Applying a Trauma-Informed Approach in Family Homelessness Prevention Settings

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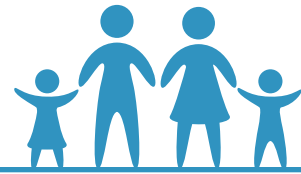
In the last thirty years, trauma-informed care (TIC) has increasingly been integrated into social services, especially those that involve assisting clients to achieve better outcomes for themselves and/or their family. The potential impact of trauma is being considered in many fields, including social work, medicine, and education. In its first issue brief on this topic, the Siemer Institute offered its point-of-view regarding the importance of trauma-informed approaches and the benefits they can bring to programs. In this issue brief, the Siemer Institute offers insights from interviews with case managers employed by homelessness prevention programs that actively integrate these principles into their programming.

In this brief we align the observations of network members with the definition of TIC offered in the Siemer Institute's first issue brief on the topic, organizing them around three components:

» Understanding and responding to the impact of trauma;

» Emphasis on psychological, physical and emotional safety for both providers and survivors;

» Providing opportunities for survivors to build or rebuild a sense of control and empowerment.

These three components are similar to other published literature on the topic, most notably Bath's (2008) three pillars of TIC (safety, community, and managing emotions) and the six guiding principles for trauma-informed care offered by the Substance Abuse and Mental Health Services Association (SAMHSA).[1]

Understanding and Responding to the Impact of Trauma

Sensitivity to trauma and its impacts throughout the system of care are crucial to TIC.

One key takeaway for any organization wishing to incorporate the principles of TIC into its service delivery is that it is a **cultural mindset**. As nearly every interviewee suggested, TIC requires an understanding of what trauma is and how it can impact behavior, and an acknowledgement that the impacts of trauma are only somewhat predictable and can vary across people.

At its most basic level, TIC means approaching clients (both adults and children) and fellow employees from a perspective of "What happened to this person to cause this behavior?" rather than "What is wrong with this person?" As one interviewee put it, "You are looking at clients in terms of what's happened and

what they've experienced rather than what's wrong with them. Trauma is an injury that can be healed. It's a separate experience from **who** the person is. That lens really helps."

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In some interviewees' minds, the main goal of TIC is **to avoid re-traumatizing clients**. This may mean avoiding triggers that are specific to the trauma history of an individual (e.g., a preference to never meet in a room with a closed door). Or it can require attention to more macro level trauma issues related to race, gender, ethnicity, or class. As one said, "Clients are traumatized not only by individual experiences—their childhood for example—but they are also consistently re-traumatized from living in poverty, utilizing social services…how they're treated in schools, as parent, on city buses. This is especially true when they have a lot of experience with agencies—they internalize a negative view of themselves…" Re-traumatization partly underlies the difficulties that clients can have engaging in programs that can benefit them, and attention to this issue can remove one roadblock that clients face.

To do this effectively, it's important that programs dive deeply into the concepts of TIC and **obtain appropriate training**. As one interviewee said, "Make sure you have good information about trauma-informed care. Some people can pick up a term, hear a piece, and think they understand it fully." For instance, one of the hallmarks of the TIC approach is the need to empower individuals and one way to do that is by offering them choices (as discussed later in this brief). However, among some domestic violence victims, who have become conditioned to NOT

having choice and prevented from exercising agency, strongly encouraging them to make a choice can be difficult or impossible. Training resources for TIC are widely available in most states and detailed information about TIC can be obtained from organizations such as SAMHSA and The University of Buffalo's Institute on Trauma and Trauma-Informed Care, among others.

Equally important, according to interviewees, is that TIC is embraced as widely as possible within the organization. "If it's going to be done, make sure everyone's changed, not just you as a person. It's not helpful if three connections use it, but three others don't. Interactions with people at the agency should be consistent." Interviewees noted this extends to front desk workers and support staff who play an important role in helping clients feel safe when entering the building or while services are being provided.

It may also be important to help the organization's partners understand why the organization has shifted toward TIC and how they can complement that work. Consistency in client expectations and experience is an important organizing principle for helping clients feel safe and gain or rebuild trust in people and the systems in which they operate. This means consistency within the organization, but when possible, consistency across the network of partners you work with to help fulfill your mission.

Finally, one interviewee said that her organization directly trains both adults and their children on the impacts of trauma on thoughts, feelings and behaviors (both their own, and those around them). Her program offers psycho-educational workshops run by counselors that raise awareness of the impact of trauma and offer resources for coping with that impact. This is not only an example of TIC in action but reinforces the need for 2-Gen programming which simultaneously serves the needs of all family members. By offering both adults and children age-appropriate information about the impacts of

trauma for themselves and those they love, this program will help strengthen resiliency and improve outcomes for the family as a unit.

Awareness of trauma must be balanced with appropriate constraints.

When staff first receive trauma-informed training, they may be tempted to be overly understanding or lenient with clients, with the laudable goal of helping them overcome their trauma and to avoid re-traumatization. However, it's important to **have guidelines and expectations**, as well as consequences for violating those expectations. Informing clients they are being unsafe or are at risk of losing access to a service, providing them with other choices they could be making instead, and sticking to the consequences are important, according to interviewees. Allowing as much flexibility as possible, and helping clients work through difficulties and mistakes is important, but only within reason. As one interviewee said, "We do give them a second chance, but if we don't hold them accountable, we're not only failing them, we're failing another family who's on the waiting list and not being served."

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Case managers walk a fine line between helpfulness and enabling. While this can sometimes result in minor issues like clients having trouble following through on specific tasks, it can also manifest in larger ways, if left unchecked. As one interviewee suggested, "Staff have to understand trauma and the policies that can work to avoid re-traumatization, but also have to have good boundaries… You have to know when safety becomes an issue. Staff must still feel safe, protected, and respected."

Staff should be encouraged to practice self-care.

Case managers play a central role for organizations incorporating a TIC approach, and this role comes with benefits and costs for providers. TIC often puts providers at risk for two common problems: compassion fatigue and secondary traumatization. **Compassion fatigue** occurs when the effects of providing care to struggling clients bleed beyond the normal stresses faced by employees, and lead to a focus on the needs of others to the detriment of self-care. This may be especially true in organizations embracing TIC, when staff are encouraged to cultivate empathy and understanding. The negative consequences of compassion fatigue include detachment, isolation, poor self-care, difficulty concentrating, and substance abuse. Personal attention to self-care by those who work in a helping profession and monitoring by organizations for signs of system-wide compassion fatigue like high absenteeism, failing to meet deadlines, negative attitudes toward work or supervisors, and fear of change or a lack of vision for future should be done to avoid the negative impacts of compassion fatigue.[2]

Secondary traumatization occurs when individuals have an emotional reaction to hearing someone else describe their own experiences with trauma. This reaction can be related solely to the experience of another individual's trauma, but it can also trigger one to re-experience his or her own personal trauma. Case managers may experience secondary traumatization while listening to and acknowledging clients' trauma stories. Symptoms of secondary traumatization are similar to those experienced by trauma survivors: jumpiness, exaggerated startle response, hypervigiliance, increased social withdrawal, difficulties with emotional regulation, as well as milder reactions.[3]

One interviewee suggested that staff should have one-on-one supervision or some other outlet for the feelings and stress that can result from practicing TIC. Others stressed the need for staff to know where they are in their own trauma journey to avoid sharing their

own trauma with clients. Importantly, these potential side effects can extend to agency partners or even vendors; one interviewee mentioned she started seeing signs of compassion fatigue in property managers who were staffing the units in which her clients lived.

Being aware of potential signs of strain and trauma in staff, giving them safe spaces to disclose, places to decompress, and resources for coping with trauma should be a central part of any TIC program.

Emphasis on Safety for Both Providers and Clients

Physical spaces and feelings of safety go hand in hand.

Safety includes both physical safety and psychological or emotional safety. Interviewees described striving to be sure their **physical spaces were safe and inviting**, including well-lit parking lots, clean and attractive spaces with homelike touches, and the use of monitoring and security guards to maintain a sense of safety. One network member said she lets clients choose where they meet to ensure the space is one in which they feel safe; some prefer their homes, while others feel best meeting at their local elementary school or other community location. However, another cautioned that security guards and other outward indicators of monitoring could be triggering for some clients, stressing the need to really understand each individual's unique experience with, and response to, trauma when considering the physical characteristics of the spaces in which clients meet with staff.

Organizations can start by assessing their physical space as they implement TIC principles into their service delivery. One interviewee shared an experience with a very minor change that helped her organization move forward on the spectrum of TIC. At this organization, staff primarily met with clients on the second or third floors of their building. If clients became emotional or frustrated during a meeting and left the office in a less calm manner, they would exit

the second or third floor via a stairwell which did not have clear signage to the building's exit; if they weren't paying careful attention, they would end up in a dark, empty basement, and become more frustrated. By more prominently marking the stairwell door for the building's exit, they lessened the potential for trauma that clients would experience in such situations.

Trust between client and case manager is a central component for feelings of psychological safety.

One of the most important benefits of TIC, and one that is most likely to help clients feel safe, is the development of trust between clients and case managers. As one interviewee put it, "The biggest

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thing is trust — be there and follow through, do what you say you're going to do." This means keeping all appointments or explaining why they can't be kept, for instance. Other interviewees discussed this in terms of the personal connection between clients and case managers. For instance, one said that TIC helps her better understand why clients do things they do, making her less reactive and more connected. Another suggested that this connection could help clients overcome the inhibitions to trusting other people and systems. As she put it, "The trust can be translated to the community at large. [Clients] recognize they have experienced personal trauma, community trauma, and stressors of poverty. They have a better chance for healing relationships…"

Boundaries are important to maintain, however. Non-counseling staff must recognize they are not responsible for helping clients actually resolve their

trauma. For this piece, case managers should refer clients to a trauma-informed therapist for help, while acknowledging the experience in an empathetic way. Again, case managers have to walk a fine line. As one interviewee put it, "[Case managers] have to be cautious about coming across as cold, or not understanding what the person's been through. They have to be able to have sympathy, show concern…but cut it off when it goes too deeply…in a caring and supportive way."

Providing Opportunities for Survivors to Build or Rebuild a Sense of Control and Empowerment

Emphasizing client strengths and giving them choice is key to empowerment.

Case managers describe working from a **strengths-based perspective** from intake, helping clients identify, name, and remember the things that are positive for them. For some clients, it may mean celebrating small successes, like congratulating them for scheduling an important appointment or on getting their children to school on time every day for a week.

This is very closely tied to the **goal setting work** that all interviewees reported doing with their clients. For some clients it can be important for them to break down one large goal (i.e., graduating from college) into many smaller milestones to allow clients to see the steps they are taking toward the goal before they ultimately complete it. One case manager said she makes sure to always end the intake interview with the strengths section so that clients leave the office and begin their work on a positive note. Another case manager said she makes it a point to call clients and ask for their advice when facing situations in which the client has expertise. Not only does this save her time, but also it reinforces to the clients that they have important strengths and advice to share.

The other strategy to help clients feel more empowered is giving them **choices**. Nearly all interviewees mentioned their clients were directly involved in goal setting and case planning, so that they were invested in the goals they were working toward. This may have special impact for clients typically served in homelessness prevention programs who often have received assistance from many other social service agencies. As one interviewee said, "The help they receive is thrown in their faces a lot. I try to provide choices whenever I can… When we can use Siemer [Institute] funds to purchase things, I involve them in the process. It might take me an extra 15 minutes to show them different beds, but it just shows a level of respect. It conveys they don't have to be happy with what they get. I also have relationships with the local Goodwill so I can give the family vouchers and the family can go in and go shopping on their own. Even with financial assistance, I try to allow them to have choices."

Equally important is helping clients understand when choices are NOT possible. Explaining such situations in a respectful manner can help clients maintain their sense of self-efficacy even in situations in which they have less agency.

> "…helping clients set goals, then break those goals down into manageable steps and work toward self-sufficiency is the essence of rebuilding a sense of control and empowering them."

Some interviewees felt this aspect defined the trauma-informed work her organization does with clients. As she said, "The definition of someone who is in control is someone who has choices—decides what they eat, where they go, how they spend their money. So, for us, helping clients set goals, then break those goals down into manageable steps and work toward self-sufficiency is the essence of

rebuilding a sense of control and empowering them." Another summed it up as, "My job is to help them see growth, success, and what they've done to make these things happen. They set goals. They do the strategies. They take the steps. They own that."

Summary

Trauma-informed care is fundamentally a client centered, strengths-based approach aimed at helping clients—both adults and their children— regain a sense of control. In this respect, it harkens to the 2-Generation or Whole Family approach discussed in previous Siemer Institute issue briefs and reinforces the strategies suggested there.

As several interviewees noted, TIC is more than just applying specific principles or dealing with clients in specific ways. Rather, it is a mindset shift that should occur throughout the organization to be most effective. This means all staff, from the receptionist who greets clients as they enter the building to the CEO or Executive Director, have to be on board with approaching client service from a this perspective. Communicating with staff about why trauma-informed

principles are important to the success of the whole family is one concrete step in this direction.

Many organizations offer self-assessment tools[1] that can be used to facilitate the process of integrating TIC principles into the larger organization.[4] These tools can be used to assess current practices to determine which are compatible with TIC and which may need to be retooled, as well as helping organizations gauge progress in making changes over time.

As with 2-Gen programming, most organizations will probably find that some of their programming is already consistent with a trauma-informed approach. This reflects both the compatibility of these principles with the general approach to the work Siemer Institute network organizations do, and the infusion of TIC principles into social work and many other client facing fields in the last twenty to thirty years. One interviewee, working in a program that has food provision as a central focus and then provides soft handoffs to other services, summed it up, "It's just something we've always done. We have to understand the issues a family has when they come in. It's not as simple as needed food. There is always something underlying that."

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[1] *One interviewee cautioned organizations about their use of the ACES questionnaire, one of the most common tools for client assessment. Tying ACES scores to identities can lead to case managers needing to take action due to their mandated reporter status. Additionally, there may be some cultural bias in the ACES instrument (e.g., it refers to mother/stepmother but doesn't easily allow children with two fathers or two mothers to report).*

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3 "Understanding Secondary Traumatic Stress" Fact Sheet prepared by the National Child Traumatic Stress Network. Downloaded from *https://www.nctsn.org/sites/default/files/resources/fact-sheet/cac_understanding_secondary_traumatic_stress.pdf*

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