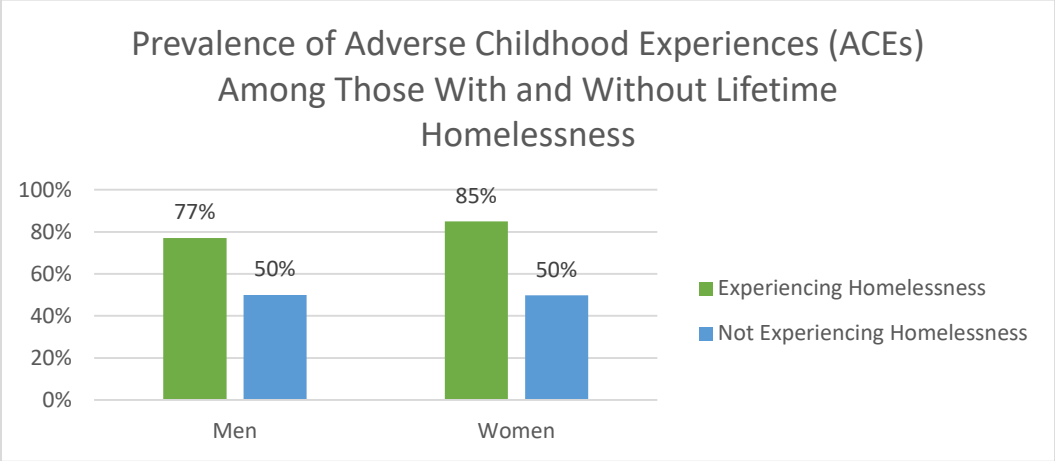
Trauma-Informed Care and Homelessness

In partnership with the USC Initiative to Eliminate Homelessness

Background

Historically, the impact of traumatic stress on individuals and families who are at risk of or experiencing homelessness has been an understated factor in the development of an effective homeless service system. Research has existed for the past twenty years evidencing the connection between trauma and the health and wellbeing across a person's life (Felitti et al., 1998). Researchers have also found that 85% of women and 77% of men experiencing homelessness indicated that they experienced at least one adverse childhood event (Roos et al., 2013). The urgent need to systematically address the negative effects of trauma has become increasingly apparent in relation to the crisis of homelessness. This literature review will discuss how trauma may affect people experiencing homelessness, the effects of traumatic stress, well-established interventions, and examples of how trauma-informed care can be adopted by homelessness service providers.



Key Takeaways:

- Traumatic stress refers to experiencing an event or series of events, or set of circumstances that are physically or emotionally challenging, harmful or threatening without sufficient internal and/or external resources to cope effectively.
- For individuals experiencing homelessness, trauma may result from past events in childhood, events leading up to becoming homeless, and/or events that occur during a period of being without permanent shelter.
- Providers and staff who work in homeless service systems of care are not always aware of the trauma that occurred, may not be prepared to offer trauma-informed environments that can help to achieve maximal outcomes, and/or may not be prepared to offer specific services to treat trauma.
- Trauma-informed care includes an understanding of the levels and kinds of trauma clients experience, the environmental and procedural actions that can inhibit access or effective use of care, and the evidence-based interventions used to treat trauma-related symptoms and disorders.
- The six core values of trauma-informed care are safety, trustworthiness/transparency, peer support; empowerment/choice/voice; collaboration/mutuality; cultural/historical/gender diversity.

Research Motivation

Traumatic stress refers to experiencing an event or series of events, or set of circumstances that are physically or emotionally challenging, harmful or threatening without the internal and/or external resources needed to cope appropriately (McVicar, 2013; Lupien, 2018). Traumatic stress is differentiated from everyday stress, which is part of the normal regulatory system's biological response to any change that disrupts the body's homeostasis (McVicar, 2013). Everyday stress can be conceptualized as an individual's ability to adapt and effectively respond to the everyday challenges of being alive and therefore can range from adapting to changing weather, using transportation, coping with work demands, or care-giving for family members (Juster, McEwen & Lupien, 2010). If, however, the impact of a stressor is excessive, overwhelming, and/or endures for long periods of time, stress may become chronic, resulting in (1) the dysregulation of the network of nervous systems and intracellular mechanisms that regulate stress, and (2) toxicity (Lupien, 2018), which can have lasting adverse effects on an individual's physical, social, emotional, and spiritual wellbeing.

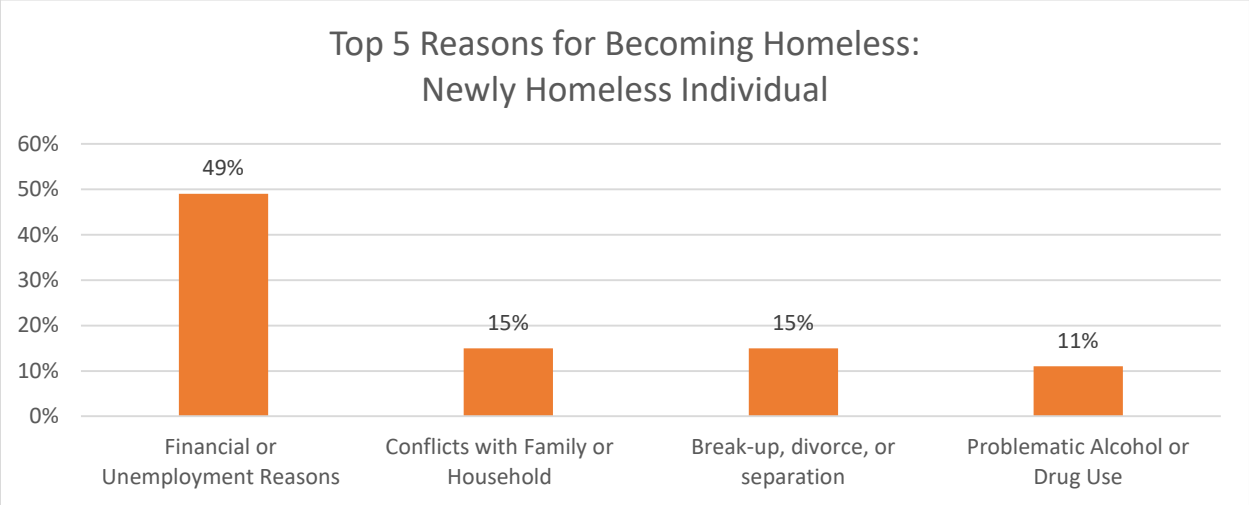
After experiencing traumatic events, adults and children may develop unhealthy (pathological) symptoms that meet criteria for trauma and stress-related disorders such as Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) (American Psychiatric Association, 2013). Symptoms include re-experiencing the traumatic event through flashbacks and distress after exposure to traumatic reminders, avoidance of trauma-related stimuli, negative thoughts or feelings that began or worsened after the trauma, and alterations in arousal and reactivity (American Psychiatric Association, 2013). Survivors may come to see themselves as fundamentally flawed and perceive the world as a pervasively dangerous place (Marzillier, 2014). Another result of this toxic state is impaired memory (Lupien, 2018). Information perceived during times of high stress may not become encoded as information that can be recalled in terms of relationships among multiple items and events. Instead, the conscious recollection is often represented as non-coherent or fragmented memory segments based within sensory, motor, and emotional centers of the brain, re-experienced in the body through activation of the sympathetic nervous system, and recalled only in fragments triggered by a particular smell, sound, image, or behavior sequence (Radulovic, 2017). Traumatic amnesia or memory loss may also occur or, conversely, trauma-related memories may be enhanced and repeat frequently (Radulovic, 2017).

Trauma & Homelessness

Stressful and traumatic events during childhood have a strong relationship to lifetime homelessness. Data from the National Epidemiologic Survey of Alcohol and Related Conditions in 2001-2002 and 2004-2005, which included 34,653 participants, highlighted the relationship between adverse childhood experiences and lifetime homelessness (Roos et al., 2013). Researchers found that 85% of women and 77% of men experiencing homelessness indicated that they experienced at least one adverse childhood event compared to 50% of the general population (Roos et al., 2013). In a landmark study in 1998, 52% of the general population indicated that they had experienced at least one adverse childhood experience (Felitti et al., 1998).

Significantly, individuals experiencing homelessness often have symptoms of complex trauma due to histories of multiple victimizations. One study of women experiencing homelessness, found that childhood sexual abuse doubled the probability of physical violence and tripled the probability of sexual violence in adulthood (Young, Shumway, Flentje & Riley, 2017). From the perspective of attachment theory, parents who have experienced traumatic events may have an impaired ability to provide the needed protection and care for healthy development of their children (Cozolino, 2017).

Ehlers and Clark (2000) developed a cognitive model of Post-Traumatic Stress Disorder which predicted that a lack of resources to cope with the external threat of imminent homelessness would lead to traumatic stress. Data from the 2019 Greater Los Angeles Homeless Count provides the top reasons for housing loss cited by newly homeless individuals (i.e. individuals experiencing homelessness for the first time and for less than a year): financial or unemployment reasons (49%); conflicts with family or household (15%); break-up, divorce, or separation (15%); and problematic alcohol or drug use (11%). This justifies concerns about the high risk of chronic or toxic traumatic responses among the newly homeless.



During a period of homelessness, individuals and families may lose a sense of security, predictability, and control due to unsafe conditions and crime victimization. According to the Los Angeles Police Department's 2018 Report on Homelessness, 76% of crimes committed against persons experiencing homelessness were violent crimes. Homicide, rape, and aggravated assault accounted for the majority (73%) of the reported violent crimes committed against persons experiencing homelessness (Los Angeles Police Department, 2018).

Unsheltered individuals who are also disabled may have additional external threats, based on health conditions and lack of medical care. In the 2019 Greater Los Angeles Homeless Count, the chronically homeless population (those persons with a disabling condition who have experienced homelessness for at least a year or more than four times in the past three years), reported significant health conditions that were 2-3 times more prevalent than among the population experiencing new homelessness (i.e. for the first time and less than a year). The two most reported conditions among people experiencing chronic

homelessness were a mental illness or physical disability – with half of people reporting that they had at least one of the two. Further, 88% of people experiencing chronic homelessness were living on the street (as opposed to in shelters) as of the 2019 Greater Homeless Count, creating higher risk of traumatic stress based on unsheltered living conditions for individuals with disabilities.

Adverse Childhood Experiences & Multigenerational Trauma

The presence of stress, traumatic stress, and toxic stress in early childhood increases the risk for chronic disease as an adult (Felitti et al., 1998). A landmark longitudinal study on adverse childhood experiences was conducted over 10 years with over 17,000 participants who were surveyed during routine care from their primary providers on a wide range of experiences within three categories: abuse, neglect, and household dysfunction (Felitti et al., 1998). The study found that 6.2% of respondents had four or more adverse childhood experiences (ACEs) that were associated with significantly higher levels of health risks. Respondents with four or more ACEs had four to twelve times the risk for alcoholism, drug abuse, depression, suicide attempts, and one to four times the risk for smoking, sexually transmitted diseases, and severe obesity than respondents who reported no ACEs. In a similar study that focused on the risk of premature mortality as related to ACEs, researchers found a 20-year difference in life expectancy for children who did not receive treatment for their ACEs compared with those who did (Brown et al., 2009).

In addition to adverse childhood experiences (ACEs), research has also shown that trauma can be transmitted from one generation to the next through patterns of inherited maternal caretaking behaviors (McGowan, et.al., 2009). Thus, a range of historical, familial, cultural, and biological factors have been associated with the transmission of trauma for such diverse groups as Cambodian refugees of the Pol Pot war (Sack et. al., 1994), Canadian Aboriginals (Pearce et al., 2008), European Jews (Bierer et. al., 2014), and ethnic groups in the United States such as Native, Japanese, and African Americans (Stevens, Andrade, Korchmaros, & Sharron, 2015; Nagata, Kim, & Nguyen, 2015; Graff, 2014; Deuster et. al., 2011).

Racial Oppression, Homelessness, and Trauma

Trauma related to the impact of racial oppression has been identified as a condition requiring specialized responses for healing to occur (Comez-Diaz, 2016; Hardy, K.V., 2013). For people of color, the role of racism has been recognized as an important factor that consists of systemic and institutionalized barriers to resources resulting in significant disparities that are intimately connected to the intersection of racism with homelessness and traumatic stress (Olivet, Dones, & Richard, 2019; Jones, 2016). According to the 2019 Greater Los Angeles Homeless Count, 72% of individuals experiencing homelessness in the City of Los Angeles were either Black or Latinx. A recent LAHSA report detailed the role of racism in relation to the chronic disparity in rates of homelessness for Black people (LAHSA, December, 2018).

The Need for Trauma-Informed Care (TIC)

The experience of one or more traumatic events often affects the way individuals approach potentially helpful relationships and their capacity to respond when services are offered. Research has shown that dissociation, substance use, tension-reducing behavior, and "acting out" behaviors are correlated to trauma exposure (Gupta, 2013). A clinical understanding of the correlation is that the behaviors are an

attempt to cope with the triggered posttraumatic emotional state, especially when the state overwhelms internal affect regulation capacities (Briere, et.al. 2010; Briere, 2006 van der Kolk et al., 1996). Thus, it may be more difficult for persons with extensive trauma histories to develop and maintain trusting and helpful relationships due to the dynamics of maladaptive coping strategies such as substance use, social withdrawal, and other avoidance behaviors (Marzillier, 2014).

As evidenced above, individuals and families seeking assistance from homeless service providers often have extensive histories and experiences of traumatic stress. However, the providers and staff who work in those systems of care are not always aware of the trauma that occurred, are not prepared to offer trauma-informed environments that can help to achieve maximal outcomes, and/or do not provide specific treatment for trauma (Harris & Fallot, 2001). Given that persistent problems of homelessness (such as shelter and housing stability) are often more immediate and tied to the mission of homeless service agencies, service providers may not be prepared to screen for trauma, maintain environments that prevent re-traumatization, or sustain organizational infrastructures that incorporate trauma specific treatment models or interventions (Harris & Fallot, 2001). Individuals, families, and service providers may not recognize the significant effects of trauma in the consumers' life or draw the connection between their trauma histories, their presenting problems, and/or their difficulty accepting or utilizing available service systems (Harris & Fallot, 2001).

Trauma-Informed Care (TIC) in Organizations

Trauma-informed care is an approach to operating, designing, and maintaining systems of care, "whose primary mission incorporates knowledge about trauma and the impact it has on the lives of consumers receiving services" (Harris, 2004, Slide 2). The goal is to ensure a sense of security and autonomy to the consumer-survivor by preventing re-traumatization and promoting resiliency (Harris & Fallot, 2001). Administrators, clinicians, and support staff often experience stressors related to providing care as well as maintaining their personal wellness and safety. Experts such as Harris and Fallot (2001) emphasize that trauma-informed approaches must include awareness of all these factors, while supporting both care-givers and consumers.

The fundamental difference between traditional and trauma-informed organizations is the collective and comprehensive understanding of trauma and the effects of traumatic stress by executives, administrators, clinicians, staff, and consumers (Harris & Fallot, 2001). In trauma-informed systems, program design includes an understanding of trauma-related neurophysiological experiences, social and institutional factors such as racial oppression, the environmental and procedural actions that can inhibit access or effective use of care, and the evidence-based interventions used to treat trauma-related symptoms and disorders (Harris & Fallot, 2001). Funding sources and service organizations have begun to recognize that TIC has potential to improve relationships between service systems and consumers, thus strengthening ability to gain and sustain housing stability.

Evidence-based Treatment Interventions for Trauma Survivors

Trauma specific services are focused on the primary task of adequately assessing clients and then addressing traumatic stress to facilitate recovery, using evidence-based interventions. The American

Psychological Association's PTSD treatment guideline strongly recommends the following as evidence-based psychotherapies for PTSD in adults: cognitive behavioral therapy (CBT) (Beck, Emery, & Greenberg, 1985), cognitive processing therapy (CPT) (Beck, Sloan, Chard, Schuster, & Resick, 2012) and suggests the use of eye movement desensitization and reprocessing therapy (EMDR) (Shapiro 1995; Shapiro 2001).

In addition, there is growing research pointed to the presence of iatrogenic effects, where traumatic stress with potential lasting negative impact on patients has been identified in relation to coercive practices and activities used to maintain control of residential facilities or clinics. Physical restraints or punitive consequences to enforce rules often trigger trauma-related reactions for individuals with significant traumatic stress (Paksarian, et.al, 2014; Moos, 2012). Given that these techniques may either precipitate or trigger traumatic reactions in patients, sufficient preparation, pro-active planning, and strong TIC infrastructure are emphasized as key elements of trauma-informed systems of care. Coercive practices and activities to maintain control of residential facilities or clinics that tend to trigger trauma-related reactions should be avoided if possible even as trauma-informed systems must recognize that administrators, clinicians, and support staff experience stressors related to providing care as well as maintaining their personal wellness and safety (Harris & Fallot. 2001). Thus, trauma-informed care requires an effort to balance and respect the needs of all parties.

The Six Core Values of Trauma-Informed Care (TIC)

In trauma-informed systems, organizational policies, procedures, and programs are developed from the framework of six core values. All members of trauma-informed organizations interact and make decisions through the lens of the following six core values: (1) safety; (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) cultural, historical, and gender issues (Fallot & Harris, 2009; Elliot, Bjelajac, Fallot, Markoff, and Reed, 2005). Trauma-informed organizations respond to the prevalence of trauma by putting the knowledge of trauma-specific principles, processes, and therapies into practice (Substance Abuse and Mental Health Services Administration, 2014), along with an ongoing process of self-reflection and adjustment.

Trauma-informed organizations engage in the following activities:

- Formalizing a commitment and intention to use trauma-informed guiding principles;
- Adopting a formal organizational plan to implement and support delivery of TIC within the agency;
- Maintaining consistent reevaluation and development of trauma-informed policies, procedures, and re-assessments;
- Establishing an infrastructure to initiate, support, and guide ongoing changes that reflect the needs of the participants;
- Involving key stakeholders, including participants with histories of trauma, in all aspects of the organization that affects them or their population;

- Conducting annual or bi-annual assessments as to whether and to what extent the organization's current policies, procedures, and operations either support TIC or interfere with the development of a trauma-informed approach.

Each of these activities reflects a commitment to participatory engagement, both by the individuals and families served and the staff (Ott, Pinard, Ithiphol, & Olwig, 2017). The processes require a depth of inquiry and involvement of people within all roles or levels of an organization (Ott et al., 2017).

Trauma-Informed Systems of Care in Practice

Multiple systems throughout the country have engaged to become trauma-informed, from the nationwide Mobilizing Action for Resilient Communities (MARC) Programs to the organizational wide initiatives at the Center for Youth Wellness in San Francisco and the Women's Community Correctional Center of Hawaii (Ott et al., 2017).

The Downtown Women's Center (DWC), a Skid Row non-profit agency dedicated to helping women experiencing homelessness, provides an example of how one group made the formal commitment to become a trauma and resiliency-informed care organization. They completed an organizational assessment in 2016 and created a Trauma and Resiliency-Informed Taskforce to develop a strategic plan and implement changes within the agency. These included monthly taskforce meetings, widespread ongoing training within the organization, a variety of internal supports to sustain the work, lifting up voices of consumers at all levels, and contributing leadership to trauma-related community collaborations. DWC's trauma and resiliency-informed efforts are aimed at building intentional changes that are community-informed, to strengthen and improve their agency systems and outcomes. They include community-level system transformation as part of their mission.

Another local non-profit community agency, the Homeless Outreach Project Integrated Care System (HOPICS), is using a trauma-informed approach to address the impact of community violence in south Los Angeles through specialized trauma recovery center. The center utilizes a variety of evidence-based trauma treatments, along with non-traditional expressive arts, music, and yoga therapies. During the last two years, the center has served over 3,000 victims of violent crime and provided over 40 law enforcement officer trainings to build a trauma-informed community environment.

Groups such as the Race Equity Institute (https://www.racialequityinstitute.com/) and Race Forward (https://www.raceforward.org/) help organizations reduce the impact of systemic racism. These groups work with leaders and communities to build greater equity, helping them to understand the various subtle and interacting conditions that can lead to disparities in outcomes, based on race. A focus on improving race equity elevates a homelessness system of care's capacity to be trauma-informed.

For organizations interested in becoming trauma informed, public access to several toolkits is available (Downtown Women's Center, 2018; Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; Bloom & Farragher, 2013). The Downtown Women's Center and National Center for Family Homelessness (Guarino et al., 2009) toolkits include assessments specifically for homeless service providers. Race equity tools can also be found at racequitytools.org.

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For questions about the USC University Initiative to End Homelessness, please contact Brenda Wiewel at frankens@usc.edu.

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