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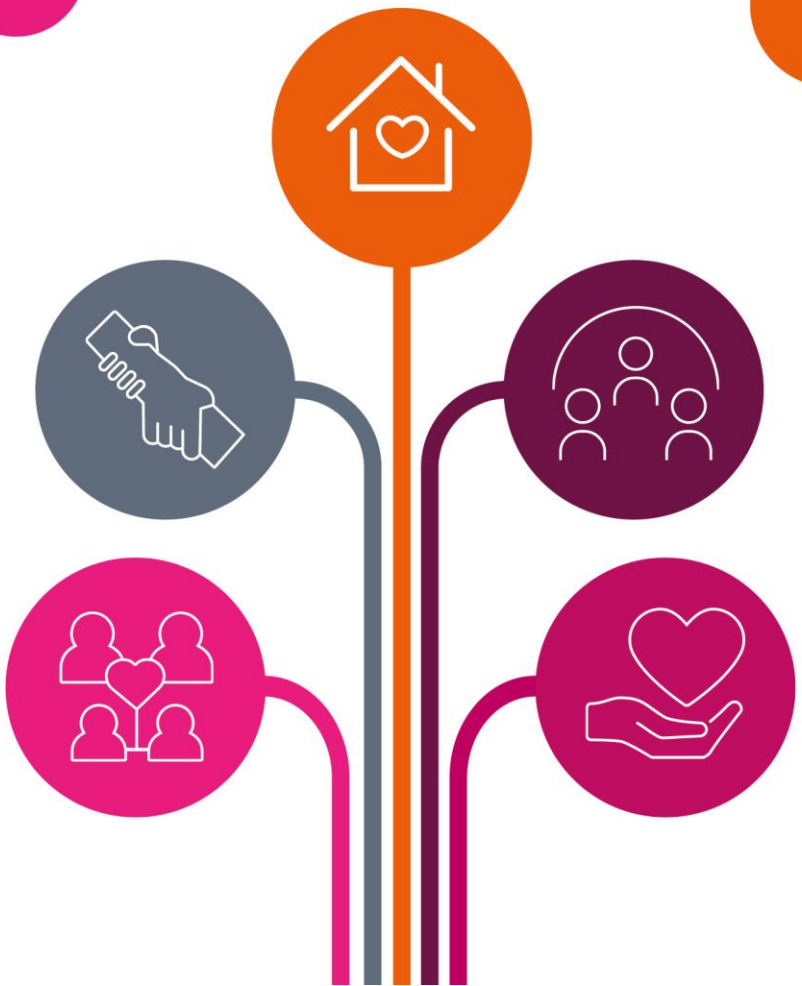
Trauma-informed approaches in homelessness practice: an exploration of practitioner understandings and implementation: *Briefing note*

October 2022



Knowledge Applied

Trauma-informed approaches in homelessness practice: an exploration of practitioner understandings and implementation

Briefing Note

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1 Introduction

This briefing note summarises findings from a one-year research study which aimed to explore how trauma and trauma-informed approaches (TIAs) are understood and implemented by services working with people with experience of homelessness and multiple disadvantage. It forms part of a wider programme of research and knowledge exchange on TIAs across housing and support services, which was funded by Sheffield Hallam University through their Early Career Research and Innovation Fellowship Scheme 2021/22.

With increasing interest over the last ten years, understanding and responding to trauma and its effects has become a central concern, not least for people experiencing homelessness and multiple disadvantage. While it is estimated that at least one in ten adults in Britain will have experienced four or more adverse experiences during their childhood, this figure increases to 85 per cent for adults facing multiple disadvantage.[1] It is widely acknowledged that not only are poverty, homelessness and trauma interlinked,[2] they are often one and the same. Homelessness, for instance – both the experience of and the factors leading up to it – is traumatic.[3]

With origins in the criminal justice and mental health systems of the US, TIAs have been defined as "organizational change process[es] centred on principles intended to promote healing and reduce the risk of re-traumatization for vulnerable individuals".[4] In the UK, TIAs are increasingly being promoted and implemented across systems and services as an improved approach to tackling multiple disadvantage.[5]

Despite this interest – or, perhaps *because of* their relative novelty – there are several knowledge gaps surrounding TIAs and how they are implemented in practice. First, there are multiple perspectives and conceptualisations of trauma and, as such, questions around how it is understood by practitioners working within TIAs. Second, without commonly agreed definitions, structures, standards or governance for trauma-informed services it is unclear what constitutes trauma-informed practice and the extent to which this might vary between services. And third, do they reflect the reality of practice? Are TIAs feasible in every context and environment?

[1] Bramley, G. and Fitzpatrick, S. (2015) *Hard Edges: Mapping severe and multiple disadvantage.* London: LankellyChase Foundation.
[2] Revolving Doors Agency and Lankelly Chase (2021) *The knot: An essay collection on the interconnectedness of poverty, trauma, and multiple disadvantage*. London: Revolving Doors Agency.
[3] Hopper, E.K., Bassuk, E.L. and Olivet, J. (2010) Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings. *The Open Health Services and Policy Journal*, 3, 80-100.
[4] Bowen, E.A. and Murshid, N.S. (2016) Trauma-Informed Social Policy: A Conceptual Framework for Policy Analysis and Advocacy. *AJPH*, 106 (2), 223-229.
[5] MHCLG (2020) *Changing Futures: changing systems to support adults experiencing multiple disadvantage* (Prospectus for local EOIs). London: MHCLG.

This study aimed to begin addressing these knowledge gaps through the following research questions, with specific focus on services working with people experiencing homelessness and multiple disadvantage (given the prevalence of trauma in this population group and the known associations between trauma, poverty and homelessness):

1. How do practitioners understand a) trauma and b) trauma-informed approaches?

2. How do understandings of trauma and trauma-informed approaches translate to practice?

3. What are the barriers and enablers to implementing a trauma-informed approach?

The study focused on one London borough council, details of which will not be revealed in this briefing note to protect participants' anonymity and confidentiality. Within this case study location, in-depth semi-structured interviews were conducted with 15 professionals, from a range of organisations[6] and covering various roles/levels (from commissioning and managerial to frontline officers). This case study work was supplemented by interviews with four professionals working in frontline, managerial and training roles across England with specific expertise in trauma and/or trauma-informed approaches.

This briefing note provides a summary of findings to emerge from the above interviews against the three research questions. The note is intended to increase understanding of existing provision of TIAs and recommend lessons for policy and practice.

[6] Organisation-types included statutory and voluntary sector organisations covering local authority, Housing First, supported accommodation, substance misuse, health and domestic abuse and sexual violence.

2 Practitioner understandings of trauma and TIAs

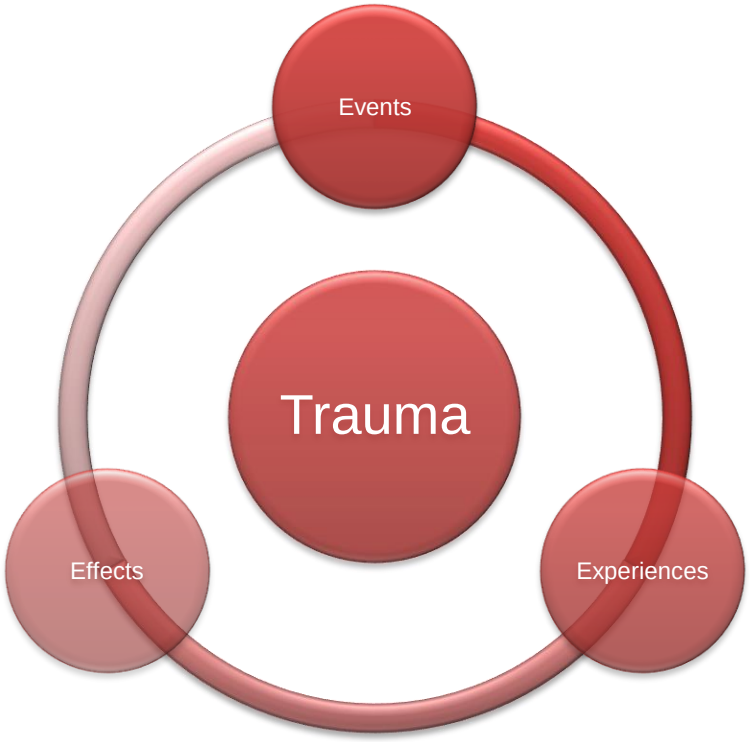
2.1. Understandings of trauma

This section focuses on research question 1a): 'how do practitioners understand trauma?'. Understandings of trauma, it is claimed, are most widely influenced by the concept developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2014: "Individual trauma results from an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being".[7]

In this study, practitioners and experts were asked the open question of 'what do you understand trauma to mean?' (or similar wording) to explore the extent to which their perspectives aligned with this definition, and to unpack any nuances that might exist, to help further develop the framework for those working in the context of homelessness and multiple disadvantage. The following discussion presents a synthesis of responses to this question under the 'three E's' of SAMHSA's concept of trauma: events, experiences and effects.

[7] SAMHSA (2014) *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Figure 1: SAMHSA's Concept of Trauma



It was importantly pointed out that it was not only clients who had experienced trauma, but that staff working within the sector may also have experienced trauma themselves, and this was seen as equally crucial to recognise and address in subsequent TIAs.

Events

Exposure to traumatic events or circumstances is central to formal definitions of trauma, as represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as “trauma and stressor-related disorders” to include exposure to a traumatic or stressful event as a diagnostic criterion.

Events and circumstances, perhaps unsurprisingly, featured in almost all responses.

> *It’s something that’s happening that’s bad (Interview 13).*

> *A single event or a pattern of events that have been traumatic and maybe considerably affected how the person views the world, how they view themselves (Interview 7).*

There was overwhelming consensus that events and circumstances need to form part of the definition of trauma. However, some respondents felt there was a tendency (within both everyday and medicalised understandings) to recognise certain events and circumstances as traumatic more so than others. For instance, it may be more widely accepted and understood that an event like a car accident is traumatic than traumas that occur in relationships associated with intimacy and caregiving.

> *I don't think it's as simple as like, you know, there's PTSD, which I think people can kind of understand a lot more, like maybe someone's had a road traffic accident and obviously that's still helpful to think of when we're thinking about trauma. But the more kind of complex trauma informed stuff is, I think, when that*

danger hasn't been in a car crash, it's been in a relationship with someone who's meant to kind of care for you or so, yeah, it comes out in lots of different ways interpersonally (Interview 12).

This was borne out in how practitioners described the kind of traumatic events and circumstances their clients had commonly lived or were living through. For this client group, trauma was seen as cyclical and cumulative. Adverse childhood experiences (including childhood sexual, physical and emotional abuse and neglect) were reported to be common, which are further compounded by events and circumstances that often occur through being homeless. This included homelessness (the loss of home) itself.

I think being homeless in itself is traumatic in terms of just not having a safe space where you know that you're definitely going to be somewhere and/or that feeling of feeling very isolated (Interview 12).

I mean like this is obviously completely anecdotal, but within [organisation name] I would confidently say that 95% of the people I've worked with, if not higher, have experienced some kind of trauma at some point during their lives, either, and I would say that the most common forms of trauma are either during early childhood like neglect, abuse. And/or during their time living on the streets as a result of that environment (Interview 15).

An important thread running through these accounts was the acknowledgement of systems and structures as bringing about traumatic events, either directly – through racism or gender inequalities and discrimination, for instance – or indirectly – via how systems and services respond (or fail to respond).

I think it's only more recently in the consciousness of homelessness organisations that that's definitely a factor as well – repeat experiences of racism over the years (Interview 1).

Women who are on the streets, that is continually perpetuated because when they're on their own on the streets they tend to latch onto males and those relationships may not be particularly healthy and they might be victims of domestic abuse so it constantly keeps re-traumatising them (Interview 7).

I'd also kind of say so just systemically kind of a lack of opportunity in terms of education. You know, having access to sort of what I would describe as like good objects, so kind of positive role models and positive experiences through the education system or through friends, having a very limited opportunity to have those experiences because of the family environment or lack of money or kind of the lack of other opportunities (Interview 10).

I think poverty and the impact that has, I think that's traumatic. I know there's loads of stuff on adverse childhood experiences and I guess within that we've got the physical abuse and neglect, sexual abuse, emotional abuse, but I also really like thinking around like adverse community environments are recognizing kind of politically and socially, there's politics that, yeah, like, you know, the changes in Universal Credit, just the living standards that some people, you know, live in, in houses or dangerous areas. And again, like the stress that can have on families or people, I think that's traumatic. Or racism, discrimination, those things kind of come up a lot (Interview 12).

What these insights add to formal definitions of trauma, then, is that rather than arising seemingly out of nowhere, traumatic events and circumstances, for people experiencing homelessness and multiple disadvantage, arise and are perpetuated by inherently political and societal factors and decisions.

Experiences

The SAMHSA definition of trauma also acknowledges that for an event or circumstance to be considered traumatic it must be experienced as such by the individual. This suggests a degree of subjectivity to trauma in that what one person may experience as traumatic may not be felt as such by another (or vice versa). This experiential aspect of trauma was recognised by practitioners:

> *There's someone I really admire, he's a Canadian physician - Gabor Maté - and I kind of resonate with how he defines trauma, it's not necessarily what happens to you but what happens in you as a result of what happened to you if that makes sense. I really like that definition because if we just stick to events, one event might be traumatising for me but not for you and vice versa (Interview 3).*

Importantly, though, to even begin to seek support for trauma, an individual must be able to recognise and communicate their experience as traumatic. Practitioners identified multiple barriers which may prevent an individual from doing so, especially within groups where levels of trauma are high. These include poor educational opportunities; a lack of access to psychoeducation; being part of a community where trauma is common (and therefore normalised); or feelings of helplessness about receiving support.

> *And that's also a huge barrier to them accessing trauma treatment because they don't often or they haven't typically often had access to the type of psychoeducation that would, you know, teach them what trauma actually is, and I think often when you're of a certain socioeconomic status, like again anecdotally, trauma is so normalised that it almost becomes a coping mechanism for people not to. You know, why would you say I've got PTSD, I've experienced trauma? Why would you allow yourself to recognize that and to confront the emotions that come with that, knowing that the people around you wouldn't necessarily agree that what you're saying is trauma is trauma, and knowing that you're probably not going to be treated for it because nobody else within your family has ever had any kind of treatment for all of the same things that you've experienced and I don't know if that makes sense, but if you think of like generational cycles of trauma and like the way socioeconomic status is linked, I think that's also a huge barrier (Interview 15).*

Effects

Lasting adverse effects are the final component of the SAMHSA definition of trauma. Examples given in this definition include an individual's ability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; or to regulate behaviour or control the expression of emotions. Much of this predominantly seems rooted in neurobiological theories around what happens to the brain. Some of this way of understanding the effects of trauma was evident in practitioners' responses, much of which had come from training they had received on trauma.

> *I remember the psychologist talking about you've got to imagine their personality, they've had so much trauma their personality's not formed properly so imagine it's a glass bowl and it's smashed on the floor and the pieces are not together, that's how they feel all the time which is why they can't regulate their emotions (Interview 7).*

However, also apparent was a move away from more medicalised understandings of the effects of trauma with many viewing them as unhelpful or inadequate explanations on their own. There was a sense that locating the effects of trauma solely in the brain could serve to pathologize.

> *Mental health services still very much use the medical lens to see people's difficulties and I think that is sometimes at odds with trauma-informed care because the medical model very much assumes there's something wrong with your brain, you've got a disease, which I don't necessarily subscribe to, I'm not saying there might not be some factors playing into it but that's not the main reason (Interview 3).*

> *I don't need to know what's happening with his brain, I just need to know where he's come from so we can understand this doesn't work for you (Interview 6).*

There was a sense that solely diagnosing the effects of trauma as neurobiological, while perhaps necessary in some ways, could also have negative effects if it resulted in potentially stigmatising labels (such as 'personality disorder'):

> *When I'm in meetings and I come up against that quite sort of rigid way of looking at people's experience where there's an idea of diagnosis and often medication and then I work with these people who sort of have had 15, 20 different diagnoses and you're like, I don't understand what this is doing then, you know, if you're gonna and always under this personality disorders sort of label which I think is problematic, just to have the word personality and disorder next to each other. You know, there's something there isn't there around people then become that, you know, the emotionally unstable, you know, it's tricky (Interview 8).*

It was generally felt that the effects of trauma went beyond – and could not easily be captured by – medical diagnoses. As such, many of the effects described by practitioners were of a more complex nature, relating to identity and safety.

> *Really kind of things around kind of violation of a person's physical safety, of their psychological safety, so kind of violation of boundaries in that kind of way. Whether it's a, you know, physical crossing of a boundary or kind of a psychological violation that is you know unwanted and confusing often, because of the element of that sort of lack of control and lack of choice (Interview 10).*

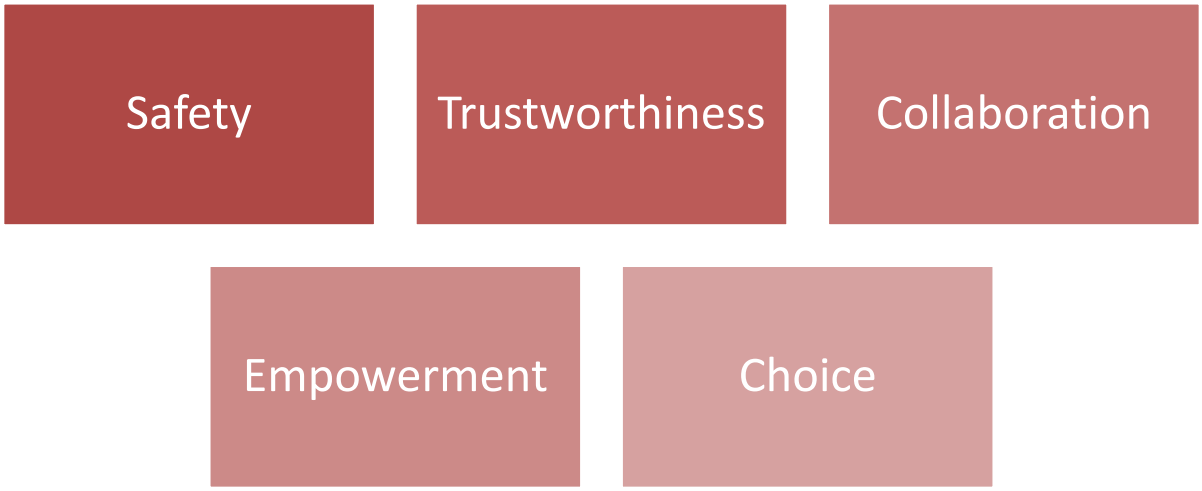
> *I think where the clinical stuff sort of struggles a bit is the more existential nature of what it is to be traumatized as a human being and that stuff that doesn't quite sit in, easily defined sort of you know it, you can't, it's not quite tangible. You know it's very difficult to hold you know and I think that's where it might struggle a bit. And I think that's maybe where it's sort of always, you know, I think that it always does struggle with lots of different definitions of sort of mental health or mental illness. You know, there's the DSM-5 sort of version of ticking these symptoms and I don't think they often fit you know what it is to be chronically depressed and where that might be coming from. And that could be, you know, feeling so out of place in your skin. And then in the world, you know? And the same with lots of these definitions. I think any time we try and put this stuff in a box, we're going to struggle just because it's so complex (Interview 8).*

Similarly, there was an emphasis on the strengths and survival strategies of those who have experienced trauma, rather than viewing effects through the negative lens of an 'inability to cope':

Now I understand that people who've experienced a lot of trauma are survivors and they keep going, healthy or not healthy they've found some kind of coping mechanisms (Interview 7).

2.2. Understandings of TIAs

Figure 2: Components of a trauma-informed approach (Fallot & Harris, 2006[8])



This section considers practitioners' understandings of a TIA before looking in more depth, in the following section, about how that translates into practice in homelessness services. This section also discusses whether practitioners saw TIAs as marking a distinct shift in homelessness practice.

In several ways, practitioners' responses to what they considered as a TIA coincided closely with the five components outlined by Fallot & Harris (2006) in *Figure 2*. Sitting above everything in this diagram, however, was the importance of recognising the impact of trauma on individuals' experiences of service encounters and interactions and ensuring this was at the centre of all elements of work with clients.

I suppose there's an openness to try to really explore the, you know, the human experience and holding the idea that trauma plays a part in that (Interview 8).

…putting that experience of trauma at the centre of everything (Interview 10).

…it's about approaching somebody as a human being, being very much led by them but understanding that what you're seeing from somebody, they might be very angry with you, they might be very dismissive of you, not taking that on board and realising that there's probably something behind that (Interview 7).

Practitioners often pointed to the key principles (or very similar concepts) of a TIA in *Figure 2* in their responses.

[8] Fallot, R., & Harris, M. (2006). Trauma-Informed Services: a Self-Assessment and Planning Protocol, https://www.unitedforyouth.org/sites/default/files/2020-08/Trauma-Informed%20Services%20-%20Self%20Assessment%20and%20Planning%20Protocol.pdf

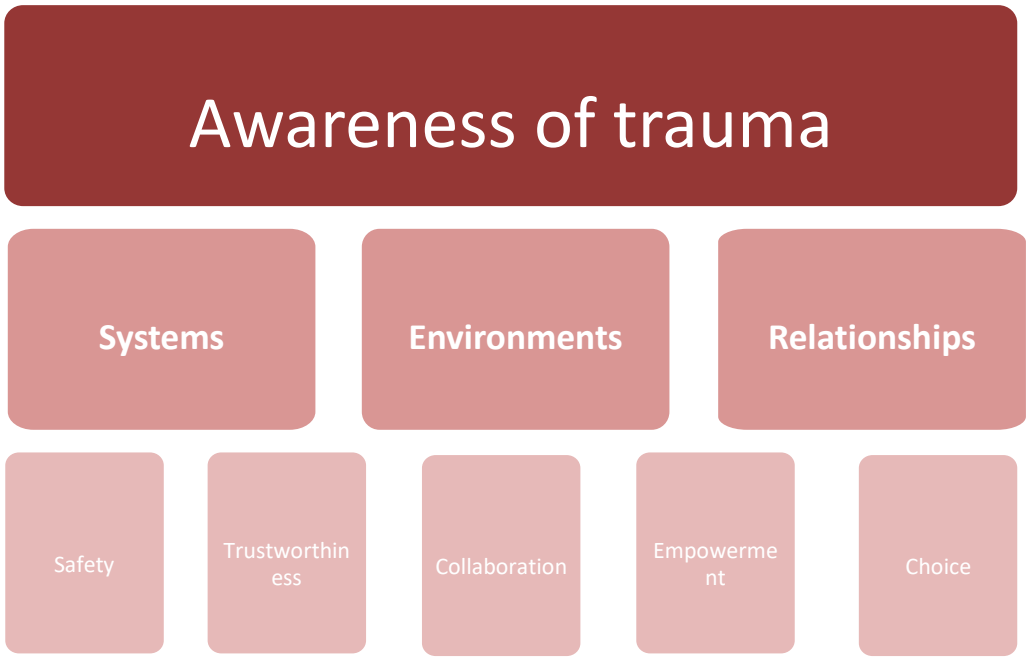
I think ultimately just giving within all of your processes and your procedures and the way your building's set up and the way you work, ***giving the client as much power*** *within that to make their own decisions as possible (Interview 15).*

…obviously increasing ***safety, control, understanding, empathy****, decreasing the risk of secondary traumatisation and decreasing the likelihood of re-traumatisation (Interview 1).*

…very client-led and just really ***compassionate*** *with an ability to* ***collaborate*** *with the person, I think that is very trauma-informed. Another buzz word at the moment is* ***co-produced*** *but I'm all for it, people need to be able to take ownership of their own journey at their own speed and not have us come in as workers and just lay down what our expectations are for them (Interview 5).*

A trauma informed approach for me has to start with the basics of the relationship of kind of being given ***choice, being trustworthy, being consistent, kind of actually seeing and hearing the person****. It's, you know,* ***doing things with and alongside rather than to*** *(Interview 10).*

Figure 3: Practitioners' understanding of a TIA



Holding trauma and its impacts, as well as the above principles, at the centre of decision making necessitated a continuous process of reflection and evaluation at various levels of service design and delivery, in terms of environments, systems and relationships. This entailed thinking about the space within which interactions took place, and aiming to make it as homely as possible; the relationships and interactions with clients themselves; and the systems and practices of the organisation (including staff training, capacity, supervision and support).

I think there's definitely something powerful about relationships. I think for me, first of all, it's recognising that as we just said all of us may have been traumatised in one way or another and just really always have that at the back of your mind, not assuming but just having it there just in case something happens, so not assuming you're okay with that or you're okay with this. Then if you're aware of that like you were saying, building relationships around that and making sure there is that trust. I agree absolutely, whether it's with members of staff, managers, commissioners or clients, unless you've got that trust and relationship there you're

not going to do much and that's definitely my experience in that role, it all starts there (Interview 3).

In terms of the 'newness' of TIAs and whether they marked a shift in the way of working, practitioners felt that while some staff in the homelessness sector may have always been working to some of these principles, it is only more recently that trauma-informed care has emerged as a named and more formalised approach. Practitioners saw value in working and coalescing around a shared philosophy. Locally, this shift was indeed deliberate in the sense that commissioners had been sponsoring it for the last 18 years or so.

I think it was really the recognition that hang on a minute we've got pretty reasonable quality accommodation and we've got drug and alcohol services and education, training and employment and yet people are not getting better, they're not moving forward, you know, what's going on? And actually the intense experience of trauma that's at the heart of it, we need to do things differently (Interview 1).

Practitioners who had worked within the homelessness sector in the case study area had noticed a shift over this time period, which they noted was marked by concrete changes in their services, such as the introduction of reflective practice for staff.

I think going back to about 2013, that's when it started to happen, we started to get things like reflective practice. For a long time when I started working as a project worker there was no such thing as reflective practice, there was no clinical supervision, there was nothing like that at all so what you were finding was very much a revolving door, the same residents that I've worked with a couple of years would just keep coming back around and around and nothing was really changing (Interview 3).

Ten years ago. Working in the private sector within addiction there's more of trauma, it's all about trauma, I don't know why because I think some of them are less trauma-informed because they are too busy pathologizing about looking at the limbic system and telling people about the limbic system and not helping that person deal with what's going on for them at the time, but that's when I started understanding a little bit more about actually this person's journey (Interview 6).

3 Implementing TIAs in practice

This section moves on to explore *how* TIAs were implemented in practice by the services interviewed, with reflections on the process of becoming trauma informed and the facilitators and barriers across the key levels of a TIA, including systemic, environmental, and relational.

3.1. The process of becoming trauma-informed

Being trauma-informed was understood as a continuous process of learning and reflection. In such a sense, there was no end point whereby a service became *truly* trauma informed. Rather, the essence of a TIA is knowing there is always more to reflect on, learn and improve. Every service adopting a TIA, then, may always be in process of becoming trauma informed. It was considered important to regularly review systems and procedures within an organisation in line with the extent to which they adhered to the principles of a TIA. In one service, this included consulting with the client group, *"really consulting with the people that we're working with in terms of you tell us, are we trauma-informed?".*

> *I don't think that any service truly reaches a final utopia of trauma-informed care, I think there's always something to work on, there's always something to improve. I think becoming trauma-informed can be a career-long process for an organisation cos something else will always pop up (Interview 14).*

> *I will always say like being PIE, psychologically informed or being trauma informed, isn't ever like a thing that you've gotten to or you've ticked off. It's like a continuous journey. And I think it's helpful to reflect on. I think part of being trauma informed is always like reflecting on what we're doing or like taking a step back and you know, I say evaluating ourselves (Interview 12).*

In other ways, being truly trauma informed at all times was also seen as an impossibility given the ongoing challenges that arise in organisations.

> *Ideally with a trauma-informed approach you're applying that to everything from the lift breaking down to the boiler breaking down to your key worker's off sick, making everything thoughtful, making everything… being reliable, empathetic, making people aware of their strengths, but actually when services are under pressure it can drop. And it's hard for workers to hold it in mind. And then organisations can prioritise other things. It's easy to do when the going's good, it's when it's going hard it's a harder task for trauma-informed to be infused through everything you do (Interview 1).*

I think that, you know, the point at which it is like truly like seamless or implicit, like genuinely part of people's everyday practice, I think that would be very hard to achieve inevitably. And there is always a bit of push and pull because obviously services have their own targets and their own criteria to meet just to exist, just to be commissioned, so we can't expect that the whole world should sort of immediately change in response to it even if there is a feeling that it would be most beneficial (Interview 11).

Despite the above, there was still an acknowledgement that different services may be at different points on the process of becoming trauma informed. As one practitioner explained, at one end of the scale, an organisation may only be 'trauma aware' if they have received training on trauma and TIAs without yet changing any policies or becoming 'trauma informed'. There was a sense from practitioners that while genuine trauma-informed services did indeed exist – including their own – there was also a small risk that it could be applied by some in a tokenistic manner. Most of the practitioners interviewed, however, believed that those services who they knew were pursuing a TIA were doing so with good intentions. Where many services may struggle to go beyond simply a 'trauma-aware' approach, practitioners attributed this to the lack of guidance available on how to implement a TIA in practice. Given this lack of guidance, there was felt to be an inevitability to how much TIAs would vary from service to service.

Karen Treisman has a really nice analogy of it, it's like called the Trauma River, so that you're like trauma aware where maybe staff have had some training or something. And then there's trauma informed like responsiveness. So you're actually OK, you've had training, you thought about it, and you're actually responding in a way. I think sometimes people, there's a danger isn't there in just attending like one training and thinking, 'OK, yeah, I know what that's about and I'm trauma informed' (Interview 12).

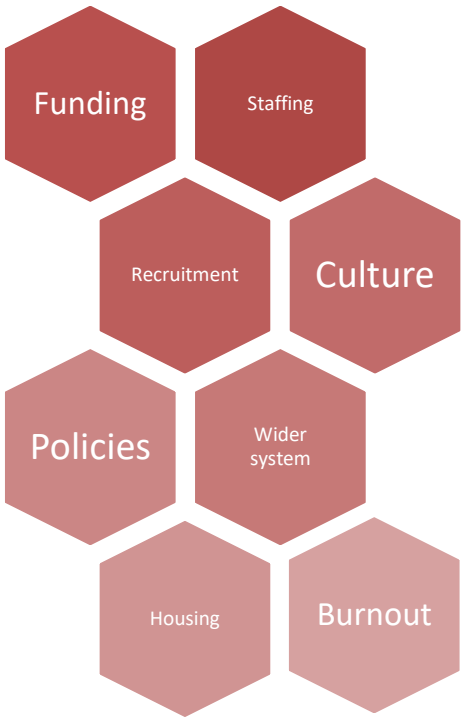
My understanding is like trauma-informed care does exist. I think homelessness services are genuinely trying to implement it with good intention. But the issue that people run into time and time again is that there's no guidance on how you implement it. So the way it gets implemented will vary naturally from service to service and it will end up meaning vastly different things in practice from service to service because of that lack of standardization (Interview 15).

3.2. Facilitators and challenges to implementing TIAs in practice

Systemic

By far the greatest type of barrier to services operating in a trauma-informed way related to structures and systems – both internally, in relation to how homelessness services function, and externally, in terms of the design and operation of wider, statutory services. This sub-section explores this category of barrier in turn alongside how homelessness services are addressing them.

Figure 4: Summary of systemic barriers and enablers



Resourcing and demand

Funding structures and requirements played a significant role in homelessness service design and delivery, and affected the extent to which a service operated in a trauma-informed way. The majority of funding was short-term which added to a sense of uncertainty and anxiety for staff in terms of job security. Further, not knowing where the next pot of funding would come from, and how long it would be for, made future planning difficult for services. A short-term funding period was also seen to work against the need for longer and more consistent client engagement that is foundational to a TIA. Similarly, funding that comes with the need to meet measurable targets and outcomes often does not encourage the kind of trauma-informed, sustained work that people experiencing multiple disadvantage require – for instance, adding to the pressure to move people on to their own tenancies from hostels where longer-term working and support may have been needed.

> *I suppose the first word that came up to me was funding. There's a real basic level of sort of a lack of money within homelessness services, and then a need to produce what look like very solid achievements where if you were looking at, in my mind, trauma-informed work doesn't sit in the tangible, in that world, you know (Interview 8).*

> *Yeah definitely funding because we work with women for a long time, we've got to build that trust with them, sometimes it takes years to build it and then some of our clients have said you're just going to leave me like everybody else has done, that could be to do with the funding or whatever reason, but it's a barrier and for us as well to have job security and want to stay and work and be able to continue a consistent trauma-informed approach cos we do know the clients, there are changes and they get a new key worker and so it's important to keep that consistent approach to be trauma informed as well (Interview 2).*

> *A lot of it is short-term funded and you may not know if it's going to be renewed, that kind of thing which of course is going to bring stresses for the workforce as well because it's sometimes funded for a year and then you don't know the future,*

so that future planning can be quite difficult as well sometimes as far as the service is concerned (Interview 3).

And I just think if services don't feel safe in terms of like how long they're going to be funded or whatever, that can kind of seep into, but also just you know, the time it might take to engage people or for you to actually see the outcomes. I do recognize there's the reality of commissioners only having so much money and this is where I think it goes back to the politics and being, you know, like the different people in government and how much funding is given to homelessness services or other services. And like the pressure, sometimes I think for hostels to move people on (Interview 12).

In the case study area, however, practitioners were keen to point out the value of having a commissioning team who actively promoted TIAs, who had been sponsoring such approaches for the past 18 years after recognising that the system needed to work differently for clients. TIAs are now built into procurement and contract management and there are many organisations on board with TIAs. This was a key facilitator of establishing a trauma-informed system though was still recognised to have gaps, in terms of the way that mental health services tend to prioritise a diagnosis-based model, for instance.

We were fortunate enough to have people within the management structure or commissioning who valued working in a trauma-informed way and seeing that something needed to change (Interview 3).

Otherwise on a more strategic level I must say our commissioners are excellent, I'm so grateful to them, they really do advocate incredibly hard for us and try and push through their own internal challenges within the borough itself (Interview 4).

What I will say, one of the reasons I have loved working in [place] these past few months, it's been a breath of fresh air because it has just reminded me of just how passionate the commissioning team and therefore the services that they commission are around PIE models, trauma-informed, co-producing, all of these things and I love it, there's a real human element to the work that they do that is able then to filter on down and I think it's fantastic (Interview 5).

I think actually, you know, the fact that they're seeing, they've commissioned sort of for my role, you know, it shows that there's thought around it (Interview 8).

Funding was also at the root of the next major barrier to operating in a trauma-informed way, around the level of **staffing** to meet current levels and complexity of need. Inevitably, homelessness services that are designed to accommodate large demographics of individuals with high levels of need will find it more challenging to work in a time-considered, trauma-informed way. Where this is the case, services can focus on responding to immediate, urgent, everyday issues without the time or capacity to give to TIAs. Such pressures were acknowledged to be even more heightened since COVID-19 when staffing levels were often reduced.

I think resourcing issues and other priorities just make it so hard to do and corners get cut, and it's hard at the moment with staffing, like at the moment with Covid staffing's really impacted. So when you're like only working with half the staff team you should you have to focus on the basics and that cuts time for being thoughtful, being reflective, tuning into people, being empathetic, reliable – reliable in particular when you've got staffing gaps so real life can get in the way. And where trauma informed isn't the priority, I think things, more corners get cut on thinking things through, being reflective and being supportive, being yeah psychologically informed (Interview 1).

I think probably in my experience of kind of working with the big hostels and assessment centres just the sheer lack of you know, the ratio between the staff and the number of residents there who are you know often quite unwell in crisis and kind of, you know, staff having to prioritize and deal with very like practical things like day-to-day in the hostel like you know, I could have broken window here that's like a health and safety thing or, you know, this crisis that's happening over here (Interview 10).

Recruiting and retaining staff with sufficient expertise and passion to carry out a TIA was seen as a challenge for services, perhaps relating to the pay and working conditions at lower grades in particular. Turnover at entry level was reported to be high, as staff moved on to jobs with higher pay and greater job security. This movement of staff meant it was difficult for services to maintain a consistent approach with clients, and that worker-client relationships often needed to be re-started.

Both of the last workers that I had were both, both have done masters in homelessness or whatever something similar, but they only lasted nine months. Bloody brilliant. But obviously they learned what they needed to learn and springboard onto the job that they wanted to do. So how do you keep those sort of people and then the next bit is that you've got 6 recovery workers that do basically all the hard work, all the hard yards and whatever. And they're on 25, 26, it's not enough. To get a quality of work and to stay for a long period of time, to be able to invest back into the client (Interview 13).

Working in the homelessness sector often entails long hours, low salaries, and encountering challenging behaviour on a day-to-day basis. Fatigue, stress and burnout were therefore seen as common. The nature of the work itself was understood to take a toll on staff wellbeing, and often could be traumatising, especially for staff new to the sector and in relation to working with clients who may not be seen to be making much progress. It was also pointed out that many staff who are drawn to this sector have experienced trauma themselves – perhaps especially so where staff members are peer navigators with lived experience of homelessness – and may be at risk of re-traumatisation when faced with particular situations, which potentially limits their capacity for supporting others if they are not receiving sufficient support themselves.

And also the job itself is traumatizing for support workers, like it's just a massive like I don't know what, like cesspit of like trauma from like, all angles and the support workers crucially don't have the tools to deal with their own trauma and they therefore don't have the tools to deal with other people's trauma. And then I just, you know, I think that's a huge barrier that's not spoken about (Interview 15).

People can become so entrenched in the ways of working, and also in some of the hopelessness that I think is really endemic in this sort of work. Like people feel really helpless, that they, whatever they do, isn't making a difference. There's, like, really high risks of like burnout, which can also make people just want to sort of retreat and just do their shift and then leave (Interview 11).

Added to situations where caseloads are high and staffing levels do not adequately meet the demand for the service, the ability to operate the service in a trauma-informed way could be limited as a result of the above resourcing and staffing issues. In many cases, where staff were seen not to be engaging in a trauma-informed way of working it was more because they could not – or did not have the capacity to – rather than they did not want to. This included having the time to take up training, reflective practice, and to reflect on the best approaches to working with individual clients. Taking a TIA was seen to require slower, more reflective ways of working which an under-resourced staff team with high caseloads may be reluctant (or unable) to put into practice.

But also just in terms of what I think staff feel they have capacity to do as well. So if you have really high caseloads and they don't have the time to sit and slow down and think about clients, then there can be a lot more, I guess resistance to thinking in a trauma informed way 'cause it opens up complexity and grey areas rather than a very black and white: 'Does this person need sectioned or not?' You know which is an easy solution in some cases and trying to slow that process down or think about something different for a person that is maybe less traumatizing. I mean it is more work for the key worker on top of an already very busy caseload that we don't have the time to do (Interview 9).

An obvious solution to the above staffing related barriers is to have well-resourced teams who have the capacity to manage complex caseloads, to have the space to slow down and think about their work in a reflective manner. Due to funding and recruitment issues, this is not always simple or possible to achieve. Facilitating staff, who are already stretched, to buy into TIAs could therefore be a challenge, though some best practice emerged from the case study and expert interviews. One overall observation was for trainers, managers and/or commissioners to emphasise how TIAs benefit staff as much as they benefit clients. Where it was seen to work even better perhaps was where the appetite for a TIA had come from the staff team themselves, rather than feeling as though it had been implemented or imposed from above in a top-down manner. Although it was still challenging work, many of the staff in services adopting a TIA spoke positively about working in a more flexible, creative way which had benefits for their own wellbeing and filtered down to their work with clients.

You know, I think part of being trauma informed that does make a difference in my role. It's like what attracted me to it is, is like if people don't engage or don't attend then you know, I don't have to discharge them or I can be a lot more flexible (Interview 12).

Having access to reflective practice – or internal or external psychology input – was spoken of as a vital component of a TIA in how it supported staff wellbeing, providing them with a safe space to offload and manage any vicarious trauma they may experience through the nature of their work. It also had benefits for staff in terms of allowing them to check in with each other, to talk through difficult cases and come up with solutions together.

As project workers we do have monthly clinical supervision sessions which are really helpful, they basically allow us to check in with each other and speak about if there's certain cases that might be a bit harder to work with than others, it is a helpful way of the team talking with one another and checking in how to manage certain things working with clients and barriers that you might experience (Interview 2).

Support for staff should extend to the whole organisation and in many ways should mirror the ethos of trauma-informed working for clients – employers ensuring their staff feel listened to, cared for and that their needs are taken into account. This may include praising staff to ensure they feel valued, having a flexible working policy, and not encouraging overtime.

I think part of being trauma informed as well is being aware of kind of self-care or the needs of staff and if we want staff to be compassionate and empathic and trauma informed then services need to give staff an experience of that as employees, of being listened to or cared for or you know 'how are you doing?'. And not, you know, not feeling alone in the work, I think as well, that's important, that it's held across a team (Interview 12).

As a manager I strongly encourage everyone to take their leave as and when it's required. We work to a TOIL system so you don't get overtime so it doesn't encourage people to do it for a financial gain but if you have lots of hours owed, which can sometimes be the case, then I'll encourage people to take it. We've got a flexible hours working policy, I think that's quite useful, it encourages people to take a few hours if they need and just really have ownership of their own working day, a lot of trust is placed in the workers to be able to manage their own diaries and treat people as adults basically (Interview 5).

Getting staff on board with a TIA, then, requires that staff are made aware of and fully informed about TIAs, and how such approaches may benefit them, as well as their organisation and clients. Running mandatory, core training in TIAs, which is appropriately tailored towards organisations working with people with experience of homelessness and multiple disadvantage, is one possible way of raising awareness, which some organisations have already adopted. Another is having psychology support embedded in the team as a way of continually developing the knowledge base and awareness. One practitioner described a TIA as an investment, in that it may require staff to spend longer thinking about how to approach situations and their work with clients, but that investment in time is likely to pay off in terms of staff and client wellbeing (if it results in less incidents per week, for instance).

We have a lot of training, the guy who delivers our reflective practice also, his team deliver training, so a lot of the training that the [organisation] staff get, it's mandatory and a lot of that is around PIE, trauma-informed practices, safeguarding, harm reduction, so people are already coming in during their period of induction of having those core trainings (Interview 3).

And I think it's difficult because lots of the kind of the keys to the trauma-informed approach kind of rely on someone's knowledge base and understanding of the rationale behind it, which is largely based on kind of psychology stuff, you know, like how kind of, you know, experiences of early trauma kind of impact things like attachment or how people relate to people or development of kind of mental health difficulties. And I guess if you're, if you don't have the kind of knowledge base and the buy-in and the understanding of that like rationale of why then you would want to, you know think about boundaries very carefully or kind of you know choice or consistency or those kind of things, I think this sort of the developing of the understanding of the knowledge base and the rationale is quite important. Even before you get down to like the kind of the practical 'how does this actually look in practice? (Interview 10).

Culture

Among some staff teams in the sector, there was acknowledged to be an underlying culture of resignation or stoicism, or of perceiving that encountering traumatic situations is part and parcel of the job, which added to a reluctance to engage with the reflective practice or psychological support on offer at an early stage. Those running reflective practice and therapy sessions found where meetings were poorly attended by staff, it was because they were seen as less of a priority than responding to immediate client needs.

And personally, I found because you gotta keep this sort of proud bravado up. It's hard to tap into some of that stuff until you're really in the place (Interview 13).

It was interesting though 'cause I think I did one self care training and it was the worst attended so you know which was quite an interesting… But there's something there isn't there, you know, it was seen as a bit of a uh right now that's

not as important as the sort of working with suicidality or working with… so there's something there, maybe there is something being missed (Interview 8).

I wanna say like you know having an internal system whereby any employee can access counselling if they need it and access like a therapeutic debrief after any situations they find distressing, but we as an organization have that and our uptake is 0. You know, like I was talking to a couple of, I was eating my lunch next to a couple of support workers the other day and they were like 'had to resuscitate [name] last night'. And I was like, what? And they're like, 'yeah, [name] was clinically dead for half an hour. And we had to resuscitate him and get the defibrillator out'. And I was like are you OK? And then they were like 'yeah, it's just part of the work, isn't it?' And I was like, no, no. But I almost sensed this, like, reluctance in them for kind of admitting that they've been affected by it because they seemed almost like a bit scared I might judge them, or that by being affected by these things it makes them less good at their job (Interview 15).

The cohesiveness of a team was also seen to be a factor influencing the take-up of psychology and psychological ways of thinking.

If a team is, I guess fairly new and not necessarily, doesn't have the kind of processes, team-feeling to begin with, what I find is they're much less receptive to maybe psychology and psychological ways of thinking (Interview 9).

This kind of culture was also spoken about as being endemic in some statutory services, who work in proximity to trauma, and was identified as an issue that needs to be tackled on a wider, societal scale.

You know there needs to be I think that you know the idea of what it means to be in trauma all the time, in proximity to it, needs to be looked at throughout society, you know, because it's crazy that sort of you know, we talk about it within the, you know the psychological community. But there's so many other parts where it's sort of recognized it's a bit of a shit job and you've got gallows humour, but actually there's huge issues for individuals within that work, but then for society itself because it's not, you're creating an abusive system (Interview 8).

Organisational policies

Another barrier concerns the balance that is struck between operating in a flexible, trauma-informed way and setting boundaries around safety. Safety is a key pillar of a TIA and certain rules and policies may need to exist within a service to uphold a sense of safety. Yet, rules – where too rigid – may also detract from other tenets of a TIA, such as choice and empowerment. Examples were given by practitioners of spaces such as hostels where there are individuals often presenting with substance misuse, aggression or behaviours that stem from trauma. The need to keep all residents in a hostel safe may necessitate the establishment of boundaries and the limiting of choice, to a certain extent, for some.

You know, there is a reality, isn't there that sort of, especially within some hostels, how do you get that first that sense of safety which people need when you're understaffed, you're managing sort of numerous people with different presentations. Some who are very chaotic, some who might be presenting with aggression or sort of you know and then you know you're to keep that space trauma informed is sort of tough because you have to manage this space in a safe way (Interview 8).

I think it's always a balancing act and I think so often it comes up where the organization has policies and things that of course we can try and think with the

organization about how to make them maybe more psychologically informed or trauma informed, but often they do have responsibility to keep everyone safe in the building and create a safe space (Interview 9).

Perhaps key to understanding how services addressed this barrier is to view TIAs not as a catch-all solution, but as offering space – whether through reflective practice, formulation, psychology support - to talk through, try out and reflect on different approaches. An example was given in one of the quotes below about self-harming behaviour by a client. While needing to follow procedure here around calling an ambulance, a TIA might also look beyond this immediate response to think about why this client might be self-harming and discussing ways to make them feel safer. Bringing the team together to safely unpack rationales behind organisational policies and explore different perspectives on decisions was what was felt to be important here – not necessarily agreeing that one course of action was right or wrong but allowing different views to be heard.

It really is just about being open and transparent in terms of your way of working. Like I said earlier there is no blame culture at all, if we get something wrong let's review it because we all make mistakes along the way, but I think the barriers within the setting that we have, it's making the staff team comfortable so then actually they can send the appropriate message to the clients and it filters through and it's really being more proactive about getting feedback from the clients, that's the most powerful thing, and just giving them as many opportunities as possible to empower them to do more, cos otherwise we're holding them back (Interview 4).

I don't think there's a right or wrong, but I think it's having those conversations with teams and these grey areas about coming together to think of a solution that might help us to find a bit of a middle ground in that. So I guess one of the things that comes up quite often is maybe around like I don't know. I guess like self-harming behaviours, is maybe one kind of example where people might, you know be self-harming and of course there needs to be a response to that and help people to be safe in that. But if we're thinking about a psychological formulation around helping someone, we might try and merge some of the policy with how like why someone is doing what they're doing as well and rather than just immediately calling the ambulance and going through that very procedural thing. What else can we be doing proactively to help them to feel safe and where they're getting to that point and that kind of thing. So always of course, being on board with the policy that organizations have in place, but trying to, I guess, sprinkle or maybe influence in more subtle ways and have discussions around these being really complex dilemmas that come up in the work all the time (Interview 9).

I think it's about bringing the team together so that you're kind of trying to minimize those splits in the team and those divisions and help different perspectives to be heard and valued so that they can think together and know that no one is right or wrong in this. It's just about what's happening, and I think sometimes you can really get into if a team feels able to or people feel able to explore what comes up for them, you know. Like how they feel about a certain client, or why they feel like they need to be stricter or less strict with someone and what's influencing them (Interview 9).

And so that's a big part of psychologists' role I think is helping with that kind of formulating or thinking about 'what's going on for this person' and understanding what's going on beneath the behaviour and thinking about how we can intervene in a trauma-informed way (Interview 12).

The wider system

A major barrier to homelessness services operating in a trauma-informed way relates to how the rest of the system for people facing multiple disadvantage is functioning. Practitioners commonly described other parts of the system – statutory services in particular – as struggling, or as being 'on their knees' as one practitioner put it. This included staffing shortages, cuts to resources and closure of some services; a lack of understanding or application of TIAs; an over-reliance on a medical, diagnosis-based model; rigid eligibility criteria and engagement thresholds; a lack of flexible, assertive engagement; and a lack of information sharing and joint working across services for this client group. This led to a sense among many practitioners that TIAs existed within a small pocket of services but stopped short at the wider system. There was a likely risk, therefore, of clients being traumatised, or re-traumatised, by their encounters with other services accessed in the case study area that did not operate in a trauma-informed way.

> *I think perhaps going back to barriers, I mean when other parts of the system are more on their knees it makes it hard. Like at the moment probation in our area the staffing is so badly impacted it's very hard to get anything in terms of responses at all. Difficulties in the mental health team, difficulties with beds – psychiatric beds. So when other parts of the system are really struggling then services feel more abandoned, more on their own, it's easier to do good work around a person when other parts of the system… and I think generally many parts of the system for multiple disadvantage are struggling at the moment (Interview 1).*

> *I find from my perspective sometimes looking across services where they may not have the same level of flexible tolerance that we have, so if we're trying to achieve something and we want to lean on a fellow partner to employ the same style of working and they don't then it's going to potentially undo everything we've come so far with the person to achieve (Interview 3).*

Mainstream mental health services, in particular, were seen to present many barriers for people experiencing homelessness and multiple disadvantage. At odds with a trauma-informed approach, mental health services were seen to lean towards a medical model of treatment underpinned by the question, 'what's wrong with you?' (rather than 'what's happened to you?'). Barriers exist in the way such services are set up that do not take into account the needs of those experiencing homelessness and multiple disadvantage. Examples were given of strict policies around non-attendance or cases being closed after a patient fails to attend a number of appointments, which speaks of the failure to recognise or accommodate for the difficulties this client group face (in meeting a new person, or sitting through an hour-long appointment, for instance). The disconnect between mental health and drug and alcohol services also fails to take into account the experiences of this client group, in terms of service exclusion criteria that requires sobriety (for mental health services) or engagement with mental health services (for drug and alcohol services).

> *So when I say about the dual diagnosis clients that we have, we do find the drugs services or alcohol services will say it's a mental health problem and then the mental health services will say no it's a drug and alcohol problem and going backwards and forwards between that structure is really challenging (Interview 4).*

> *I think it's definitely sort of difficult when services for example in like the client group that we work with when services have quite strict policy on if you don't sort of attend X number of appointments, then we'll close your case. Again, kind of from my perspective, that kind of the lack of understanding of like how difficult it might be for someone to go and meet a new person or kind of sit through an hour-long assessment (Interview 10).*

Inflexible access and engagement criteria were also mentioned as being a feature of physical health and drug and alcohol services, whether in terms of accessing detox and rehab, having to attend group sessions, or the normative expectations around touch in physical health settings.

> *I think that a lot of services fall into this trap very inadvertently. So it could be something as simple as the way a lot of services are set up to be very prescriptive and non-flexible in their approach. So the expectation that people have to engage in a certain way and that engagement itself can be re-traumatizing. So whether that's like physical health setting exams and expectation that you should be happy to be touched (Interview 11).*

> *Another one, again, we know that substance use is really an issue for lots of people with trauma, so similarly with like rehab programmes maybe a lot of that entails like group work or group therapy, so again, people who've experienced trauma often feel quite nervous in groups or exposed. But then, like they have to agree to sign up to the group work but then that puts people off (Interview 12).*

> *For example [service name] was a detox in [place], it was pan-London, it was accessible to all and in order to access [service name] you had to phone up in the morning, they would tell you to phone back in the evening and in the evening they'd say phone back in the morning and if you were able to do that for two or three days they took that as your commitment for wanting this and then you went in and detoxed (Interview 5).*

In mainstream services more broadly, practitioners were aware of discriminatory attitudes and assumptions towards their client group. Examples were given of experiences with the Police and within NHS services. In one case, detailed in a quote below, a practitioner describes an instance where a nurse was reluctant to administer morphine to a client receiving palliative care because of their assumptions about his drug use.

> *Another sad case, we've had a client who became very unwell, had a cancer diagnosis and just fell through the cracks in the system, was not getting the support that he probably needed earlier to give him a longer life and then having to look at exploring palliative care for him and the discrimination that he experienced of being a drug user, he was a crack user and the nurses were very reluctant to actually come into the provision, we'd even put him into our health cluster and they were like 'we can't give him any morphine because he's going to become addicted to it' and I was like 'he's not a heroin user though, that's not how it…' and he's not even smoking and he doesn't have the capacity to smoke (Interview 4).*

> *I'm thinking about the detox and rehab. This has come up more recently in our team in terms of you know where they're willing to accept people who maybe do have difficult behaviour or are presenting in a way that isn't usually helpful but then you know, then they don't, then they get not barred from a service, but they don't get the service that they should be entitled to (Interview 9).*

A fragmentation across different services, and the requirement for clients to re-tell their stories multiple times, was also seen as a trigger for re-traumatisation.

> *But it's also just the systemic failures where nobody talks to one another. So actually the system is set up to encourage re-traumatization because people won't know, you know, they don't share information enough to know what's happened to somebody (Interview 11).*

Practitioners speculated on a number of reasons as to why mainstream services may struggle to operate in a trauma-informed way for this client group, concerning risk management policies and the need to meet certain targets to be funded and commissioned; however, much of it was also attributed to a general lack of awareness and understanding of the needs of this client group and TIAs.

Practitioners spoke of attempting to work around these barriers to the extent possible by communicating with clients and preparing them on what to expect from services that do not work in the same (trauma-informed) way. Practitioners would also advocate for clients and, to some degree, challenge some of the more rigid practices of partner organisations where they disadvantaged clients.

> *I suppose it's a systemic thing, any places that we refer people onto, if they're not trauma informed then there's not that consistent way of working so then it's about how do you communicate, it's about preparing clients for different organisations and that people work differently and you might not like how they're talking to you but they're trying to help (Interview 7).*

> *I think that many of those like structures, the way they were set up, you then kind of have to, like, challenge some of the way that they work in order to have that partnership, but you can't challenge it too much, if that makes sense (Interview 11).*

One way of attempting to address the barrier around clients' access to wider mental health services was to bring specialist psychology support in-house – whether based in the service full-time or spot-purchased externally - which many of the services interviewed had done and spoke of as being crucial to a TIA.

> *Some of the stuff [name] does she does because she's trained for years, we might pick up a lot of that and have the skills, if we decided to retrain could probably become brilliant psychologists as well, but there is a limitation in what project workers can do. So I think that's where it's essential that everybody has psychology, maybe if they're not based in the team full time but have an outlet that psychology support can be spot purchased in is definitely key (Interview 3).*

> *So we did have a clinical psychologist onsite which was such an amazing asset, I've not had that in any of the services that I've managed before, she was able to really put in that therapeutic aspect and looking at starting to build that foundation and the relationships with the clients as well as looking at bringing CBT into their lives and just very basic tools to enable them to just be a bit more open, even if they don't want to speak to her in more detail, but just to sow the seeds about engagement and how powerful communication is essentially (Interview 4).*

Housing

A significant barrier relating to the wider system concerns gaps in the housing pathway and the lack of suitable interim and move-on accommodation for sections of the cohort with higher needs in particular. This came up in relation to Housing First clients. Despite the Housing First organisations involved in the study having good partnerships with housing providers in the local authority area, there was still reported to be significant delays (sometimes eight to nine months for one organisation) between putting in a nomination and securing a suitable property for a client. If the client is accommodated in unsuitable temporary accommodation during this time, it can become an obstacle to working in a trauma-informed way as that sense of physical and emotional safety, that comes from being suitably accommodated, is missing. As one Housing First practitioner pointed out, finding suitable interim accommodation for clients while the service prepared them for a tenancy is a challenge since Housing

First clients tend to have needs that are too high for the majority of temporary accommodation in the local authority area. Many are accommodated in hotels or bed-and-breakfast accommodation instead, which is unsuitable in terms of providing a safe base for trauma-informed working.

> *Thinking from a trauma-informed perspective, the thing about offering the Housing First is about this recognition that in terms of working in a trauma-informed way you have to provide safety, whether it's emotional or physical safety, well both, so if then the workers are working with someone who isn't safe, they remain unsafe in all senses of that word and the housing's not coming through, that can be such a challenge for them (Interview 2).*

> *One other barrier that our clients face in terms of accessing services from a Housing First perspective, I touched upon it with ASB with other services, would be finding a suitable interim accommodation while we prep them for tenancy, I'd say that's something I've noticed, they're not suitable for hostels which is why they're on the cohort in the first place, they're too high needs for the majority of the temporary accommodation that the borough offers but yet they're not quite tenancy-ready. So we've some people languishing in hotels that I think is not really ideal (Interview 5).*

There was felt to be a number of clients who fell through gaps in the housing pathway – those who may not have been picked up by Housing First services but whose needs were too high to maintain a temporary accommodation place – these clients were said to revolve between temporary accommodation and sleeping rough. The existence of some gaps was reaffirmed by the commissioning team. These were felt to be clients who had experienced substantial trauma throughout their lives, and for whom TIAs would be especially necessary.

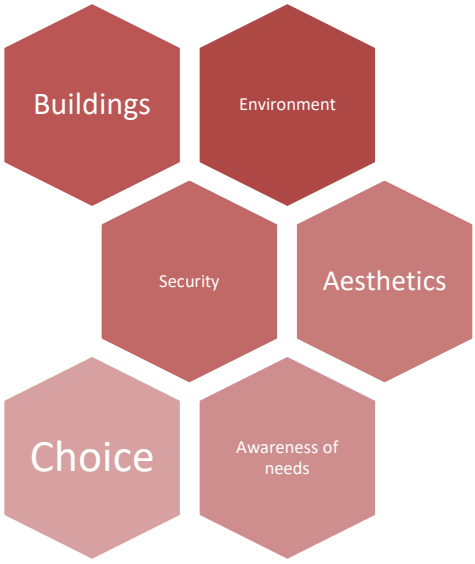
> *The certain clients that you cannot put anywhere and there is nothing out there at the moment for those type of clients and they end up on the street. Because there's no way you can only lock him up in a secure unit for so long or whatever. And so there's, I feel like there's a gap for these really traumatized people that have been through you know shit when they were younger, but now through life, every day a trauma happens to them (Interview 13).*

> *Well the need is just so intensely high, so intensely high so we do the best we can. But what are some gaps, ok… we can handle it if you're a couple, a couple with a dog, but then if you're a couple with a dog and say you can't go back to the hostel because you were threatened by a drug dealer there, we haven't got another option if you're a couple with dogs. We've got quite a few hostels for women with high needs but if you've been evicted from three of them then we're scratching our head… so really we're good on couples, dogs, what else... continuing drinkers and we really do our best but the need is just so intense and there are a lot of people in a way who are finding it difficult to move forward that swill around that it's hard to think of new things (Interview 1).*

Environmental

> *There's a psychoanalytical term of the 'brick mother', which is sort of how important the building is. And that it should be like this space of safety and it should be, you know, somewhere where people feel held and especially people where sort of family systems are broken down and, you know, I think there's something really important about the physical space and that's not saying the work can't happen if it's not there, it does happen, you know, but it is a block, I think it's definitely something that gets in the way in a very tangible way, you know, you can see it (Interview 8).*

Figure 5: Summary of environmental barriers and enablers



Many of the barriers of implementing a TIA related to the environments of homelessness services and those of wider services that people experiencing homelessness and multiple disadvantage access. This includes the physical structure of the building itself and the security and safety systems that are part of it, the size of the buildings and how many units they contain, as well as the general aesthetics of a space. Safety and choice are central aspects of a TIA and if an individual does not feel safe in their accommodation, or does not feel they have had sufficient choice over where or how they were housed, neither will they feel in the right place to be able to fully engage in other aspects of support, such as substance use and mental health. In fact, it may even (re)traumatise them or reverse any good progress individuals have made with addressing issues like substance misuse (as the quote below highlights).

> *It's really hard when you're supporting someone who's saying to you I really want, you know, if I can just have a space that looks like this then I'll be able to work on some of this, which makes complete sense if we think about meeting people's basic needs first and when that resource is limited then sometimes you can feel a bit stuck between a rock and a hard place because I have got one client who's asking for you know, accommodation and things, albeit it needs to be a certain way so it's not kind of really traumatizing for him. But that option doesn't exist, and then when he is offered other things like hostels and things where he's saying, you know, if I go into that place I'm just going to use more like it's kind of you feel like you're setting them up to fail and he feels that as well (Interview 9).*

Buildings in the case study area were identified as a central challenge. The local authority is reliant on a historic stock of temporary accommodation provision, and given the cost of purchasing new stock in the borough, are constrained in the sense of having to utilise existing buildings, or reducing provision where buildings are deemed too unfit. The current stock was described as having poor accessibility and wheelchair access, which is not ideal for the proportion of residents with mobility needs.

> *I'd say our central difficulty is buildings essentially. We've got this historic provision – would we have built our range of provision if we had a blank canvas now? No way in a zillion years would we. And we're stuck with those buildings. Not good accessibility, not a lot of wheelchair access, and we've got a lot of people with mobility needs. But we've got what we've got, and it costs a lot of money*

doesn't it to buy in [place] so we just have to make do with what we've got (Interview 1).

Many of the hostels accommodated a large number of bed spaces in order to meet the rising demand and homelessness applications in the borough. The compromise, however, is that larger buildings that accommodate a large volume of residents with high needs are also likely to foster chaotic environments unconducive to a TIA.

Can you have that [a TIA] in a 70-bed hostel with a high turnover? Some places split it and have the more therapeutic basement accommodation, no it's not, it's just shutting the noise out at the door, they still go out and the chaos is there, they're still fighting out the front, there's still people going mad upstairs, what's trauma-informed about that? (Interview 6).

Barriers, I would say it's around accommodation for the people's needs and a lot of people have cycled around hostels already and hostels, particularly if someone's experienced trauma, they're very triggering and I would say they're not the best environment for clients (Interview 7).

A **chaotic environment** is likely to be experienced as unsafe for residents who have lived through trauma, but is also, as one expert pointed out, difficult to manage for staff who are pulled into addressing more immediate issues rather than having the time to work in the slower, more considered way characteristic of a TIA.

I also think that sometimes the chaos, I've worked in homeless services for years, so the chaos that comes with that, the level of practitioner skill that is needed to retain a trauma-informed lens when you're working in your spit and sawdust, salt of the earth but absolutely wonderful homeless service, whether it's a night shelter, a day centre, a more transient type of homeless service say, the chaos that comes with that drags practitioners out of a trauma-informed approach (Interview 14).

There is also a tension between the **security systems** installed for resident safety and the ability of buildings and environments to foster a TIA. For a trauma survivor, the security systems, walls, glass barriers, CCTV cameras, and intercoms intended to keep residents safe might be experienced as threatening and anxiety-provoking – 'bad things happen here then because the level of security needs to be so high'.

So sometimes the security systems in homeless services are the biggest barrier, a person walks through the door, there are gates that go like prison gates, I'm thinking of a particular hostel in [place], you step into a vacuum of gates, you automatically feel like you're in a prison straight away, then you come to a major glass barrier, everything says 'you're frightening, you're scary, you could hurt me', barrier. A lot of services, I understand why they are there but what they communicate is a barrier to somebody feeling, the five core values, if you use Harris and Fallot's five core values, safety, trustworthiness, choice, collaboration, empowerment, safety straight away, you've already said 'it's not safe here' and in order to make it safe we've had to add walls and glass windows and time locks and intercoms and what does that say to a trauma survivor when they walk into an environment like that, they're like bad things happen here then because the level of security needs to be so high. A trauma survivor doesn't process threat in the sense of there's all these nice six feet glass windows here, that's wonderful, they're like why did they need six feet glass windows? So the environments themselves are a barrier because they are threatening (Interview 14).

The **aesthetics** of a space – how it is decorated, arranged, and made to feel more homelike – is another important factor in facilitating a TIA. Smaller practicalities make a difference to services accessed by this client group more widely. A practitioner drew

on the example of a detox ward and how its lack of proximity to a smoking area made it difficult for some of her clients to access as detoxing from drugs or alcohol at the same time as having to reduce their cigarette intake was too overwhelming.

> *Sometimes I've really noticed as well is like just thinking about the environments of services. So a good example of this is like the detox ward specifically for homelessness here. They're set up specifically for homelessness, which is great because that helps us maybe, these people have an idea of the people's experiences and it can be tailored to people who are homeless. But then just simple things like, or maybe not simple, I don't want to like bad mouth people but like but basically this detox ward doesn't have access to a smoking area so there are multiple clients who really want detox but often they're heavy smokers which is another issue in itself but they're just like I can't go to detox and quit smoking, they've told me that I can only have 3 cigarette breaks a day. So then just that feels for them too overwhelming. That's like a practical example, you know what I mean, just thinking about like where people are or like could this ward be, again I know it's not easy, could this ward have easier access to a smoking area? (Interview 12).*

Given the constraints around changing building stock, attempting to make environments more palatable was the main area where practitioners were able to make alterations. This included consulting clients on how they wanted the space to look. One poignant example here was a Housing First client who wanted a red carpet for her flat, which the Housing First service was able to source for her. The importance of allowing the client **choice** over things such as the colour of her carpet cannot be overstated – as a survivor of domestic violence the client had escaped an environment where everything had been controlled by the perpetrator.

> *We had one client, she wanted red carpet for her flat and it was going to be nothing less than red carpet because the previous flat she'd had in the past the perpetrator had controlled everything so it was important to give her that choice and even though it was a nightmare for the worker to sort out this carpet, source a decently priced red carpet, managed to get it in for her (Interview 2).*

Another example included consulting hostel residents on ideas to improve the building which resulted in changing the colour of the walls, putting more plants and artwork up, and changing the layout of rooms. Others made changes to make the space less institutional – removing staff lanyards and signs above bathrooms to lessen the barrier between staff and residents.

Making a space feel safe, however, also required looking beyond the aesthetics. Practitioners spoke of giving thought to individuals' needs when it comes to allocating their room in a hostel or where to hold a one-to-one meeting with them. Knowing that a female resident has experienced sexual violence from a male perpetrator, for instance, may mean choosing to allocate them a room on a female-only corridor. Being able to make a space feel safe for a client requires having some prior **knowledge of their needs and experiences**. Several practitioners raised the point that, for some clients, outside space felt safer (perhaps for those who had been confined indoors through a prison sentence or Sections or who had difficult home lives in their pasts), and for these clients, they would hold key-working or therapy sessions outdoors. It was important therefore that staff remain attuned to different notions of safety that might seem counterintuitive to societal norms. What may feel safe for one client may feel traumatising for another. This is illustrated in the quote below where a practitioner describes how finding an appropriate space for therapy is dependent on the client. Whereas the space upstairs in the day centre was decorated with plants and had a more pleasant aesthetic, the fact that it was upstairs made it more difficult for clients

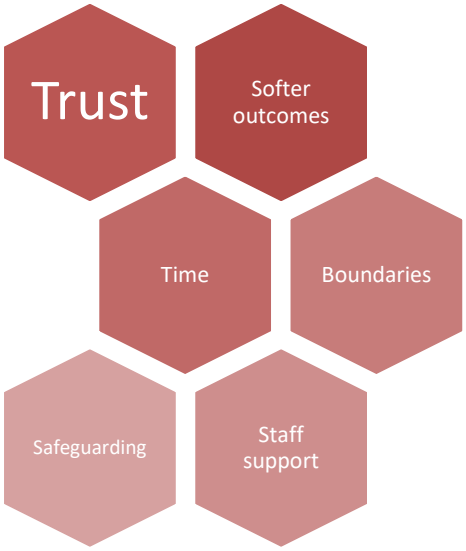
to feel like they could freely leave and perhaps less safe than the plainer room downstairs closer to the exit.

> *So there's a space kind of downstairs in the day centre where people might feel more safe 'cause they can kind of leave quite easily, and there's a space upstairs. It's a bit nicer. That's got some plants in, that feels a bit more safe, but that's upstairs and people might not feel like they're able to leave, you know, if they are feeling like being in a confined space is really difficult. So I guess it's just playing around with the space that we do have and trying to meet the needs and influence the organization again and coming up with kind of more creative ways to use the space or change things where we can (Interview 9).*

It is perhaps inevitable that any space – especially one that houses people with high needs – will have the potential to be traumatic. This section has shown, however, that despite the constraints it is possible to make an environment less traumatic, as the considerations and actions by practitioners highlighted above demonstrate.

Relationships

Figure 6: Summary of relational barriers and enablers



Relationships are central to implementing a TIA in terms of establishing the five key elements of safety, trustworthiness, empowerment, collaboration and choice. It is important to note that for trauma survivors, many of the relationships they have had in the past – whether with partners, family, or services – have been negative, or often the source of the trauma itself. Relating to others, then, is known to be much more difficult for this group. This is perhaps one of the primary motivations for services to pursue a TIA, but this does not mean it comes without challenges.

A TIA requires an awareness and understanding that a client may be behaving in a certain way because of the trauma they have experienced throughout their lives. As opposed to more punitive and conditional approaches used in homelessness services, a TIA would seek to understand the reasons for a client's behaviour ('what's happened to you?') rather than viewing them only *as* their behaviour, as explained in the quotes below.

> *So when power and control is the major tool for behavioural management of clients you stop seeing them as this is Dave, Dave has a complex PTSD diagnosis, he was the victim of a paedophile ring in his childhood, he's been misusing substances for 15 years to cope, he's also been medicating an untreated mental*

ill-health condition that he's been suffering with for 25 years, they don't see Dave like that, they see Dave who rocks up with his can of Special Brew and if they don't open the door within two seconds he's banging on the window, he's coming in, he's swearing at them, so it's changing the view of the client (Interview 14).

What we do in [place] is formulation and I think that's really a big part of what [name]'s team and the psychologists deliver, that's where we start to understand what do we know about this person, why is he being thrown out of every hostel cos he's aggressive and everyone just pushes him away, well let's ask him why he's angry for once instead of saying go away, it makes a big difference (Interview 6).

In their ongoing work with clients, practitioners described their approach as being empathic, flexible, persistent, hopeful, reliable, patient, moving at the client's own pace and being client-led in terms of goals and actions. Practitioners emphasised the need to work slowly with clients and allowing them to engage on their own terms – rushing a client into telling their story or opening up about past traumas when they were not ready or had not established trust has the potential to re-traumatise. The journey to building up trust was slow and practitioners learned how long each client was able to spend with them at a time (which in some cases may only be ten minutes). Likewise, agreeing a course of action was done with a client and not to them – for instance, supporting them to reduce their substance misuse when or if they are ready. Where psychologists were part of the service, they would start with a light engagement approach to establish trust and safety until the client felt ready to open up about trauma on their own terms. However, that did not mean there was strict criteria for accessing therapy, as there often is for mainstream mental health services. If a client was using substances, for instance, but otherwise felt ready to talk about their trauma and mental health then the psychology team would work with them.

Just being in addiction is very traumatic, so we are dealing with trauma all the time, you tell someone to stop using drugs, what do you mean, they've been doing it for 20 years, they don't know any different, it must be really scary and that's traumatic and we need to understand that (Interview 6).

And again, kind of being aware of the physical and psychological safety actually a trauma informed approach needs to think about in terms of intervention, like what is this person able to tolerate, actually maybe we need to grade the intervention and, you know, one-to-one therapy that's too much, that would kind of be too close in terms of the person's psychological safety. We need to kind of dial it back a bit and think about a lighter engagement approach. So it's the kind of the graded and kind of thinking about you know how safe does this person feel, where's their kind of window of tolerance and so that's where that kind of you know, flexible, creative engagement and where sort of the collaboration and the choice and boundaries and psychological and physical safety comes in and in terms of the understanding the you know impact of trauma on someone's relationship to help-seeking so kind of putting kind of that experience of trauma at the centre of everything (Interview 10).

Whereas our psychology team, like we don't, I would work with someone on their mental health if they were, you know, a heroin user, you have to work in meeting someone where they're at and working like within the trauma rather than working from these very like rigid definitions of oh, we can't possibly help with their mental health or, you know, give them medication (Interview 10).

Key to relationships in a TIA are what might be termed 'softer outcomes'. Hence, not immediately trying to 'fix' people or solve all their problems but trying to make them feel safe, or as one practitioner describes in the quote below, 'sitting with uncertainty'.

This required time, in terms of staff capacity, funding and not having to meet rigid outcome measures.

> *But again, I think a trauma-informed approach is thinking actually, 'are we pushing them too much or like is this realistic?' Actually, you know, like thinking with a person like 'what draws you to alcohol' or 'when you don't have it, how are you gonna cope with this feeling or like that's gonna be really scary', like being able to sit with not just problem solving essentially, I think we do that too much and I don't think that's very trauma informed. I think you need to sit with the feeling or sit with the uncertainty. Yeah, not just like, 'OK, we're gonna do this, this and this'. Actually, that just sets the client up to maybe feel quite powerless or like you're setting them up to fail or too rushed, and it is actually just for us as professionals to make us feel better (Interview 12).*

On the other hand, there was felt to be a common misunderstanding about TIAs that they allow for no boundaries at all. Where it was felt that clients had experienced a lack of boundaries in their lives, it was sometimes considered more trauma informed if they were offered some. Such boundaries may be to ensure the safety of the client and the worker as well as other clients.

> *I think, like trauma-informed care, people think you need to be this, like, angelic, compassionate angel all the time and that there is something definitely to being compassionate and empathetic, warm, friendly, engaging, but also part of trauma-informed care is holding like boundaries, actually and saying no sometimes, you know, having a threshold where we need to monitor risk or we need to think about whether someone's safe staying here or what is the team approach so actually I think part of trauma-informed care is also putting in firm boundaries for staff and people that we're supporting to enable people to feel safe because otherwise I think the system just gets stressed and we get pulled into everyone feeling kind of traumatized and burnt out. So yeah, I guess relationships, like being really mindful of that in your work (Interview 12).*

Managing relationships *between* clients in a service was perhaps the most difficult aspect to control, and one where clearer boundaries were needed in order to keep everyone safe. This entailed teams weighing up tolerance with structures of risk management and safeguarding. A clear example of this kind of negotiation was given by a practitioner in relation to a couple being supported in their service, a residential project for people with complex mental health, addiction and other specialist support needs. The service became aware of several incidents of domestic abuse perpetrated by the male partner while they were both residing at the project. The suspicion that the female client may follow her partner to return to rough sleeping if they evicted him made this a particularly difficult situation to address. After discussions with the team and the in-house psychologist, the practitioner decided that the best course of action was to evict him, to ensure the project remained a safe space for the female client. But the careful deliberations and reflection that went into reaching this decision, rather than taking the immediate decision to evict him, show the workings of a TIA. These complexities and nuances around managing relationships are a challenge of working in a trauma-informed way but also an integral part of it.

> *Me and [name] had a good chat about this and it's like at the same time if I didn't evict him what am I signalling to her, that this is okay, this is normal, because that's re-traumatising her and even in her own language she was really pissed off with me when I evicted him, initially she seemed relieved but afterwards expressed that she was upset with me, but when I explored that with her she was just like this is just life, this is what happens, and I'm like no, it's not, it doesn't have to be your life going forward. That was difficult cos now I feel like in a position where we haven't really safeguarded her because now she's spending most of*

her time out with him but it was a really difficult one and always for me that's where most of my learning has been in the last years, how we work with couples more effectively while having best practice, not being too punitive in our approach but really getting that balance right that we're not colluding with domestic abuse either and that's been tricky […] So that's been really difficult and it's something that I think about 15 years ago we wouldn't even have been having much thought of that because he would just have been evicted and that would have been the end of it, and now looking at the psychological aspects of that, being able to talk that over with [name] looking at what we can do (Interview 3).

On more of a micro level, it was acknowledged that encountering difficult behaviour from clients on a frequent basis – even where that behaviour was understood to come from trauma – inevitably took a toll on staff and tolerance and empathy may at times slip. This reiterates the importance of having some boundaries in place to prevent staff from feeling traumatised and burnt out (and that filtering through to clients), as well as having the support systems (reflective practice etc.) in place for staff to access and making these a core part of their roles. Another way of managing this barrier was to allocate more than one worker to a client, partly so that clients do not depend solely on one worker, but also to manage burnout, staff absence and leave, and so that the workload of managing difficult behaviour falls on more than one person.

I'd say one of the biggest barriers, I'm thinking of one client in particular, one of the biggest barriers he faces is his own ASB and how he manages his own distress and his own trauma and the challenges and abuse that he can present with has meant that he's been excluded from multiple services across the borough so I find that an interesting case. I don't know him well and we're in the honeymoon period, I've only seen him on best behaviour but equally it's hard, I'd say that's always a challenge for services, how do you balance being trauma-informed with someone that is being extremely abusive. It's all very well understanding and recognising where their trauma comes from and acknowledging and trying to work with that, but equally if you've got someone that's being verbally and physically abusive it's a hard one (Interview 5).

On a human level sometimes you've just got 10 people shouting at you all day and as a worker sometimes do you actually have the empathy or the headspace to, but that's on a very micro level. I saw someone recently who was just picking at everything I said and I could feel myself losing patience so I guess just having that humanity, or being human about it and going I can't do this anymore and just absorbing that and that's okay and then working out how to mitigate that happening again so that people aren't getting negative responses from you. I don't know if they picked up on my frustration but I was certainly picking up on it (Interview 7).

Being trauma informed also meant being alert to the possibility of trauma among the staff team and that some subjects may be triggering to those with lived experience. Psychologists spoke of being sensitive to such possibilities in reflective practice sessions in the quote below:

As a psychologist if there is that recognition for trauma we may be, just to give you an example, a bit more sensitive in a team meeting or in a reflective space and I've had instances like that, this is just an example, not from [service name], if I knew someone did have lived experience of self-harming I would be very sensitive about how I talk about that, or how we talk about that in a meeting because I'm aware that individual might be more sensitive around that area (Interview 3).

4

Summary and recommendations

This briefing note has drawn on interviews with practitioners working with those with experience of homelessness and multiple disadvantage in one London borough, as well as experts in trauma and TIAs across England, to provide a deeper understanding of how TIAs are perceived and implemented in practice in the housing/homelessness sector. The study revolved around the three research questions below:

1. How do practitioners understand a) trauma and b) trauma-informed approaches?

2. How do understandings of trauma and trauma-informed approaches translate to practice?

3. What are the barriers and enablers to implementing a trauma-informed approach?

This section provides a summary of the key points from the study under each research question, before moving on to consider emerging recommendations in terms of future roll-out of TIAs in this sector for policy and practice.

4.1. How do practitioners understand trauma and trauma-informed approaches?

- 'Events', 'experiences', and 'effects' featured in practitioners' **definitions and understandings of trauma**, in line with the concept of trauma developed by SAMHSA (2014). There was evidence, however, of more nuanced, encompassing and critical understandings than standard medical definitions. This was manifest in their inclusion of systems and structures in bringing about traumatic events; their acknowledgment of barriers to the recognition of an event as traumatic in individual experience; and the expansion of the effects of trauma as going beyond the purely neurobiological to encompass more complex effects on safety and identity.
- Practitioners' responses to **what they considered as a TIA** coincided closely with the five components outlined by Fallot & Harris (2006). Sitting above everything, however, was the importance of recognising the impact of trauma on individuals' experiences of service encounters and interactions and ensuring this was at the centre of all elements of work with clients. Holding trauma and its impacts, as well as the five principles of safety, trustworthiness, collaboration, empowerment and choice, at the centre of decision-making necessitated a continuous process of reflection and evaluation at various levels of service design and delivery, in terms of environments, systems and relationships.

4.2. How do understandings of trauma and trauma-informed approaches translate to practice?

- Being trauma-informed was understood as a **continuous process of learning and reflection**. There was no end point whereby a service became truly trauma informed. Rather, the essence of a TIA is knowing there is always more to reflect on, learn and improve.
- Practitioners felt that while some staff in the homelessness sector may have always been working to some of the principles, it is only more recently that trauma-informed care has emerged as a named and more formalised approach. Practitioners saw **value in working and coalescing around a shared philosophy**. Practitioners who worked within the homelessness sector in the case study area noticed a shift over the last 18 years or so since TIAs had been promoted by the local authority, which they noted was marked by **concrete changes in their services**.

4.3. What are the barriers and enablers to implementing a trauma-informed approach?

- There was much evidence of services included in the study working in line with a TIA despite the barriers of implementing such an approach that cut across systems, environments and relationships.
- By far the greatest type of barrier to services operating in a trauma-informed way related to **structures and systems**. This included funding levels and structures; workforce resource, roles, conditions and salaries; the delivery models of wider services; local housing systems; and the acceptance of a trauma-informed 'culture'.
- Many of the barriers to implementing a TIA related to the **environments of homelessness services and those of wider services**. These included the physical structure of the building itself and the security and safety systems that are part of it, the size of the buildings and how many units they contain, as well as the general aesthetics of a space.
- Relational barriers to implementing a TIA included **managing relationships** between clients and weighing up tolerance with structures of risk management and safeguarding; as well as the job itself which entails encountering challenging situations and behaviour on a frequent basis.

Systemic barriers and enablers

Barrier	Enabler/facilitator
Uncertain funding climates with short-term contracts; 'hard' / measurable outcome targets.	A commissioning team that actively promote TIAs and build these approaches into procurement and contract management.
Insufficient staffing levels to meet size and complexity of demand; recruitment and retention issues; low salaries and long hours; high levels of burnout.	Well-resourced teams; emphasising the benefits of TIAs for staff as well as clients; access to psychology input and reflective practice; whole organisation support for staff.
Cultural acceptance of TIAs; reluctance to take up reflective practice due to perception that encountering challenging situations is 'part and parcel' of the job.	Some evidence of this changing with time but this is an issue that needs tackling further (see Recommendation 5).
Organisational policies, such as rules and procedures around safeguarding, limiting flexibility and choice.	Bringing the team together to safely unpack rationales behind organisational policies and explore different perspectives on decisions.
The functioning of the wider system for people facing multiple disadvantage.	Communicating with clients and preparing them on what to expect from services that do not work in the same (trauma-informed) way; advocating for clients and, to some degree, challenging some of the more rigid practices of partner organisations; bringing specialist psychology support in-house. These measures went some way to lessening the impact of poor service encounters with the rest of the system but there remains ongoing major barriers to TIAs operating effectively due to the wider system (see Recommendations).
The lack of suitable interim and move-on accommodation for sections of the cohort with higher needs.	This is an issue that needs tackling further (see Recommendations).

Environmental barriers and enablers

Barrier	Enabler/facilitator
Historic stock of temporary accommodation provision, poor accessibility, large number of bed spaces, chaotic environments.	Consulting clients on how they want the aesthetics and layout of a space to look; allowing the clients choice over furnishings etc; giving thought to individuals' needs; remaining attuned to different notions of safety.
Security systems installed for resident safety, institutional-type environments.	Making changes to make the space less institutional – removing staff lanyards and signs above bathrooms to lessen the barrier between staff and residents.

Relational barriers and enablers

Barrier	Enabler/facilitator
Managing relationships between clients in a service; weighing up tolerance with structures of risk management and safeguarding.	Case formulation and meetings with the rest of the team and/or psychology support.
Encountering challenging situations/behaviour on a frequent basis taking a toll on staff wellbeing and tolerance.	Having some boundaries in place to prevent staff from feeling traumatised and burnt out; support systems such as reflective practice; allocating more than one worker to a client.
The possibility of trauma among the staff team; some subjects may be triggering to those with lived experience.	Being sensitive to such possibilities in reflective practice sessions and team meetings.

4.4. Recommendations

This section draws on key lessons from the findings of the study to suggest recommendations for policy and practice. Although the services involved in the study showed significant alignment with a trauma-informed approach, there are still barriers relating to their implementation and overall effectiveness that require support and investment at a higher level. Despite some seemingly insurmountable barriers, notably around how the wider system functioned for those experiencing homelessness and multiple disadvantage, it was nevertheless deemed vital to pursue a TIA (even if it did somewhat exist within a 'pocket'). The difference it made to individual clients – who for the most part have been let down by services – to experience one kind encounter is just one justification of their value.

1. At a **governmental level**, recognition and endorsement of TIAs as one of the most appropriate models of working with people with experience of homelessness and multiple disadvantage is required. This should take the form of commitments to TIAs in rough sleeping and homelessness strategies which are backed up by sufficient financial support.

2. While support for TIAs in homelessness services is welcomed, without addressing issues in the wider services accessed by those experiencing homelessness and multiple disadvantage there is a risk to long-term recovery. Government should follow the approach of the Scottish Government[9] in their ambition for a trauma-informed and trauma-responsive workforce and services across all sectors. Similar to Scotland, this ambition should be accompanied by a national trauma training programme.

3. Further to the above, there needs to be significant investment in suitable temporary and move-on accommodation, with the appropriate support, to allow people to begin addressing their needs from a place of safety and stability.

4. There is a need for bespoke toolkits and training programmes to support organisations working with people experiencing homelessness and multiple disadvantage in planning and delivering trauma-informed services, which take into account the specific contexts and challenges of the sector.

5. At a **service level**, TIAs work best where there is organisational support and buy-in at all levels. The benefits of TIAs – for clients, staff and the organisation –

[9] Scottish Government (2020) Trauma-Informed Practice: A Toolkit for Scotland. Available at: https://www.gov.scot/publications/trauma-informed-practice-toolkit-scotland/

should be promoted widely across the organisation by management. Raising awareness and educating staff about TIAs and their value could be enforced by mandatory core training (see Recommendation 4).

6. The inclusion of regular reflective practice sessions as part of work schedules should be a key component of a TIA for organisations in the homelessness sector. Where possible, this is best carried out by a psychologist – either embedded in the team full-time or spot-purchased externally – but can also be done by teams themselves. This is crucial for making considered, informed and collaborative decisions on cases, as well as for supporting staff well-being.