness services was published by the Department for Communities and Local Government in 2012.[19] The authors explain that a PIE will 'enable clients to make changes in their lives' in areas such as managing behaviours, emotions and mental wellbeing, improved relationships with others and reducing maladaptive coping strategies. In PIE, 'relationships are seen as a principal tool for change and every interaction between staff and clients is an opportunity for development and learning'.

The guidance sets out a framework which can be used to redesign a service to become a PIE. The framework consists of:

1. **Developing a psychological framework** allowing services to have a shared understanding of, and response to, the people they support.
2. **Adapting the physical environment and social spaces** to improve the space available to engage and support people in the service.
3. **Staff training and support,** which enables workers to move away from crisis management and work in a more therapeutic and planned way. Using reflective practice is a way of doing this.[20]
4. **Managing relationships** to help staff and clients self-manage their emotional and behavioural responses to triggering events.
5. **Evaluation of outcomes** to enable staff and clients to evaluate their effectiveness, for ongoing development and to evidence service impact.[21]

18 Visit https://pielink.net for resources and forums related to PIE.

19 Keats, Helen, Maguire, Nick, Johnson, Robin and Cockersell, Peter (2012) Psychologically informed services for homeless people. Southampton, GB, Communities and Local Government (Good Practice Guide) https://eprints.soton.ac.uk/340022/1/Good%2520practice%2520guide%2520-%2520%2520Psychologically%2520informed%2520services%2520for%2520homeless%2520people%2520.pdf

20 Read Homeless Link's guidance on reflective practice in homelessness services: https://homeless.org.uk/knowledge-hub/reflective-practice-in-homelessness-services

21 PIELink have recently developed these five core themes, known as 'PIE 2.0': https://pielink.net/pies-2-0-the-basics

The original guidance has informed a toolkit that can be used to implement PIE.[22] The toolkit can be used to self-assess how psychologically informed a service or organisation currently is and for the continued development of a PIE approach.

What is the difference between PIE and TIC?

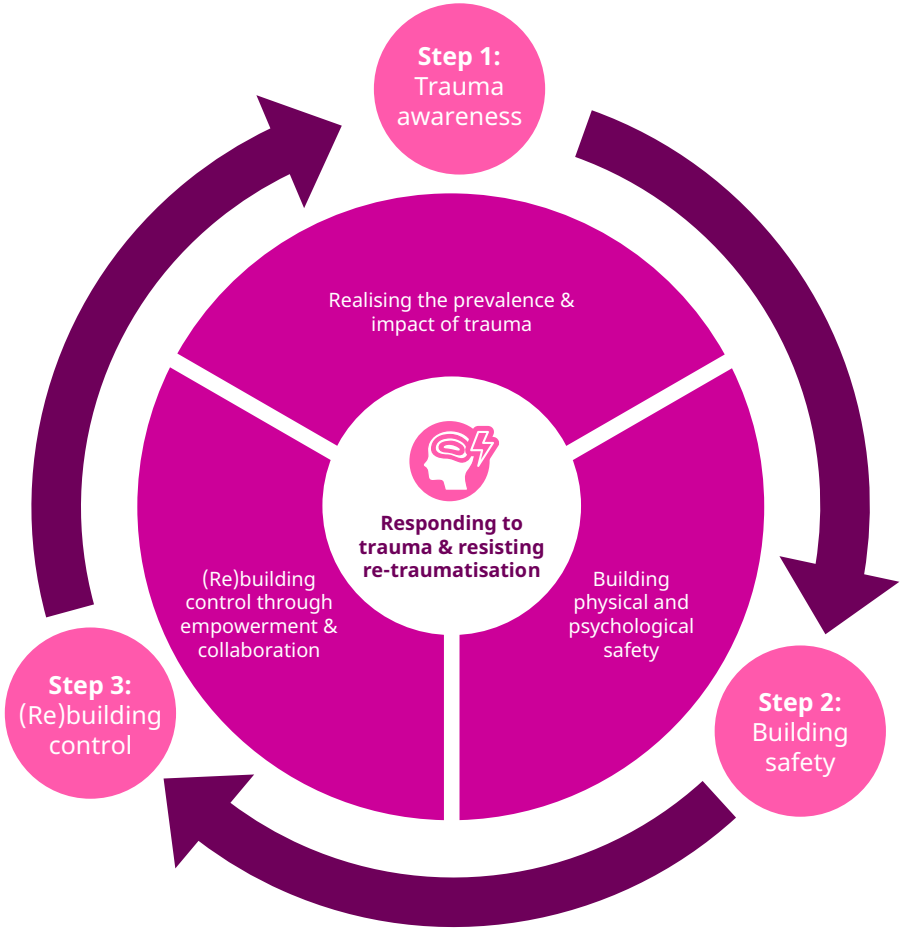
Both the intent and outcomes of services adopting PIE or TIC are essentially the same – that they are aiming to improve the psychological and emotional wellbeing of people accessing them or working there. Both approaches stem from the recognition that an individual's experiences will impact how they present and engage with support. The main difference between the approaches is that PIE describes a broader approach within which a range of choices can be made about the psychological framework adopted, while in a service that uses TIC, the psychological framework adopted is explicitly trauma theory and research. Trauma awareness is the framework that provides a consistency in understanding and response from which all other changes in the design and delivery of the service are viewed. It could be said therefore, that a service adopting TIC is a model of PIE.

22 No One Left Out: Solutions Ltd for Westminster City Council (2015) Psychologically Informed Environments: Implementation and Assessment. https://meam.org.uk/wp-content/uploads/2015/11/2015-Creating-a-Psychologically-Informed-Environment.pdf

Practice Development Framework

The tool below has been designed to allow services to reflect on their practice and identify areas of development. We have decided to combine both SAMSHA's principles of TIC[23] and Hopper et al's thematic areas to outline the following steps of delivering trauma-informed care. We believe that by following the three steps, services will reduce the chance of re-traumatisation for both clients and people working in them.

The tool is divided into a series of tables; each focusing on one of the steps identified in the diagram. Each table examines how the step should be applied in terms of people accessing services, staff, and governance. It poses a series of questions to support reflection. You will need to consider a variety of methods for responding to each question. This may involve asking clients and having conversations with staff, volunteers, and other agencies.



23 https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf - Page 10

Step 1: Trauma awareness

Step 1: Trauma awareness

Realising the prevalence of trauma within the homeless community

Many people experiencing homelessness have also experienced trauma. Homelessness is a traumatic event in itself and exposes people to further risk of harm. Research commissioned by Oasis Community Housing looking at the prevalence of trauma among individuals with experience of homelessness in England, found that 92% of respondents had experienced trauma, and almost two-thirds of respondents reported experiencing four or more traumatic experiences, or trauma over a prolonged period.[24] Moreover, 73% of respondents had experienced both homelessness and trauma, and two-thirds of respondents made links between trauma and their housing situations. Research by the Lankelly Chase Foundation also found that there is a strong association between severe multiple disadvantage (a term used to signify the problems faced by adults involved in the homelessness, substance use, and criminal justice systems in England) and experiences of childhood trauma.[25]

People experiencing homelessness are likely to have additional needs around their mental and emotional wellbeing. In Homeless Link's research on health and homelessness, 82% of respondents reported a mental health diagnosis, with 45% of these reporting that they were self-medicating with drugs or alcohol to help them cope with their mental health.[26] Researchers have also found a high prevalence of personality disorder among people who are homeless.[27] For someone's personality difficulties to be considered a 'disorder', those difficulties must be problematic (negatively affecting them), persistent (chronic and ongoing) and pervasive (impacting various aspects of their life).[28] Personality difficulties often arise from histories of trauma, beginning in childhood.

These complex and interrelated issues can be highly challenging for support services – even more so in the homelessness sector where most staff do not have clinical training. People experiencing homelessness are 'among those most in need of psychologically informed help but are also among those least able to access mainstream psychological therapy services'.[29] While housing and homelessness services should not replace clinical services, it is essential that organisations have a clear understanding of the prevalence and impact of trauma and are able to adapt their services accordingly. Through a focus on developing trusting relationships, staff working in homelessness services play a vital role in helping people move forward.

24 https://www.oasiscommunityhousing.org/wp-content/uploads/2022/10/The-prevalence-of-trauma-among-people-who-have-experienced-homelessness.pdf

25 https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

26 https://homeless.org.uk/knowledge-hub/unhealthy-state-of-homelessness-2022-findings-from-the-homeless-health-needs-audit/

27 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

28 Wood, Heather and Bolton, Winifred and Lovell, Kath and Morgan, Lou (2014) Meeting the challenge, making a difference: Working effectively to support people with personality disorder in the community. Project Report. Department of Health, London.

29 4 Keats, Helen, Maguire, Nick, Johnson, Robin and Cockersell, Peter (2012) Psychologically informed services for homeless people. Southampton, GB, Communities and Local Government (Good Practice Guide).

Recognising the impact of trauma on people experiencing homelessness and on staff

In Oasis Community Housing's research, 70% of respondents said trauma had a 'significant' impact on their lives.[30] The most significant impacts of trauma were poor mental health, or emotional difficulties, experienced by 90% of participants. 72% of individuals stated that relationship difficulties were an impact of trauma, reporting problems with being able to build trusting relationships with others.

There are many psychological impacts of trauma, which can fall into three categories: hyperarousal, intrusion and constriction.[31] Hyperarousal means that an individual is persistently expecting danger, in a constant flight/flight/freeze response that ultimately impacts sleep and responses to situations. Intrusion refers to the fact that an individual who has experienced trauma has an 'imprint' of this trauma, so that even small reminders of the trauma, can promote an emotional response. Constriction is a process of emotional numbing and detachment to cope with situations. Ultimately, for someone who has experienced trauma, their perception of safety and control, their ability to regulate their emotions and their capability of forming relationships may be hugely impacted.

Individuals working in the homelessness sector are often exposed to both those who are traumatised and to traumatic situations.[32] For example, those working on the frontline may continually hear about their client's experiences of trauma. Over time, this can lead to what is called vicarious trauma or secondary traumatic stress. These terms are often used interchangeably, with both describing a type of indirect trauma experienced by an individual as a result of working closely with trauma survivors.[33] The term 'vicarious traumatisation' was coined by Pearlman & Saakvitne (1995) to describe the shift in world view that can occur in professionals when they work with individuals who have experienced trauma.[34] Vicarious trauma is about the cognitive shift that happens in individuals, for example, changes in their world views and how they think about themselves and others, after repeated prolonged exposure to other people's suffering. Symptoms of vicarious trauma can include experiencing nightmares, flashbacks and/or intrusive thoughts, hypervigilance and difficulty concentrating, as well as difficulties in relaxing and falling asleep – all symptoms of those who have experienced trauma directly.

It is also important to note that people working in the homelessness sector may have their own experiences of trauma, which they bring with them to work. These experiences may trigger reactions in the workplace, especially when exposed to others' trauma.

30 https://www.oasiscommunityhousing.org/wp-content/uploads/2022/10/The-prevalence-of-trauma-among-people-who-have-experienced-homelessness.pdf

31 https://www.feantsa.org/download/feantsa_traumaandhomelessness030734712190529468107 38.pdf

32 https://link.springer.com/article/10.1007/s10597-018-00364-7

33 Read Homeless Link's guidance on 'Understanding burnout, vicarious trauma and secondary traumatic stress'. Available at: https://homelesslink-1b54.kxcdn.com/media/documents/Understanding_burnout_vicarious_trauma__secondary_traumatic_stress.pdf

34 Pearlman, L. A., & Saakvitne, K. W. (1995). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors. W. W. Norton & Company.

Trauma awareness

- How can you continuously embed trauma knowledge and awareness into your service?
- How can you recognise the impact of trauma on people accessing services, staff and volunteers?
- How can you ensure there is peer support?

Who?	Aim	Areas for reflection	Evidence & areas for development
People accessing services	**People accessing services are aware of how their experience of trauma may impact them and have access to support.** » People can access therapeutic services to address their trauma. » People are aware of peer support opportunities and access them where appropriate.	» Have you made links with external therapeutic services? Are individuals able to access these? Have referral rights been discussed? *E.g. local mental health services, third sector organisations.* » Are people offered a range of further support based on mutual aid/recovery/positive peer connection to ensure empowerment and the formation of positive social connections? » Are people's pathways always through the lens of next steps/long-term growth? How is aftercare/ongoing support considered when a person leaves your support? » Is there a range of meaningful activities *(E.g. training, employment opportunities, hobbies, sports, interests, etc)* suitable for all people's needs, both internally and externally? Are these appropriate for those with further needs (learning disabilities, neurodiversity, mental health needs). » Are co-production and lived experience groups utilised to help people engage and feel included? (See page 32 onwards for more information).	*Type your answer here...*

Trauma awareness

Who?	Aim	Areas for reflection	Evidence & areas for development
Staff and volunteers	**All staff and volunteers have an awareness and understanding of trauma and trauma-informed care.** » Staff and volunteers are trained in trauma-informed care. » Staff feel confident to speak to people accessing services about the potential impact of trauma.	» Can you include training[35] in trauma-informed care as part of your organisation's mandatory training? » Are staff offered training in mental health and homelessness?[36] » Do staff have the skills to advocate for clients to negotiate access to/continue engagement with services and ensure their trauma is 'seen'? » Have you spoken to other organisations about trauma-informed care training to ensure a consistent approach to support? *E.g. consider doing a group training session with different organisations in the local area.* » Ask staff how they wish to learn about trauma – are there alternatives to training you could consider? *E.g. group workshops, reflective practice, written resources for self-study.* » Do any staff members want to be 'TIC Champions'? (This would involve supporting the organisation to ensure their trauma-informed approach is moved forward and to hold the organisation to account, ensuring it is an ongoing, and sustainable process. This could be a development opportunity for staff.)	*Type your answer here...*

35 Homeless Link delivers training and consultancy on trauma-informed care: https://homeless.org.uk/what-we-do/developing-the-workforce/training-for-organisations/trauma-informed-training-and-consultancy/

36 Homeless Link delivers training on Mental Health & Homelessness: https://homeless.org.uk/team-training-courses/mental-health-and-homelessness

Trauma awareness

Who?	Aim	Areas for reflection	Evidence & areas for development
Staff and volunteers	**Staff and volunteers have access to peer support.** » Reflective practice is available for all staff and volunteers. » Staff and volunteers have opportunities to build supportive relationships with colleagues.	» Is team cohesion and wellbeing of primary importance in team meetings, supervision and all other formal and informal connections? » Are vicarious trauma and burnout regularly discussed? *E.g. in team meetings, reflective practice, and supervisions with managers.* Do staff feel empowered to challenge the effects using pro-active tools and approaches? How is this supported by management? Do staff understand what it means to be a reflective practitioner? » Do staff have access to regular reflective practice?[37] » Are managers modelling reflective behaviours? *E.g. attending reflective practice, ensuring time is set apart for teams to attend?* » Are all staff encouraged to attend reflective practice, for example, senior leaders, maintenance staff, shift workers etc.? » Are managers delivering supervisions in a trauma and psychologically informed way?[38] *E.g. recognising and supporting staff with their own traumas, and vicarious trauma as a result of their work.* » What reflective practice and peer support do senior managers have that enable them to lead in a trauma-informed way?	*Type your answer here...*

37 Read Homeless Link's guidance on Reflective Practice in Homelessness Services: https://homeless.org.uk/knowledge-hub/reflective-practice-in-homelessness-services

38 Read Homeless Link's guidance on 'Psychologically Informed Management for more information: https://homeless.org.uk/knowledge-hub/psychologically-informed-management

Trauma awareness

Who?	Aim	Areas for reflection	Evidence & areas for development
Governance	**The mission and values of an organisation align to a trauma-informed approach.** » A trauma-informed lens is embedded within HR, learning and development and relevant policies. » There is an understanding at all levels about the prevalence and impact of trauma.	» Has adequate funding been sourced to ensure trauma-informed care training is available to all staff and that reflective practice can occur on a regular basis? » Do sickness and absence policies take into consideration the impact and prevalence of primary and vicarious trauma? » Do HR policies and procedures formalise the expectation that supervisions are delivered in a trauma and psychologically informed way? » Is trauma considered in recruitment processes and during interviews? *E.g. considering the environment where interviews take place and the power dynamics within them.* » Do senior managers and board/trustee members understand how experiences of trauma may impact how people accessing services and staff respond? » Is decision making and leadership in line with a trauma-informed approach? » Are expectations around delivering KPIs viewed through the lens of giving consideration to the impact of trauma on staff and people accessing services?	*Type your answer here...*

Step 2: Building safety

Step 2: Building safety

Trustworthiness and transparency

Safety is often thought about in its physical sense, and while this is important, psychological safety and safety within relationships is equally important.

When an individual experiences trauma, they will most likely experience a loss of safety. This can influence how people think about the world, for example, their view of others, their sense of safety, their future and themselves.[39] Trauma survivors often feel unsafe in daily life, whether there is a real or perceived threat, so prioritising safety is a key element of TIC. Within a trauma-informed framework, physical and psychological safety must be considered, for both people accessing services and staff members.

Some traumatic experiences can be a result of having trust broken, for example, by a caregiver. For others, trust can be breached during or after a traumatic experience. Consequently, trauma survivors are likely to find it difficult to trust people – this being a way of protecting themselves – which can lead to challenges in forming connections with others. Building trusting relationships is the foundation for effective support in homelessness services and a way of encouraging the engagement of people accessing these services. Engagement can be defined as 'the process by which a trusting relationship between worker and client is established'.[40] If a person does not feel safe in a service, a positive relationship cannot be built.

Relationships should be authentic, respectful and have clear boundaries.[41] Consistency is also key when working with people who have experienced trauma, for example, not changing workers constantly. Being transparent about your limitations as a worker means that an individual knows what to expect and is not given false hope, which could ultimately reduce trust, and therefore feelings of safety. As workers, being reliable and doing what you say you will do, will avoid re-traumatisation of trauma survivors.

Cultural, historical and inclusivity

Hopper et al. state that, as professionals, we should view trauma through a sociocultural lens, and think about the importance of culture in understanding people's experiences of trauma. Consideration of cultural, historical and gender contexts are key in delivering TIC because trauma disproportionately affects marginalised populations.[42] To understand how trauma has affected an individual, you must first understand their life experiences and cultural background. Cultural competency is therefore essential within services, with the delivery of services performed in an inclusive and non-judgmental manner. Services, and the policies within them, should seek to understand the impact of, and be responsive to, culture, race, ethnicity, gender, age, sexual orientation, disability and socio-economic status. Creating inclusive services reduces the risk of re-traumatisation, as for some people, their experience of trauma could be inextricably linked to a lack of knowledge and/or support around their sociocultural needs.

39 https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4816.pdf

40 Erickson S, Page J. To dance with grace: outreach and engagement to persons on the street. In: Fosburg LB, Dennis DL, Eds. Practical Lessons: The 1998 National Symposium on Homelessness Research Washington, DC: U.S. Department of Housing and Urban Development; U.S Department of Health and Human Services 1999

41 Hopper et al. *Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings.* 2010

42 Bowen E. and Murshid N.S. (2016), Trauma-Informed Social Policy: A Conceptual Framework for Policy Analysis and Advocacy, American Journal of Public Health, 106

Services should actively move past cultural stereotypes, challenge unconscious biases and recognise and address historical trauma. Ensuring that services are culturally and gender appropriate accounts for the fact that men and women respond to trauma differently, and experience will differ further across cultures, ethnicities, and age groups.[43]

43 Changing Futures Programme/DLUHC: Trauma-informed approaches to supporting people experiencing multiple disadvantage: A Rapid Evidence Review. April 2023.

Building psychological safety

- To what extent do the organisation's activities and environments ensure psychological safety for staff, volunteers and people accessing services?
- How can services be modified to ensure this safety more effectively and consistently?
- How is safety built through trustworthiness and transparency?
- How does the organisation deliver inclusive services that respect individuals' culture, ethnicity, gender, and sexual identities?

Who?	Aim	Areas for reflection	Evidence & areas for development
People accessing services	**People accessing services feel welcomed and relaxed.** » The physical environment is friendly and inviting. » People are welcomed into the service with clear information and given time to 'settle in'.	» How are spaces for people appropriately adaptive? Are visual and aural interest considered in reception areas? *E.g. calming music, artwork, plants.* » How clean and fresh is the space/furniture? » How are light and colour used to create soft spaces? Is furniture comfortable and does it provide a 'homely' feel? » Are the spaces such as reception, interview rooms etc. comfortable and inviting? » What visual materials/signs are in the service? Is the language supportive as opposed to punitive? » Is there a mix of information and effective artwork displayed? » Have people accessing services been consulted about the physical design of the building/space? *E.g. for supported accommodation, bedrooms, and communal spaces.*	*Type your answer here...*

Building psychological safety

Who?	Aim	Areas for reflection	Evidence & areas for development
People accessing services (continued)		» How are people welcomed into the service for the first time? » Are people able to get to know staff and share information in their own time? » How much opportunity is there for people to settle into the service before having a formal intervention? *I.e. for supported accommodation, is there an opportunity for people to view their room before signing a licence agreement?*	*Type your answer here...*
	People accessing services are clear about what is involved and potential outcomes. » Clear information is provided to people accessing services. » Information about the service is easy to understand and process. » The service is open about any limitations to support. » Support is provided in a way that suits the needs and wishes of people accessing services, over those of the service provider. » Confidential information is stored in line with data protection regulations.	» Are people given clear information about what the service can offer them? *I.e. being told in advance of accessing the service what they can expect.* » Are people clear about the processes that they will go through and the potential outcomes? » Is information shared at multiple points (not just at first meeting) and at times when people are able to digest it? » Is the service honest about what can be achieved? » How much paperwork is there? When is this completed? Are questions kept to a minimum? » Can 'safety plans' be used instead of risk assessments? *I.e. focussing on how to keep the individual and those around them safe, and identifying any personal triggers over identifying their 'risks'.*	*Type your answer here...*

Building psychological safety

Who?	Aim	Areas for reflection	Evidence & areas for development
People accessing services (continued)		» Is all data collected relevant to the service being offered and inappropriate data gathering limited? *I.e. avoiding overly intrusive questions not related to statutory or commissioning requirements.* » Are people given clear information on how their information will be gathered and stored, how safeguarding processes will be utilised and what options are available to them? » Do people have access to their own data on request? » Do confidentiality agreements include clear sections about when there needs to be a different approach and are these communicated clearly? *E.g. when there is a serious risk of abuse/harm to themselves or others.*	*Type your answer here...*
	Services are inclusive and accessible for all. » People accessing services feel safe and able to receive support tailored to their individual identities and needs. » Services are genderinformed: people accessing services feel safe to be open about their gender identities.	» Are resources/services available in different languages? Has funding been allocated for translation services? » Where diversity needs are identified, do staff ensure the individual is offered to connect with appropriate support *e.g. LGBTQ+ groups, faith-based communities.* » Has accessibility of the building/service been considered for those with disabilities?	*Type your answer here...*

Building psychological safety

Who?	Aim	Areas for reflection	Evidence & areas for development
People accessing services (continued)		» Have religious and cultural requirements been considered? *E.g. specific dietary requirements, rooms to accommodate prayer.* » Where limitations exist in services, are there specialist services people can be signposted to? » What is the make-up of people accessing services in terms of ethnicity, race, gender, sexuality, or neurodiversity? How might this impact the safety of others? » Are people offered support appropriate to their gender identities, in initial engagements and beyond? *E.g. having dedicated women-only spaces and keyworkers who are women.* » Are staff aware of, and sensitive to, different gender identities, including people who are trans or non-binary, and their needs? Is this considered in all engagements and is appropriate language always considered? *E.g. using their correct pronouns.* » How do assessment forms allow for recording of all identities?	*Type your answer here...*

Building psychological safety

Who?	Aim	Areas for reflection	Evidence & areas for development
People accessing services (continued)	**People accessing services are able to provide feedback and have their voices heard.** » There are effective and responsive complaints and feedback policies. » There is transparency regarding how the feedback is used.	» Are there opportunities for people accessing services to share their feelings? » Do people feel able to openly share the things that are important to them? » How can this feedback be elicited in a trauma-informed way? *E.g. via confidential means if necessary.*	*Type your answer here...*
Staff and volunteers	**Staff and volunteers feel psychologically safe within the organisation.** » The wellbeing of staff and volunteers is a priority. » The working environment is comfortable and provides space for reflection. » There are support structures in place to promote wellbeing.	» Are staff wellbeing opportunities wide ranging? Is there a culture of utilising these? » Is reflective practice available to all staff? Do they understand the benefits of this? » Are there spaces within the organisation to enable staff to reflect? Is there space for staff to take breaks and work without distraction when required? » How clean and fresh is the space/furniture? » How are light and colour used to create a calm environment? » Are staff given opportunities to de-brief after a challenging interaction and to gain support from managers and colleagues?	*Type your answer here...*

Building psychological safety

Who?	Aim	Areas for reflection	Evidence & areas for development
Staff and volunteers (continued)		» How do staff feel empowered to take breaks/time outs to ensure their ongoing safety? *E.g. managers modelling this behaviour, rotas in place to ensure cover.* » Is peer support encouraged amongst colleagues?	*Type your answer here...*
	Staff and volunteers work in a clear and consistent way. » Staff have a clear understanding of their role and how to meet their objectives. » Staff have clear and consistent interpersonal boundaries.	» How are staff trained and supported to deliver support in line with their role description? Is this clear in inductions and reviewed regularly in supervision? » Are desired outcomes/targets clear and relevant to the role description? » How are supervision sessions utilised to review targets to ensure they are effective, clear and in line with service values? » Are staff confident to push back and challenge partnership organisations if they are asked to do something not in line with their role/values? How do managers support staff if this was to occur? » Are staff able to maintain clear boundaries while remaining warm and open to building positive relationships with people accessing services?	*Type your answer here...*

Building psychological safety

Who?	Aim	Areas for reflection	Evidence & areas for development
Staff and volunteers (continued)		» Do staff feel confident to explore boundary issues in supervision and reflective practice to ensure boundaries protect rather than restrict? » Do staff regularly discuss and reinforce boundaries with people accessing services, colleagues and managers in both formal and informal channels?	*Type your answer here...*
	All staff, including leadership, understand the importance of Equality, Diversity, and Inclusion (EDI). » Staff are sensitive to people's cultural and gender identities when offering/providing support. » Staff feel safe to be open about their own identity. » There is diversity within the organisation, which is celebrated.	» Are all staff trained in equality, diversity, and inclusion as part of their induction/mandatory training and is this reviewed regularly?[44] » Do staff have an understanding of how people's identity affects their experience of the world? » Do staff have an understanding of gendered trauma responses and the ongoing impact of gender-based violence? » Are staff clear/honest about any limitation within the service/their ability to support certain groups? *E.g. people with severe physical disabilities.* » Are there active conversations around challenging cognitive/unconscious bias in supervision/reflective practice/team meetings in the spirit of continued development?	*Type your answer here...*

44 Homeless Link delivers training on Equality, Diversity & Inclusion: https://homeless.org.uk/team-training-courses/equality-diversity-and-inclusion

Building psychological safety

Who?	Aim	Areas for reflection	Evidence & areas for development
Staff and volunteers (continued)		» What is the make-up of staff present in terms of ethnicity, race, gender, sexuality, or neurodiversity? How might this impact the safety of others? » How is diversity encouraged within teams and the wider organisation?	*Type your answer here...*
	Staff and volunteers are able to provide feedback and have their voices heard. » There are effective and responsive complaints and feedback policies. » There is transparency regarding how the feedback is used.	» How is feedback gathered in team meetings and supervisions used to actively shape the service? » Are there opportunities for staff and volunteers who may lack confidence to provide anonymous feedback? » How do staff have influence over the procedures that are in place? » How are staff involved in strategy development? » How are staff encouraged to provide feedback? How are views heard in team meetings? » Are feedback and complaints procedures written through with trauma in mind? » Do senior management have clear formal and informal links to operational staff to ensure feedback is constantly encouraged and utilised? » How do senior management ensure they are approachable? *E.g. open-door policies.*	*Type your answer here...*

Building psychological safety

Who?	Aim	Areas for reflection	Evidence & areas for development
Governance	**The service operational policies and procedures are designed through a trauma-informed lens.** » Policies and procedures are designed in a way which allows the service to be delivered in a psychologically safe way. » People accessing services have the opportunity to provide feedback on policies affecting them.	» Are all staff trained in the same approaches and aware of policies and procedures, including people in non-client facing roles? » Is there a trauma-informed approach to client exclusions/appeals and reviews of decisions where sanctions/bans/evictions have been applied? » Are clients' levels of 'engagement' seen and understood by acknowledging the impact of trauma? Can policies regarding engagement provide a degree of flexibility? » Are copies of relevant policies and procedures available to people using services? How and where are these kept? » Are client and staff/volunteer policies written in accessible language and translations available? » Are policies kept to a minimum to ensure people are not overwhelmed? *E.g. think about the way policies are presented – could there be a 1-page overview with the key points?* » Are operational policies and procedures reviewed regularly? Are they developed or revised alongside people accessing the service? » Have you consulted people accessing your service to understand what makes them feel safe?	*Type your answer here...*

Building psychological safety

Who?	Aim	Areas for reflection	Evidence & areas for development
Governance (continued)	**HR policies and procedures are designed through a trauma-informed lens.** » There is a focus on staff wellbeing. » Organisational plans are in place to ensure staff can access support structures.	» Is the impact of trauma taken into consideration in the staff performance management policy? » Is strengths-based practice adopted by management when reviewing staff development and support? » Are there dedicated policies and procedures in place to support staff wellbeing? » Can an Employment Assistance Programme be funded? » How does the organisation deal with common barriers to accessing support structures? *E.g. not having enough time, dealing with a crisis/incident.* » Are contingency plans in place to ensure staff can attend reflective practice/wellbeing groups during core working hours? » How are policies and procedures shared, as well as co-designed and co-evaluated, with staff and volunteers? *E.g. co-production groups.*	*Type your answer here...*

Building psychological safety

Who?	Aim	Areas for reflection	Evidence & areas for development
Governance (continued)	**Policies and procedures exist to keep all staff feeling safe.** » EDI is considered for all policies and procedures. » Recruitment of people from diverse backgrounds is prioritised.	» Are policies and procedures in place to support staff with protected characteristics? *I.e. allowing for reasonable adjustments.* » Does the organisation have an EDI strategy in place with clear actions? » Is there a diversity lead in the service/team? » Is a diversity calendar used throughout the year to highlight and celebrate a range of events? » Do people involvement/co-production strategies ensure a clear focus on diversity/inclusivity needs? Are they reviewed with people involvement groups? » Do senior management/the board of trustees reflect the diverse makeup of the people the organisation supports? » How is diversity encouraged in recruitment, including recruiting people with lived experience?	*Type your answer here...*

Building physical safety

- To what extent do the organisation's activities and environments ensure physical safety for staff, volunteers and people accessing services?
- How can services be modified to ensure this safety more effectively and consistently?

Who?	Aim	Areas for reflection	Evidence & areas for development
People accessing services	**People accessing services are physically safe within the building/ space.** » The design of the space ensures the physical safety of those accessing it. » Policies are in place to ensure that those who access services are not at risk of harm from others. » Incidents are well-managed, with lessons learnt for the future.	» Are there easily accessible exits? Is signage clear, *e.g. fire exits?* » Are there multiple entry points to the service? » Are there 'hidden spaces'? *I.e. areas that are out of sight of staff which could be a safety issue and make people feel more vulnerable.* » Can the space be adapted, or measures taken to ensure the space is safe? » Who else is present in the building? *E.g. consider if ex-partners/perpetrators of violence are together.* What is your visitor policy and is door/entrance management in place? » Is CCTV used and monitored (if necessary)? Has consideration been given to where CCTV is placed? *I.e. only in essential areas to avoid over-loading areas with cameras.* » Are there security staff? Does this resolve or lead to incidents? Are security guards necessary for your service? If so, are they trained in trauma-informed care to provide a consistent approach?	*Type your answer here...*

Building physical safety

Who?	Aim	Areas for reflection	Evidence & areas for development
People accessing services (continued)		» What events have occurred that indicate a lack of safety (e.g. arguments, conflicts, assaults)? What triggered these incidents? What alternatives could be put in place to minimise the likelihood of their recurrence? » Have different approaches for post-incident debriefs/reflections with people accessing the service been considered?[45] *E.g. restorative practices.*[46]	*Type your answer here...*
Staff and volunteers	**Staff and volunteers are physically safe within the building/space.** » Infrastructure is in place to keep staff and volunteers safe. » Incidents are well-managed, with lessons learnt for the future.	» What procedures are in place for ensuring that the space is safe? *E.g. reception and admission policies, staffing, adequate exits and alarms.* » Are mechanisms in place for instances of staff shortages to ensure safety? *E.g. agency staff, rotas.* » Have lone-working devices been provided to staff? » Have staff been trained in incident management? » Do staff understand the potential impact of traditional safety measures such as barriers and security staff on a trauma-informed environment? *I.e. risk management approaches shouldn't be punitive, but focus on safety and support.*	*Type your answer here...*

45 Listen to Series 2, Episode 5 of Homeless Link's 'Going Beyond' podcast which explores critical incident debriefing: https://homeless.org.uk/knowledge-hub/going-beyond-homeless-links-practice-podcast

46 Restorative Practices involves training and supporting people with specific skills to be better equipped to talk about and resolve conflict. Its focus is on restoring relationships that have broken down, rather than punishment and exclusion.

Building physical safety

Who?	Aim	Areas for reflection	Evidence & areas for development
Staff and volunteers (continued)		» Do frequent incidents of verbal or physical abuse occur? If so, what opportunities are there to reflect on how to reduce these? » Are incidents managed effectively by staff? » If incidents could have been handled better, does the service admit learning opportunities and share how this will be implemented moving forward? » Do staff understand how to use reflective techniques when dealing with challenging behaviour? *I.e. considering how experiences of trauma can impact people's reactions/behaviour.* » Can a monitoring system be put in place for incidents? *E.g. number of incidents over time by type, to understand trends?*	*Type your answer here...*
Governance	**The structures, policies and procedures of the organisation support physical safety.** » Policies and procedures exist to keep the space safe.	**Are policies and procedures in place to cover:** » Keeping the building safe in terms of fire and other potential risks » Preventing and managing incidents in a trauma-informed way, using restorative processes. » Providing adequate space for people accessing services, staff and volunteers to provide feedback and have their voices heard. » Ensuring there are adequate staffing levels to deliver trauma-informed and safe services. » Ensuring that staff and volunteers receive appropriate training.	*Type your answer here...*

Step 3: (Re)building control

Step 3: (Re)building control

Strengths-based approach

For individuals who have experienced trauma, a sense of a loss of control and self-esteem is common. Re-gaining a sense of control and empowerment is vital within recovery, and enabling people to identify and build their strengths can help to reinforce a sense of competence, often eroded by trauma.[47] Regaining control means being listened to, heard and believed, and having the choice and ability to make decisions.[48] It is important to note that when working with trauma survivors, it cannot be assumed that all individuals have had control at some point in their life. It is also important to recognise that control means different things to different people.

Strengths-based approaches focus on the person's strengths (what they are good at, their positive social networks and what they would like to achieve), rather than looking at someone's deficits (such as their 'problems' and what is 'wrong' in their lives).[49] Being strengths-based involves building an equal and trusting relationship so that the individual is able to share their hopes and goals and unlock their own self-esteem.

Organisations working in a trauma-informed way should use strengths-based assessments and support planning. Being strengths-based involves a genuine belief in each person's future and their ability to live a fulfilled life, including those going through difficult periods so starting the relationship based on this is fundamental.[50] Re-framing risk assessments into 'safety plans' is also a great way of identifying strategies that an individual, and those around them, can use to make themselves feel safe. Alongside other risk assessment approaches, these are good tools that empower people to understand their own needs and coping mechanisms. This helps build resilience.

Collaboration and peer support

Creating collaborative relationships involves taking the time to understand an individual's experiences so that staff can promote the message that everyone has valuable personal expertise and knowledge about their presenting needs. This creates a collaborative approach to support and gives the individual more control over thinking about steps forward.

For organisations to be trauma-informed, people accessing services need to play an active role in shaping the services and the support they receive. Using client consultations to co-produce services is a good way of doing this and means that organisations are responding to the needs of the client group. Employing people with direct experience of homelessness[51] (either paid or voluntary roles) can bring a deeper level of empathy, understanding and insight to an organisation, leading to better service delivery. However, this needs to be done well, with appropriate levels of support in place depending on where each person is in their own recovery.

47 SAMHSA, *Trauma-Informed Care in Behavioural Services, TIP 57,* 2014

48 Herman, J. L. (1992). Trauma and recovery: The aftermath of violence - from domestic abuse to political power.

49 Read Homeless Link's guidance on strengths-based practice: https://homeless.org.uk/knowledge-hub/being-strengths-based

50 https://homelesslink-1b54.kxcdn.com/media/documents/Becoming_strengths-based.pdf

51 Read Homeless Link's briefing on involving and recruiting people with lived experience: https://homeless.org.uk/knowledge-hub/involving-and-recruiting-people-with-lived-experience

Empowerment, voice and choice

Empowerment is about helping people feel greater power and control over their lives and supporting them to take the steps they feel ready to take.[52] Services working in a trauma-informed way should consider providing opportunities for people to try new things, for example, wellbeing activities, and empowering individuals through delivering life skills and confidence building sessions. People accessing services should be involved in deciding what activities are on offer, giving control back in simple ways.[53]

Developing peer support services within organisations and involving people with direct experience of homelessness in organisational structures, such as within trustee roles and in their wider community, reinforces client empowerment. Platforming people's voices that could have been silenced due to trauma brings back their sense of control.

52 SAMHSA, *Trauma-Informed Care in Behavioural Services, TIP 57*, 2014

53 Listen to Homeless Link's 'Going Beyond' podcast, Series 1, Episode 5 on 'Rebuilding Control': https://homeless.org.uk/knowledge-hub/going-beyond-homeless-links-practice-podcast

(Re)building control

- How does the organisation implement strengths-based practice?
- To what extent does the organisation embed collaboration and co-production within its services?
- What opportunities are provided for individuals to feel empowered?

Who?	Aim	Areas for reflection	Evidence & areas for development
People accessing services	**Strengths-based practice is used across the organisation.** » There is a focus on strengths, potential and goals. » Building good relationships in a priority. » People accessing services believe that they have the potential to lead a positive, fulfilled life.	» How is a strength-based approach embedded in referrals, assessments, support planning and risk/ safety management processes? » Are referral forms and assessments strengths based? How is deficit-based language avoided at all costs? » **Read Homeless Link's framework for strengths-based working.**	*Type your answer here...*
	Services are co-produced by those accessing them. » The voices of people accessing services are heard. » People accessing services feel empowered. » People exert choice over the support they receive.	» Is feedback gained through a range of informal and formal approaches? How is this feedback used and are people notified of this? » Are people encouraged to provide feedback in formal and informal engagement to ensure the service is constantly improving to meet their needs? » What opportunities are there to listen to people in their own time? » Are people involved in decisions made about the organisation's physical spaces?	*Type your answer here...*

(Re)building control

Who?	Aim	Areas for reflection	Evidence & areas for development
People accessing services (continued)		» Are people accessing services involved in recruitment? *E.g. the design of roles, adverts, recruitment processes and interviews.* » How are people provided with meaningful feedback opportunities at the end of their support? *E.g. 'exit interviews'.* » How are people able to choose their support? *E.g. deciding where to meet workers, at what time etc.* » Can people choose their support/key worker? » Can people choose how they work with them and for how long?	*Type your answer here...*
Staff and volunteers	**Strengths-based practice is adopted by staff and volunteers.** » Staff and people accessing services work towards mutually agreed goals.	» How are staff trained and supported on how to work with people to achieve their goals, gaining meaningful outcomes and not just 'ticking the box'? *I.e. trained in strengths-based practice, effective key working, relationship building, motivational interviewing etc.* » How are staff encouraged and supported to utilise a strengths-based approach to ensure constant growth and independence?	*Type your answer here...*

(Re)building control

Who?	Aim	Areas for reflection	Evidence & areas for development
Staff and volunteers (continued)	**Services are co-produced by those accessing and working in them.** » Staff encourage the voices of people accessing services to be heard. » Staff are involved in service level changes.	» Is there a co-production lead within the organisation? » Is the voice of lived experience heard at a senior level? » Are team meetings psychologically safe and encouraging feedback from all members? » Are team meetings open, honest, and flexible? Are there clear feedback loops for staff to understand how their comments/views are taken on board and acted upon? » Are team meetings supplemented with further forums for staff to help drive change? *E.g. trauma-informed champions in teams, reflective practice, etc.*	*Type your answer here...*
Governance	**The organisation aims to uncover people's strengths, interests and goals.** » KPIs include hard and soft outcomes. » Personalisation budgets are available to support people's goals.	» How can KPIs be tailored to reflect soft outcomes such as wellbeing, resilience and engagement outcomes? What spaces are there for more narrative based/creative impact measurement? » Are funds available to support people's goals? How can this funding be increased?	*Type your answer here...*

(Re)building control

Who?	Aim	Areas for reflection	Evidence & areas for development
Governance (continued)	**Services are co-produced by those accessing and working in them.** » The organisation actively seeks to include the voices of people accessing services, staff and volunteers in decision-making about the service.	» Does a co-production policy exist? How is it used and reviewed? » Do services supplement their staffing offer with a range of peer mentors/volunteers to empower and build skills for people in recovery, and enable peer-to-peer learning? Is appropriate support in place? » How are people with direct experience involved in interview panels? Are they provided a clear role in recruitment? » Is value-based interviewing utilised alongside competency-based recruitment? *E.g. using questions focussed on an individual's morals and professional standards and how they implement these in the workplace, rather than focussing on skills/experience.* » Are people involvement/co-production groups used to help design recruitment processes and ensure questions asked are appropriate to their needs? » Are clients involved in service reviews and evaluations?	*Type your answer here...*

What We Do

Homeless Link is the national membership charity for frontline homelessness services. We work to improve services through research, guidance and learning, and campaign for policy change that will ensure everyone has a place to call home and the support they need to keep it.

Homeless Link

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