THE TRAUMA AND HOMELESSNESS INITIATIVE

RESEARCH FINDINGS

An initiative by the Australian Centre for Posttraumatic Mental Health in collaboration with Sacred Heart Mission, Mind Australia, Inner South Community Health, and VincentCare Victoria

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EXECUTIVE SUMMARY

The importance of understanding the impact of trauma is increasingly recognised amongst services working with people who experience homelessness. This is particularly the case for those who experience long-term homelessness, or those at risk for experiencing long-term homelessness. The ultimate goal of the Trauma and Homelessness Initiative (THI) is to investigate the relationship between trauma and long-term homelessness and to develop a trauma and homelessness service framework for Sacred Heart Mission (SHM), Mind Australia, Inner South Community Health (ISCH) and VincentCare Victoria. The key focus of this project was on people at risk of experiencing or currently experiencing long-term homelessness. This group tends to move in and out of homelessness, or constantly live with the threat of homelessness. They tend to remain homeless for long periods of time, often cycling between the street, institutions and poor quality temporary accommodation. They represent a highly vulnerable group.

The initiative involved four stages of research designed to investigate the nature of the relationship between trauma and long-term homelessness, with each stage building on the findings of the last. The first three stages involved a literature review (stage I), and qualitative interviews with service users (stage II) and direct service workers (stage III). The final stage (stage IV) of the THI involved a quantitative study with service users. This executive summary provides an overview of the key findings from each of these stages.

Stage I: Literature review

This review aimed to present the current state of knowledge on the nature of the relationship between exposure to traumatic events in people's lives and the experience of homelessness. It aimed to highlight areas that were particularly relevant to the development of a trauma and homelessness service framework for agencies that work with people experiencing homelessness. In conducting this review, specific criteria were applied to the literature to ensure that this was a methodologically robust review. An overview of the literature review for specific questions developed in consultation with SHM, Mind Australia, ISCH, and VincentCare Victoria is presented below. References for all of the information that is presented below can be found in the body of the literature review.

Defining trauma

- Broadly speaking, trauma refers to experiences or events that by definition are out of the ordinary in terms of their overwhelming nature. They are more than merely stressful – they are also shocking, terrifying, and devastating to the survivor, and often result in profoundly upsetting feelings of terror, fear, shame, helplessness, and powerlessness.
- Type I trauma: events that typically occur at a particular time and place and are usually short-lived. Traumatic events in this category include (but are not limited to) natural disasters, serious motor vehicle accidents, sudden death of a parent, and single incident sexual assault.
- Type II trauma: events which are typically chronic, begin in early childhood, and occur within the child's primary care-giving system and/or social environment. They usually have the following characteristics: (i) they are repetitive or prolonged; (ii) they may involve direct harm and/or neglect by caregivers, or witnessing direct harm and/or neglect by caregivers; and (iii) they occur at developmentally vulnerable times for a child. Central to this concept is that exposure to this trauma occurs within an environment where escape is impossible (especially when the trauma is perpetrated by a primary caregiver). Type II trauma is associated with complex and long-term mental and social difficulties.

Types of traumatic events experienced by people who experience long-term homelessness

- High rates of exposure to traumatic events among people who experience homelessness are well documented. Australian studies have found that between 91% and 100% of people experiencing homelessness had experienced at least one major trauma in their lives. In comparison, 57% of the general Australian population reported one major traumatic event in their life.
- Few rigorous studies have investigated the prevalence of childhood trauma in people who experience long-term homelessness. The few published, well-designed studies found that adults who experienced homelessness had experienced high rates of childhood trauma including sexual abuse (ranging from 23% to 84%), and physical abuse (70% to 77%).

- The types of traumatic events that were particularly prevalent within adult homeless populations included physical abuse, witnessing someone being badly injured or killed, rape and sexual abuse.
- In summary, the research found that people who experienced homelessness had often experienced traumatic events in their childhood/adolescence. They were also at increased risk for experiencing traumatic events during the time spent homeless.

Prevalent mental health disorders

- The research identified that a vast majority of people who experienced homelessness also experienced at least one psychiatric disorder, and the prevalence of psychiatric disorder among adults experiencing homelessness was much higher than in representative community samples. In terms of research investigating the prevalence of Axis I disorders (see Glossary of Terms) in homeless samples, mood disorders, psychotic disorders (i.e., schizophrenia and bipolar disorder) and trauma-related disorders (e.g., posttraumatic stress disorder [PTSD]) have all been found to be over-represented amongst adults experiencing homelessness.
- An Australian survey of men and women experiencing homelessness found that 73% of men and 81% of women met criteria for at least one mental disorder in the past year (12 month prevalence) and 40% of men and 50% of women had at least two mental disorders.
- Research suggested that psychiatric disorder often preceded homelessness, but there is also evidence that some people became mentally ill as a result of experiencing long-term homelessness.
- Surprisingly few studies had assessed PTSD among people experiencing homelessness, and the studies that had been conducted failed to show a consistent picture.
- The only Australian peer-reviewed study to examine PTSD prevalence rates in adults experiencing homelessness found that 79% of the sample met criteria for a lifetime diagnosis of PTSD, while the 12 month prevalence of PTSD was 41% (PTSD present in the last 12 months).
- When PTSD occurred in the context of homelessness it was also associated with high levels of comorbidity with other psychiatric disorders. For example, in an Australian study of adults experiencing homelessness, of those who met criteria for current PTSD, 55% screened positive for psychosis; 69% scored in the severe or extremely severe range for depression; 50% scored in the severe or extremely severe range for anxiety; 63% screened positive for harmful or hazardous drinking or alcohol dependence; and 88% screened positive for substance use, probable abuse, or dependence.

Risk factors that contribute to recurring homelessness after the experience of trauma

- Studies in non-homeless samples report that individual characteristics increase the risk for developing PTSD after exposure to a traumatic event. These include: previous psychiatric history, prior trauma history, family history of mental illness, and early childhood adversity. Other factors such as a low level of education, female gender, and personality traits have been identified as increasing risk for PTSD. Importantly, these characteristics have also been identified as risk factors for becoming homeless.
- At the macro level, risk factors for homelessness include poverty, social exclusion, poor education, and long-term unemployment. Familial factors include family dysfunction, family violence and sexual abuse, childhood institutionalisation, and poor family and social support. Individual attributes such as mental health problem, physical or mental disability and coping ability were also identified in the literature.
- In one of the only longitudinal studies to examine risk factors of long-term homelessness, the most important predictors were: older age, past or current unemployment, a lack of earned income, poorer coping skills, less adequate family support, a history of substance abuse, and an arrest history.

Impact of trauma exposure and resulting mental health problems upon homelessness

- There was little literature that investigated the relationship between trauma exposure and mental health problems. The literature that was identified suggested that trauma, PTSD, substance abuse and physical and mental illness often occurs before, during and after periods of homelessness, but the causal pathways and nature of the relationships among these factors remain in need of systematic empirical study.
- Very few studies investigated the relationship between PTSD and homelessness within the context of time (i.e., which occurs first), but there was some evidence to suggest that the development of PTSD commonly precedes the onset of homelessness.

Barriers experienced by people who experience homelessness in receiving mental health interventions

- The literature indicated that despite high levels of need, many people who experience homelessness did not receive adequate or appropriate physical or mental health care.
- Systematic barriers identified included the apparent lack of a responsive community mental healthcare system to respond to the needs of people with severe mental illness; the general inaccessibility of healthcare to people who experience homelessness; and the pressures of extreme poverty – such as the necessity to obtain food over healthcare.
- Other barriers included providers who were reluctant to treat clients experiencing homelessness, and clients who were distrustful about the providers and authorities.
- People experiencing homelessness with mental health problems were less likely than other mental health consumers to experience continuity of care.
- Difficult client behaviour, such as behaviours related to active substance use, and difficulties with engagement were also identified barriers to recovery.

Working with people who experience homelessness: A trauma-informed practice model

- The literature indicated that few programs serving individuals experiencing homelessness directly addressed the specialised needs of trauma survivors.
- Some programs that serviced clients who experienced homelessness were developing trauma-informed services. These services recognise the significance of trauma exposure in understanding client problems.
- A consensus-based definition of Trauma-informed Care (TIC) has been developed by Hopper, Bassuk and Oliver (2010). The themes encompassed by this definition include trauma awareness, emphasis on safety, opportunities to rebuild control, and a strengths-based approach.

Conclusion

- The literature review explored the nature of the relationship between traumatic events in people's lives and homelessness, and also examined service issues such as barriers to care and trauma-informed care.
- It identified that the construct of Type II trauma would be useful to examine in the homeless population because it may provide a framework of understanding the complex mental and social difficulties of those experiencing homelessness.
- It identified that there has been some research investigating trauma within homeless populations, and the mental health consequences of trauma exposure. However, generally, the literature was limited, with few published studies reporting on trauma outcomes in homeless populations. Very few studies examined the different types of trauma experienced by this group, particularly in relation to Type I and Type II trauma. It was evident that well-designed studies are necessary to examine the relationship between trauma, mental health and homelessness.
- The content of the review was used to develop a series of studies which investigated the nature of the relationship between traumatic events in people's lives and their state of homelessness. It also assisted in the development of a trauma and homelessness service framework.

Stage II: Service user qualitative interviews

In stage II of the THI, we tested ideas that had been developed from the literature review about the nature of the relationship between trauma and homelessness. To do this, we interviewed 20 service users from the four agencies: SHM, Mind Australia, ISCH and VincentCare Victoria. The service users who participated in this study were experiencing long-term homelessness or were at risk of experiencing long-term homelessness. We used a qualitative methodology to investigate the relationship between a history of homelessness, exposure to traumatic experiences, and mental health. The section below provides an overview of the key findings from these qualitative interviews with service users.

Methodology

A qualitative methodology was used, including open-ended questions. Interviews were digitally recorded and transcribed. The data was analysed using the Thematic Analysis methodology which enables key themes to be identified.

Key findings

General background

- Eleven males (55%) and 9 females (45%) were interviewed.
- Average age was 42.35 years (range 22-61).
- Marital status: single (n=13, 65%), separated or divorced (n=6, 30%), widower (n=1, 5%).

Current and past accommodation

- Participants lived in a range of accommodation: supported accommodation (n=6, 30%); public housing (n=5, 25%); transitional housing (n=3, 15%); community housing (n=3, 15%); rooming house (n=1, 5%); van (n=1, 5%); and in a hotel (n=1, 5%).
- First experience of homelessness ranged from birth to 50 years of age (average first experience at 17.2 years of age).

Participants were asked about what needed to happen for them to be housed in the long term. The following themes emerged.

- Changes external to the participant. Examples included, finding employment, finding suitable housing, or having increased financial support.
- Changes internal to the client, which included personal changes such as improved parenting strategies.

Events that led to the participant's first experience of homelessness were identified under four themes. They included:

- Childhood trauma
- Disintegration or absence of family unit
- Mental health issues
- Accumulation of stressful life events.

Factors that made it hard to find somewhere permanent to live were identified as:

- Lack of employment
- Lack of affordable housing and availability
- Personal experiences and attitudes of others, such as being used to being homeless, and experiences of social exclusion.

Participants identified a number of events that got in the way of staying in secure housing. These were grouped under the following themes:

- Disintegration or absence of family unit
- Difficult interpersonal relationships
- Drug use
- Mental health issues.

Traumatic experiences

- All 20 participants (100%) reported experiencing at least one traumatic event in their lifetime.
- Type I trauma was experienced by 20 (100%) of the participants.
- Type II trauma was experienced by 15 (75%) of the participants.
- Sixteen participants (80%) had sought professional assistance for dealing with these experiences in the past.

Mental health issues

Participants were asked if they had experienced emotional regulation difficulties (i.e., strong emotions or feelings that were hard to manage). Participants reported a number of emotions that were difficult to manage including:

- Feeling down or hopeless (n=20, 100%)
- Anger (n=16, 80%)
- Anxiety (n=18, 90%)
- Experiencing panic attacks (n=15, 75%)
- Hyper-vigilance (n=14, 70%)
- Strong cravings or urges (n=15, 75%).

When asked how these emotional regulation difficulties impacted on the participants' lives, the following themes emerged:

- No perceived impact (n=8, 40%)
- Perceptions of being unable to cope (n=5, 25%)
- Interpersonal and relationship difficulties (n=5, 25%)
- Impulsive and risk taking behaviours (n=3, 15%)
- Two participants (10%) reported having dissociative experiences.

When asked about social relationship difficulties (i.e., difficulties finding or maintaining good relationships with people), most participants described having relationship difficulties (n=18, 90%). The perceived reasons for these difficulties were:

- Low levels of trust in other people (n=9 out of the 18 people who had relationship difficulties, 50%).
- The belief that they had nothing to offer to a relationship (n=4 out of 18, 22%).
- The belief that having poor relationships did not impact on them (n=3 out of 18, 16%).
- Poor communication skills leading to an inability to maintain the relationship (n=1 out of 18, 6%).

Participants were asked about their risk taking behaviour, and the extent to which they put themselves in danger. Participants reported the following types of experiences:

- Risky substance use (n=16, 80%)
- Interpersonal risk taking (n=15, 75%)
- Self-harm/suicide attempt (n=13, 65%)
- Risk of physical harm (n=13, 65%)
- Risk of sexual harm (n=9, 45%).

Participants were asked about their views of self. The themes to emerge included:

- Negative views of self (n=11 out of the 14 people who responded to the question, 78%)
- Self as a survivor (n=3 out of 14, 22%).

They were also asked how they perceived the world. The themes to emerge included:

- The world is a dangerous place (n=6 out of the 14 people who responded to the question, 43%)
- There is good in the world (n=8 out of 14, 57%).

Discussion

- The qualitative study served as an opportunity to test whether emotional constructs identified in the literature review were relevant to this group.
- This pilot study showed that traumatic events were experienced often by this group, with Type I and Type II trauma occurring frequently.
- Mental health difficulties were experienced by this group, with this being particularly the case for emotional regulation difficulties, difficulty with social relationships, negative views about the self and the world, and risk taking behaviours.
- The findings from this study supported the need for a larger quantitative study to investigate trauma exposure and its consequences in the homeless population. These findings helped to refine the focus of the various constructs proposed from the literature review to be explored in the larger quantitative study.

Stage III: Staff focus groups

Focus groups were conducted with 42 support/case workers from SHM, Mind Australia, ISCH and VincentCare Victoria.

The aim of the focus groups was to gather information and perspectives from these support/case workers about the relationship between trauma exposure and homelessness, and factors that help or hinder the provision of services to this population. The section below provides an overview of the key findings from these staff focus groups.

Key findings

What is the link between trauma and homelessness?

- *Client characteristics:* exposure to trauma was seen to impact on many aspects of the individual including their behaviour and ability to form healthy social relationships, which in turn was seen to impact on housing security.
- *System characteristics:* the experience of homelessness or living in unsecure accommodation was seen to increase risk for further exposure to trauma.

What worked well in supporting people with trauma?

- *Characteristics and competencies of staff:*
  - Ability to build a strong therapeutic relationship (which included characteristics of trust, consistency and clear boundaries)
  - Having good skills (i.e., confidence and competence in using a trauma-informed approach).
- *Service characteristics:*
  - Being well versed in what the system/service offers
  - Having good links with other services
  - Being able to refer clients on when appropriate, while maintaining continuity of care.

What tended to get in the way of working effectively with these clients?

- *Practitioner characteristics:*
  - A lack of confidence and relevant skills.
- *System characteristics:* These were seen as the most substantial barriers to effective work. Issues to do with the system included:
  - Problems with the inflexibility of the system
  - Long wait lists
  - Limited time for support/case workers to spend with clients
  - Large caseloads
  - Limited options for referrals.
- *Client characteristics:* The following characteristics about the clients were seen to get in the way of effective work:
  - Reluctance to engage
  - Experiencing ongoing difficulties such as being in crisis
  - Presenting in denial or with a lack of insight about their mental health issues.

How can your agency respond more effectively to people who have experienced trauma?

- *Service characteristics:*
  - Additional training and clinical supervision
  - Increased flexibility and consistency
  - Decreased caseload, more time with clients
  - The capacity to work long-term
  - Smoothing the transition between services
  - Need to employ multidisciplinary teams in order to improve their response to people with trauma, including in-house trauma counsellors
  - Agency-wide implementation of trauma-informed policy and practice.

How can your staff respond more effectively to people exposed to trauma?

- *Staff training and supervision:*
  - Staff to be well-trained
  - Good understanding of trauma and trauma-informed practice
  - Good supervision.
- *Staff self-care:*
  - There is a need for staff to be aware of the impact of their work on themselves.

Do you have anything else that you would like to add?

- The key additional comments that were made were:
  - Need for a diverse range of housing options; safe accommodation
  - Social isolation is a key issue for this client group and staff should aim to support individuals in developing or maintaining social connections
  - Cyclical and interwoven nature of trauma and homelessness
  - Disparity between client and case worker expectations.

Discussion

- Staff identified trauma as impacting on their clients in many ways, and raised trauma as an important issue to address.
- Staff also identified that this group of clients experience a complex range of related behavioural and social issues, making people with trauma a difficult group to effectively engage in services.
- The staff identified many barriers to addressing trauma, and also considered that addressing the consequences of trauma was important at a procedural and policy level.

Stage IV: Service user quantitative study

In stage IV, 115 service users from four agencies, SHM, Mind Australia, ISCH and VincentCare Victoria, were interviewed. The service users in this study were currently experiencing long-term homelessness or were at risk of experiencing long-term homelessness. A quantitative methodology was used to investigate the relationship between a history of homelessness, exposure to traumatic experiences, and mental health. The section below provides an overview of the key findings from this study.

Background

The aim of this study was to examine the relationship between a history of homelessness, experiences of trauma (including type [Type I or Type II] and frequency of trauma exposure), and mental health issues. The specific key questions that this study sought to investigate were:

- What are the types of traumatic events that are experienced by people who experience homelessness?
  - What is the frequency with which traumatic events were experienced?
  - What is the prevalence of Type I and Type II trauma?
  - At what age did each traumatic event occur?
  - When did each traumatic event occur relative to becoming homeless?
- Does the experience of trauma contribute to homelessness (as measured by the length of time that someone has experienced homelessness to date)?
  - Does experiencing trauma prior to homelessness contribute to length of time spent homeless?
  - Does the experience of Type II trauma contribute to length of time spent homeless?
  - Does the number of traumatic events (lifetime) contribute to the time spent homeless?
  - Do people who develop PTSD after experiencing trauma spend more time homeless than those who do not develop PTSD?
- What is the prevalence of mental health disorders amongst people who experience homelessness?
  - What are the prevalence rates of PTSD, depression, psychosis, and substance use disorders?
  - What are the prevalence rates of other mental health difficulties often associated with complex trauma presentations such as emotional regulation difficulties, negative risk taking, suicidal thoughts and/or behaviours, dissociation, and difficulties maintaining social relationships? Are these difficulties more likely to be experienced by those who have a history of Type II trauma relative to those who have not been exposed to this type of trauma?
- What are the levels of social support, community connectedness and social exclusion that are experienced by those who experience homelessness?
- What are the barriers encountered by people who experience homelessness in seeking help for issues related to trauma or mental health?

By addressing these questions, this study aimed to provide valuable information for the final part of the project, the development of a trauma and homelessness service framework.

Methodology

In this multi-sited study which involved SHM, Mind Australia, ISCH and VincentCare Victoria, 115 people experiencing homelessness or at risk of homelessness were recruited for participation. This represents one of the largest Australian studies examining the trauma experiences of this highly marginalised population. A rigorous quantitative methodology was used, including random selection of participants, the use of validated clinical interviews and self-report measures (for details see the Method section of Stage IV, later in this report), and the collection of data across multiple services. All interviews were digitally recorded to ensure that responses were captured in an accurate and comprehensive way. In recognition of the potential distress associated with the interview, after each interview the researcher provided feedback to the team leader. The scope of this feedback was limited to how the participant coped with the interview, and team leaders could alert case managers if a participant required additional support.

Key findings

General background

- Seventy-seven males (67%) and 38 females (33%) were interviewed[1].
- The average age was 45 years (range 18-86) with 22% of participants under 35 years (see Demographics section of Stage IV for a graph of participant age).
- The majority of the sample was single (61%).
- Participants lived in a range of accommodation, that is: rooming house (24%), public housing (24%), the street (19%), supported accommodation (6%), community housing (5%), transitional housing (5%), couch-surfing (5%), traditional housing (4%), vehicle (4%), and other (4%).
- The average age participants first experienced homelessness was 23 years. This ranged from some participants being born into homelessness, to first experience at 56 years of age.

The main events that led to the participants' first experience of homelessness were:

- Childhood trauma (17%)
- Disintegration or absence of family unit (26%)
- Mental health issues (10%)
- Accumulation of stressful life events (15%) (for a definition of this, refer to glossary).

Traumatic experiences

- There was an extremely high level of reported exposure to trauma events, with all 115 participants reporting at least one traumatic event in their lifetime. Type I (single incident) trauma was experienced by 98% of the participants. There were very high levels of exposure to interpersonal violence (including sexual and physical assault) as well as natural disasters, and life-threatening accident. Type II trauma was directly experienced by 60% of the participants.
- Most participants reported exposure to multiple traumatic events. Over 97% of those interviewed had experienced more than four traumatic events in their lifetime (see Traumatic Experiences section of Stage IV, for further details on the nature of these traumas). The comparable rate in the general community is 4%.
- Seventy percent of participants experienced at least one trauma before experiencing homelessness. The majority of participants were exposed to trauma during their childhood. For many participants this childhood trauma was prolonged and repeated, and constituted Type II trauma (e.g., child abuse). For others, it was exposure to other events such as motor vehicle accidents, natural disasters, and violence (Type I trauma).
- Trauma was often identified as a precipitant to becoming homeless.
- Although most of the sample was exposed to trauma prior to becoming homeless, trauma exposure escalated after becoming homeless such that the majority of trauma exposure occurred after becoming homeless.

Mental health issues

- A structured clinical interview enabled assessment of current and lifetime mental health disorders. These assessments showed that 88% of the sample met criteria for current diagnosis of a mental health disorder. These included PTSD (73%), depression (54%), alcohol abuse disorder (49%), alcohol dependence disorder (43%), substance abuse disorder (51%), substance dependence disorder (44%), and psychotic disorder (33%). Definitions of these disorders can be found in the Glossary of this report.

[1] There were 8 participants who identified as being transgender, however these participants were asked to nominate which gender they most identified with, and this was the gender that was used for the purpose of analysis.

- PTSD was highly comorbid with other disorders including major depressive episode (67% of PTSD was comorbid with major depressive episode), current alcohol abuse (54%), alcohol dependence (47%), substance abuse (61%), substance dependence (54%), and current psychotic disorder (38%).
- Participants reported high levels of symptoms often associated with exposure to repeated and prolonged traumatic events. These included: emotional regulation difficulties (62%), difficulty maintaining social relationships (93%), risk taking and putting self in danger (41%), suicidal ideation (19%), dissociative experiences (72%), and negative perceptions of the world and self (66%).
- The literature review identified that Type II trauma was associated with high levels of complexity across a number of mental health domains. Our findings partially supported this. In our sample, participants who had experienced Type II trauma had a somewhat more complex presentation than those who had experienced Type I trauma only. Specifically, those who had experienced Type II trauma were significantly more likely to meet criteria for a diagnosis of current PTSD than those who did not, and their PTSD severity scores were significantly higher. They were also significantly more likely than those who had experienced Type I trauma only to meet criteria for a diagnosis of lifetime PTSD, to experience emotional regulation difficulties, and have high levels of risk taking and self-endangering behaviour.
- However, those who had experienced Type I trauma only (without Type II trauma exposure) also had a complex presentation across a number of other mental health and social domains. In this sample, those experiencing Type I trauma only reported high levels of negative social relationships, dissociation, negative views of the world or themselves, and suicidal preoccupation. They also had high levels of major depressive episode, anxiety, alcohol and substance use disorder, and psychotic disorder. They had low levels of social support and social connectedness and high levels of social exclusion. Across these domains, those who had experienced Type I trauma only looked very similar to those with Type II trauma, in terms of complexity.
- The high level of complex mental health presentation seen in those who had experienced only Type I trauma may be driven by the high level of trauma exposure experienced by this group. Those participants who were exposed to Type I trauma only experienced this trauma in a repeated, frequent and ongoing way, such that their mental health and social difficulties looked similar to those who had experienced Type II trauma.

Impact of trauma on homelessness

- In simple analyses, it was identified that people who experienced trauma prior to homelessness were significantly more likely to have longer periods of homelessness than those who experienced trauma after homelessness.
- When a planned stepwise multiple regression was conducted, characteristics of trauma exposure or mental health did not significantly account for the length of time spent homeless, after controlling for age. One potential explanation for this finding is that the incredibly high rates of trauma exposure by all people in the sample led to the inability to discriminate differences within the sample in terms of trauma.
- These findings may also indicate that the factors which influence the length of time people experience homelessness are very complex and multi-dimensional. Our analyses tested whether trauma had a direct relationship with length of time someone was homeless (it would appear that it did not). However, it may be that trauma experienced played an indirect role on length of time spent homeless. For example, trauma may have impacted upon a person's mental health, or social relationships, which in turn may have impacted upon the amount of time they spent experiencing homelessness. Future studies with larger sample sizes may be useful to explore these indirect relationships.

Social support and social connectedness

- The sample had low to moderate levels of social support and social connectedness and moderate to high levels of social exclusion. This is consistent with the finding that 95% of the sample reported high levels of difficulties maintaining social relationships.
- Social difficulties as a whole were experienced at a high level regardless of whether the individual had experienced Type II trauma or Type I trauma only.
- Taken together, social disadvantage represented a fundamental component of the relationship between trauma and homelessness.

Help-seeking

- Of those who experienced trauma, 67% (n=77) sought assistance for dealing with these experiences at some time in their lifetime. The most frequent help-seeking activity was to visit a psychologist (27%, n=21 out of the 77 people who sought assistance) or a GP (25%, n=19 out of 77). Sixty-five per cent of these people (n=77) described the assistance that they received as beneficial.

- However, 50% of the total sample reported that there had been a time when they did not get professional help for a mental health issue, despite wanting to do so. The most common reasons for this included: not knowing how to get help (35%); not trusting anyone (11%); thinking that no one could understand their situation (11%); cost (7%); and not caring or feeling ready to engage (9%).

Discussion

- One of the strengths of this study is the fact that participants were sampled from a diverse range of services that worked with people experiencing homelessness.
- Our sample of people experiencing homelessness reported an exceptionally high rate of trauma exposure. Trauma exposure generally occurred across the lifespan with very high rates of trauma being experienced in childhood. Trauma was often identified as a precipitant to becoming homeless, and exposure to traumatic events escalated upon becoming homeless.
- The majority of people experiencing homelessness in this sample met criteria for at least one psychiatric disorder, and most met diagnostic criteria for PTSD. In addition to these disorders, many participants experienced complex difficulties in emotional regulation, maintaining social relationships, anticipating and avoiding risk, and dissociation. Taken together, it is likely that these difficulties contribute to ongoing trauma exposure.
- In our sample, people experiencing homelessness who reported being exposed to Type II trauma were at increased risk for developing PTSD and having a highly complex mental health presentation. However, those experiencing homelessness who had not experienced Type II trauma also presented with a highly complex mental health presentation.
- Trauma exposure and homelessness were so closely linked in this study that it is difficult to examine statistically how trauma exposure contributed to the length of time spent homeless.
- Difficulties maintaining social relationships, low levels of social support and connectedness and high levels of social exclusion represented social disadvantage in this group. Taken together, this social disadvantage represented an essential component of the trauma and homelessness equation in this sample.
- Findings from the study suggested that long-term homelessness, trauma exposure, mental health difficulties and social disadvantage represent a cluster of vulnerability. They occur together, and drive each other with significant consequences across a lifetime.
- The findings from this study suggest that for the majority of people experiencing long-term homelessness, trauma exposure usually begins in childhood, is a precipitant to becoming homeless, and then escalates upon becoming homeless.

Integration of the initiative's key findings

- The findings from the THI present a picture of a cyclical interrelationship between trauma exposure, long-term homelessness, mental health difficulties, and social disadvantage. The following points speak to how trauma is central to this cyclical and perpetuating interrelationship.
- Trauma drives homelessness: Traumatic events are often a precursor to becoming homeless. The THI research found that many people left their home to avoid ongoing trauma in the form of assault, child abuse, and other forms of interpersonal violence.
- Homelessness drives trauma exposure: Being homeless is a risk for experiencing further trauma. The THI research showed that the frequency of trauma exposure escalated when people lost their secure accommodation.
- Trauma drives social difficulties: Trauma, especially that which is caused by the primary caregiver, or other forms of interpersonal trauma, impacts on an individual's sense of safety and connection with other people, and therefore impacts on the ability to develop and maintain social relationships.
- Trauma drives mental health problems: Exposure to traumatic events in both childhood and adulthood are associated with mental health problems. The THI research showed that not only were the prevalence rates of psychiatric disorders elevated in this population, but other adverse mental health experiences were also frequently reported. These included difficulties such as emotional dysregulation, dissociation, suicidal thoughts or behaviours, negative views about the self and world, and risk taking. These experiences were all frequently reported regardless of whether trauma had been experienced in childhood or adulthood.
- A diagram of the explanatory model of the reciprocal and interconnected relationships between trauma, long-term homelessness, mental health difficulties and social disadvantage is presented in the Integration of the Initiative's Key Findings section, later in this report.

Implications for practice

- A model of recovery must take into account this cyclical interrelationship between trauma exposure, long-term homelessness, mental health difficulties and social disadvantage.
- A model of recovery for people experiencing long-term homelessness has been developed using the findings of the THI research. This model describes the factors that support recovery from the nexus of trauma, long-term homelessness, mental health difficulties and social disadvantage. This model is depicted in the Implications for Practice section, later in this report.
- The centre section of the model illustrates the interrelationships between long-term homelessness, trauma exposure, mental health difficulties and social disadvantage.
- The innermost concentric circle describes principles that support recovery and resilience: promotion of hope, safety, calm, connectedness and self-efficacy.
- The second concentric circle describes a set of foundational psychosocial stability skills that are considered to promote resilience and recovery from trauma. These are specific skill-based activities that a range of workers can offer across a variety of situations.
- The final concentric circle recognises that recovery occurs within a wider service system which can make critical contributions to the resolution of complex biopsychosocial difficulties.
- The factors in this model are strongly supported by the literature, and the findings of the THI. Importantly, they are also consistent with the existing philosophical and practical orientations of the THI agencies.

INTRODUCTION

Every night, around 105,000 Australians experience homelessness [1], and according to the 2006 Census, 20,511 Victorians were recorded as homeless. This represented a 15% increase in the decade from 1996 [2].

Among the population of people that experience homelessness, three general subgroups have been identified. The largest group comprises people whose primary issues are a lack of affordable housing and/or work opportunities. People in this group typically need relatively little support and most of these people return to housing quickly [3]. The second group, which is sometimes referred to as the 'transitional homeless', experience homelessness for more diverse reasons, remain homeless for longer, and have greater support needs than the first group [3]. The third group consists of people who have remained homeless for long periods of time, often cycling between the street, institutions and poor quality temporary accommodation [3]. People in this group are often described as experiencing long-term homelessness. An examination of homelessness in inner Melbourne found that long-term homelessness (12 months or longer) was experienced by 70% of people aged between 19 and 24 who had experienced homelessness, and 85% of people 25 or older who experienced homelessness [4]. For people experiencing long-term homelessness it is now widely understood that affordable housing alone is unlikely to be an adequate or lasting solution to homelessness [5].

Many people who experience homelessness also experience mental health difficulties. Rates of depression, substance abuse [6] and severe mental illness (including psychosis and schizophrenia) [7] are elevated in homeless populations.

Front line experiences of the agencies working with people experiencing long-term homelessness recognise that this group is exposed to much trauma. This is confirmed by studies, both in Australia and internationally, that have documented that people who experience homelessness also report disproportionate exposure to traumatic events. For example, in Australia, a major driver of homelessness is domestic and family violence. Escaping violence is the most common reason provided by people who seek help from specialist homelessness services [8].

However, agencies working with people experiencing long-term homelessness also recognise that the current service system does not always have the necessary tools or responses to maximise the opportunities that arise when clients present with trauma histories.

In 2012, four service agencies who work with people experiencing long-term homelessness, SHM, ISCH, Mind Australia and VincentCare Victoria, commissioned the ACPMH to complete a two-year project. The aim of the project was to undertake research to explore the relationship between long-term homelessness, trauma exposure, and mental health. This research was conducted to inform the development of a trauma and homelessness service framework that will assist services' understanding and responses to the needs of people experiencing homelessness. The project consisted of four related studies:

- A review of the literature pertaining to homelessness, mental health and trauma exposure, and trauma-informed care models.
- Staff focus groups to identify the needs of staff when dealing with trauma-exposed people experiencing homelessness.
- A qualitative study of service users examining trauma exposure, homelessness history, mental health difficulties and social disadvantage.
- A quantitative study of service users examining trauma exposure, homelessness history, mental health difficulties and social disadvantage.

This report presents the findings of each of these four studies, as well as an integrated discussion of the project in its entirety.

STAGE I: LITERATURE REVIEW

The questions addressed by the literature review were developed by the THI reference group whose membership included representatives from SHM, Mind Australia, ISCH and VincentCare Victoria. The key question addressed was:

What is the nature of the relationship between traumatic events in people's lives and homelessness?

While literature that addresses this specific question is somewhat limited, there is an extensive trauma literature that can be used to inform the question, giving rise to the following subsidiary questions:

- What are the types of traumatic events that are experienced by people who also experience long-term homelessness?
- What are the mental health disorders that are prevalent amongst people experiencing homelessness?
- What are the risk factors that contribute to recurring homelessness after the experience of trauma?
- What is the impact of trauma exposure and resulting mental health problems upon homelessness?
- What are the barriers experienced by people who experience homelessness in receiving mental health interventions?
- What is the evidence to support a trauma-informed practice model?

Within this agenda, this literature review has primarily been written to:

- Review the existing body of empirical literature related to the key question
- Review the grey literature related to the key question
- Assist in the development of a research project that investigates the nature of the relationship between traumatic events in people's lives and their state of homelessness
- Assist in the development of a trauma and homelessness service framework that will guide practice and service delivery of agencies who work with people who are homeless.

Literature review methodology

An extensive search of databases was conducted using the search terms: "homeless", "homelessness", "stress", "trauma", "PTSD", "mental*health", "barriers*care", "mental*health*intervention", and "trauma*informed*service". The literature was sourced using standard scientific databases, notably Medline, Web of Science and PsychInfo. This search yielded 674 research articles.

On the basis of information contained in the abstracts, articles related to the key questions were then selected for inclusion in the review. Where possible, literature involving Australian people experiencing homelessness was utilised, and in the absence of this, research from other similar countries such as the USA and the UK was used. In cases where there was an absence of literature relating to trauma and homelessness, other trauma literature (such as interpersonal violence research) was drawn upon.

Priority was given to high quality studies including systematic reviews and randomised controlled trials. The process resulted in a primary group of 142 articles which were matched to the scope of this review, in terms of context and content. As a quality control process, the first author cross-checked 10% of these primary articles against the review scope. To ensure that the review was comprehensive, after the initial draft of the review was completed, each of the primary and secondary articles was examined once again, to ensure that all key findings were included.

To supplement the literature review, a search of the grey literature (including government reports, research working papers and other authoritative reports) and publically available website resources was also conducted. The aim of this search was to identify any reports or papers in Australia and internationally which have reported on the nature of the relationship between traumatic events in people's lives and homelessness. This served to ensure that the review captures research and service development initiatives which exist outside of the scientific literature. The same key words were used as for the scientific literature review. In

addition, during consultation that occurred prior to this literature review, the researchers were provided with several reports and documents from SHM, VincentCare Victoria, ISCH and Mind Australia. Relevant information from these reports was drawn upon in this review. Combined, these strategies contributed to a thorough and robust methodology for this literature review.

Defining trauma

The word trauma can mean different things in both scientific literature and lay terminology. For the purpose of the THI research, it is necessary to establish a shared understanding of trauma. Broadly speaking, trauma refers to experiences or events that by definition are out of the ordinary in terms of their overwhelming nature. They are more than merely stressful – they are also shocking, terrifying, and devastating to the survivor, resulting in profoundly upsetting feelings of terror, fear, shame, helplessness, and powerlessness [9].

Traditionally, traumatic events are defined as the experience of actual or threatened death, serious injury or sexual violation, or exposure to the death, injury or suffering of others. This includes witnessing these events as they occur to others (especially significant others), or learning that these events occurred to significant others. These traumatic events are often referred to as Type I trauma, and are events that typically occur at a particular time and place and are usually short-lived. Traumatic events in this category include (but are not limited to), natural disasters, serious motor vehicle accidents, sudden death of a parent or child, and single incident sexual assault.

Reactions to these events are likewise traditionally described as a range of traumatic stress symptoms which include (but are not limited to), intrusive memories about the event, behavioural and emotional avoidance, high levels of arousal (such as increased startle response and hypervigilance), sadness, anxiety and guilt. Some people may develop psychiatric disorders such as PTSD or depression following exposure to a traumatic event (see Glossary for definition).

More recently, there has been growing recognition of the need to differentiate types of traumatic events that can result in more complex and pervasive outcomes. Defined as Type II trauma [10], these events involve prolonged and/or repeated trauma, and usually occur in early childhood and involve people known to the child (i.e., immediate or extended family) who have primary responsibility for care. These events have the following characteristics:

- Trauma may involve direct harm and/or neglect by caregivers, or witnessing direct harm and/or neglect by caregivers
- Trauma occurs at developmentally vulnerable times for a child.

Central to this concept is that exposure to this trauma occurs within an environment where escape is impossible (especially when the trauma is perpetrated by a primary caregiver).

Exposure to these early traumatic experiences can result in a broad range of complex adverse outcomes, including PTSD, anxiety and depression, difficulty regulating emotional responses, and negative perceptions of self and the world [11]. Difficulties maintaining social relationships is also an important outcome from exposure to Type II trauma [11]. In children (and adults) the process of being traumatised by a person with whom they have strong emotional ties can lead to insecure or problematic relational attachments, which impacts on the ability to have healthy social relationships [12]. Type II trauma may occur in adulthood, and involves prolonged and repeated exposure to trauma where escape is impossible. This includes kidnapping and torture, especially during war or civil conflicts. The literature would suggest that people exposed to Type II trauma would have more severe and complex outcomes than people exposed to Type I trauma.

In the community, the majority of people who experience traumatic events recover over time. That is, the majority of individuals are resilient to the impacts of trauma exposure. In a significant minority of people, however, traumatic stress symptoms increase in severity and develop into psychiatric disorders which require treatment. The factors that cause some individuals to be more vulnerable to the effects of exposure to traumatic events, and others to be vulnerable to homelessness, will be discussed in detail, in the section, *What are the risk factors that contribute to recurring homelessness after the experience of trauma?*

What types of traumatic events are experienced by people who experience long-term homelessness?

A high incidence of trauma among people who experience homelessness is well documented, particularly in the US [13-15]. Studies have confirmed similarly high rates of trauma among people who experience homelessness in Australia [16-18].

Buhrich, Hodder & Teeson [19] found that all women and 91% of males who experienced homelessness, in a large sample from inner Sydney, reported at least one major trauma in their lives and many reported multiple traumas. Similarly, Taylor and Sharpe [20] found that 98% of their sample from inner Sydney had experienced at least one traumatic event in their lifetime, and 93% had experienced two or more. In comparison, 57% of the general Australian population report one lifetime trauma and 32% report two or more traumas [21]. In this section, we will review the literature related to the types of traumatic events that are experienced by people who experience long-term homelessness, and the frequency with which they experience such events.

In terms of the types of traumatic events that are experienced in the lifetime of those who experience homelessness, one US study found that over two-thirds of women reported an experience of physical abuse in their lifetime [22]. A study of people experiencing homelessness in inner Sydney found that half the women and 10% of men reported they had been raped in their lifetime [16]. For men, the experience of rape usually occurred in an institutional setting. In the inner Sydney sample, 57% of men and 61% of women were seriously attacked or assaulted in their lifetime, while 55% of men and 55% of women witnessed someone being badly injured or killed.

More often than not, people who experience long-term homelessness have experienced some form of childhood trauma [16, 23, 24]. However, very few studies have investigated the prevalence of childhood trauma using rigorous methodology. One study found that 52% of people experiencing homelessness experienced childhood trauma. However, the authors did not specify whether this referred to physical or sexual abuse, or both. Differences in the prevalence of childhood trauma between males and females were not assessed in this study [23]. In another well designed study it was found that 70% of men and 77% of women experienced physical abuse in childhood, while 64% of men and 84% of women experienced sexual abuse [25].

In the Journey to Social Inclusion (J2SI) study [3], a sample of people experiencing long-term homelessness in Melbourne was examined. Eighty-seven per cent of participants had experienced childhood trauma, and the average age at which they first experienced a traumatic event was 12.7 years. A key indicator of the extent of adverse childhood experiences was growing up in the out-of-home care system (e.g., foster, group or institutional care). In the J2SI study, 40% of participants reported that they had spent time in the child protection system when they were growing up [3]. Other research has shown that people who are involved in the child protection system typically grow up in homes where parental substance abuse and family violence are common [27, 28]. Almost all of the J2SI participants (95%) had experienced significant trauma. When the researchers looked at specific types of trauma, it was found that 52% of participants had experienced sexual abuse (66% of women versus 36% of men); 75% had experienced physical assault in their lifetime; 12% had experienced physical assault in the previous six months; 67% had witnessed someone being badly injured; 57% had been threatened with a weapon or held captive; and 54% had been involved in a life threatening accident [3].

People who experience homelessness also report traumatic experiences during homeless episodes. Living without a stable, safe residence and having limited financial and social resources contributes to people experiencing homelessness being vulnerable to exposure to a variety of traumatic events. A study of older people experiencing homelessness in New York found that nearly half were robbed and over one-quarter were physically assaulted in the previous year [29]. Another US study found that in the previous two months, 18% of a sample currently experiencing homelessness had been threatened with a weapon, 16% had been beaten and 6% had been sexually assaulted [30]. People experiencing homelessness are at greater risk of violence than those who are housed [5, 31], with international research suggesting that violence, especially sexual violence, is more prevalent among homeless women [32, 33]. This is of particular importance given that violence may increase the likelihood of prolonged or long-term homelessness [34].

Factors which may render people experiencing homelessness vulnerable to physical assault include alcohol and drug intoxication, the seeking-out of illicit substances, cognitive impairment, and physical frailty [16]. Not surprisingly, fears about personal safety and security are common [20]. In some circumstances this fear may itself contribute to further trauma exposure. Researchers have found that some women seek increased safety through a male partnership that may ultimately lead to violence [35]. In addition, people experiencing homelessness are vulnerable to injury. A survey of homeless adults in the US found that traumatic injuries (many of which resulted from interpersonal violence) were most frequently reported as the reason for last visiting a hospital emergency room [36]. This accounted for 39% of all the annual emergency room visits by people experiencing homelessness, and surpassed all other reasons. Research from the US has also found that people who “sleep rough” (i.e., sleep on the streets) are significantly more likely to experience chronic health

problems and have a mortality rate three to four times higher than that of the general population [37].

The ISCH 2009 Client Survey found:

- Clients reported an average of eight life events that were reflective of trauma and associated with difficulties
- Assault had been experienced by 33.7% of clients, family violence by 30.6%, abuse by 10.7%, sexual abuse was reported by 6%, rape by 0.3%, and war and famine was experienced by 0.4%

The SHM 2010 Client Survey found:

- Seventy-five percent of respondents said they had a history of trauma
- Trauma occurred before homelessness for 10% of clients, after homelessness for 10%, and both before and after for 55%

In the general community, men are more likely than women to experience traumatic events [38, 39], and in particular, non-sexual violent assault (such as being shot or stabbed, mugged/threatened with a weapon or beaten badly) and other accidental injury [7, 38-40]. A number of studies have found that homeless women experience higher rates of assault than their housed counterparts [41-43], although this finding needs replication. Past research has suggested that homeless women are significantly more likely to be physically assaulted than men [30, 44]. However, in one of the only studies that made a direct comparison, there were no statistically significant differences between women and men in reported rates of assault. Women were, however, more likely to experience sexual violence [45]. In this study respondents were asked to report assault within the last 30 days, whereas most other studies included a wider time frame.

As will be discussed in the section *Mental health disorders that are prevalent amongst people experiencing homelessness*, people experiencing homelessness have a higher prevalence of psychiatric disorders compared to the general Australian population. Unfortunately, poor mental health also increases the risk of exposure to traumatic experiences, with schizophrenia [45], more severe psychotic symptoms [30], a history of psychiatric hospitalisation [14], and general psychological distress [46], all having been associated with violent assault of people experiencing homelessness.

What mental health disorders are prevalent amongst people experiencing homelessness?

Research has found that the vast majority of people who experience homelessness also experience at least one psychiatric disorder [16, 47], and that the prevalence of psychiatric disorders among homeless adults is much higher than in representative community samples [48]. In this section, we examine the prevalence of posttraumatic reactions amongst those who experience homelessness, and the most prevalent mental health disorders.

Psychiatric disorder often precedes homelessness [49], but there is also evidence that some people become mentally ill as a result of experiencing long-term homelessness [50]. Consistently, research has found that mood disorders [51], psychotic disorders (i.e., schizophrenia and bipolar disorder) [52] and trauma-related disorders (e.g., PTSD) [16] have all been found to be over-represented amongst adults experiencing homelessness. There is also a body of literature that has examined the level of comorbid psychiatric disorder amongst those who have experienced traumatic events, and this research is discussed below.

Trauma and homelessness

There are a number of psychiatric disorders that can develop in the aftermath of exposure to traumatic events. PTSD is specifically linked to experiencing a traumatic event, and as such, is the disorder that most of the scientific literature has focussed on. There is, however, increasing awareness that other disorders can develop after trauma, including major depressive episode (depression), anxiety disorders, and substance use disorders (such as alcohol use disorders).

Evidence suggests that people who experience homelessness are at elevated risk of experiencing PTSD. PTSD is made up of three clusters of symptoms, including recurring and distressing recollection of the event (e.g., intrusive memories or nightmares), avoidance of reminders of the event (e.g., avoiding people with characteristics similar to an assailant), and increased arousal (e.g., increased heart rate or sweating when reminded of the trauma, and poor sleeping). These symptoms are very distressing and can lead to significant levels of social and functional impairment.

Given the high incidence of exposure to multiple traumatic events in the homeless population, one

might expect a high prevalence of PTSD [53]. Furthermore, many of the factors which increase the risk of PTSD (e.g., a history of childhood trauma, history of psychiatric disorder, inadequate support systems, low socioeconomic level) are often found in people who experience homelessness [25, 53]. However, surprisingly few studies have assessed PTSD among people experiencing homelessness. Furthermore, the studies that have been conducted fail to show a consistent picture. For example, two international studies which examined lifetime prevalence rates of PTSD (PTSD present at any time during lifetime) in women experiencing homelessness, reported a range from 34–36.1% [25, 54]. The only study that examined the one-month prevalence rate (PTSD present in the past month) for women found a rate of 17.4% [54]. Only one study could be found which examined the lifetime prevalence rate of PTSD for men, reporting a rate of 18% [25]. No studies examining the current prevalence rate for men experiencing homelessness could be identified.

In the only Australian peer-reviewed study to examine prevalence rates in adults experiencing homelessness, it was found that 79% of the sample (both males and females) met criteria for a lifetime diagnosis of PTSD, while the 12 month prevalence of PTSD (PTSD present in the last 12 months) was 41% [20]. These prevalence rates are considerably higher than those observed in the international studies. The variation in the prevalence rates is most likely due to methodological issues, such as the instruments used to measure PTSD. For example, the Australian study allowed PTSD to be diagnosed by either the US diagnostic criteria [Diagnostic and Statistical Manual of Mental Disorders (DSM-IV); 55] or the international criteria [International Classification of Mental and Behavioural Disorders (ICD-10); 56], whereas the international studies used DSM-IV criteria alone. Although a breakdown of the prevalence rates for males and females was not reported in the Australian study, it was reported that there were no significant differences in the rates of PTSD between men and women. This finding is similar to that in youths experiencing homelessness, where gender differences in PTSD have not been found [57]. In contrast to the PTSD rates of adults experiencing homelessness, the 12 month prevalence rate of PTSD in the Australian general community is relatively low at 1.5% [21], as is the lifetime PTSD prevalence rate at 5–10% [39].

The VincentCare Homeless and Drug Dependency Trial – Rebuilding Lives (2005) found:

- 9% of clients had been previously diagnosed with PTSD, while 25% had been diagnosed with an anxiety disorder, and 57% had been diagnosed with depression

As discussed in the previous section, people who experience homelessness often experience multiple traumatic events in their lifetime. A study that examined the relationship between types of traumatic events experienced by homeless men and trauma symptoms, found that being diagnosed with a life threatening illness (e.g., HIV/AIDS, cardiac problems and hepatitis) and witnessing violence were most strongly related to trauma symptom severity [58]. This finding is consistent with other research that has found that those who experience multiple traumatic events have worse long-term outcomes than those who have experienced fewer events [59]. In addition, the number of stressful life events and the presence of a mental health disorder emerged as significant predictors of trauma symptom severity for homeless men [58].

Given the relative dearth of literature related to the prevalence and correlates of PTSD in adult Australians experiencing homelessness, it is important that future research aims to develop a more complete picture of the relationship between these issues.

Other mental health disorders and homelessness

The prevalence of serious psychiatric disorder and substance abuse is high among people experiencing homelessness in many Western cities [60-62]. Common psychiatric diagnoses in this group include major depression, bipolar disorder, schizophrenia and personality disorders.

In a US national survey of people experiencing homelessness, it was found that 39% of respondents had a current mental health disorder, 50% had a current alcohol and/or drug problem, and 23% had concurrent mental health and substance use problems [63]. In comparison, an Australian national survey of people experiencing homelessness, utilising specialist homelessness services, found that 12% of respondents had a current mental health disorder, 19% had a current alcohol and/or drug problem, and 5% had both mental health and substance use problems [64].

A survey of a representative sample of men and women experiencing homelessness in inner Sydney found that 73% of men and 81% of women met criteria for at least one mental disorder in the past year (12 month prevalence) and 40% of men and 50% of women had at least two mental disorders [65]. The prevalence rate of schizophrenia among men and women was 23% and 46%, respectively. The prevalence of any mental disorder was found to be four times higher among homeless men and women in inner Sydney than within the Australian general population. When gender differences were examined, for men in inner Sydney there was a prevalence of 49% for alcohol use disorder, 34% for drug use disorder, 28% for depressive disorder and 22% for anxiety disorder [65]. For women the rates were 15% for alcohol, 44% for drug use, 48% for depressive disorder and 36% for anxiety disorder, respectively. Although mood and anxiety disorders occur commonly in the general Australian population [66], the research suggests that these disorders have a much higher prevalence within the homeless population.

There is also a high level of comorbidity between PTSD and other psychiatric disorders. Comorbidity, the concurrence of two or more psychiatric disorders in the same individual, is gaining increasing attention in the psychiatric literature [62]. In a study of Australian adults experiencing homelessness, of those who met criteria for current PTSD, 55% screened positive for psychosis, 69% scored in the severe or extremely severe range for depression, 50% scored in the severe or extremely severe range for anxiety, 31% met criteria for a diagnosis of Obsessive Compulsive Disorder, 56% scored in the severe or extremely severe range for stress, 63% screened positive for harmful or hazardous drinking or alcohol dependence, and 88% screened positive for a substance use problem, abuse or dependence [20].

As discussed in the section *Types of traumatic events that are experienced by people who also experience homelessness*, there is research to suggest that people who have schizophrenia and psychosis are more likely to be physically assaulted. A systematic review of the prevalence of schizophrenia in homeless persons found rates ranging from 4–16% and a weighted average of 11% in the ten most methodologically sound studies [67]. A study of people experiencing homelessness in inner Sydney found that those with a history of schizophrenia or any other psychotic disorder were 3.1 times more likely to be physically assaulted than those without such a history [31]. It has been proposed that the relationship between assault and psychosis occurs because the symptoms of psychosis often lead to impaired judgment which in turn affects one's ability to identify risk (thus leading to an increased risk of assault). Furthermore, responding to psychotic symptoms (e.g., auditory hallucinations or other positive symptoms) by talking to oneself, and engaging in disordered behaviour draw attention to people with psychotic disorders, increasing the likelihood of violence [68].

The People Living with Psychotic Illness 2010 report found:

- Over half (57.2%) of people with a psychotic illness reported experiencing a distressing or traumatic event in childhood, with 16.1% reporting being sexually abused in childhood

As described earlier, substance abuse and dependence have been associated with trauma and PTSD in people who experience homelessness. However, the relationship between addiction and PTSD is complex. Some researchers have suggested substance abuse may be an antecedent to trauma exposure. Others have suggested that substance abuse is a consequence of PTSD, used as a mechanism to cope with the symptoms of the disorder. Similarly, there is a common perception that substance abuse and homelessness are linked, but there is considerable contention about the direction of the relationship [69, 70]. A study of people experiencing homelessness in inner Melbourne found that 15% of the sample had substance abuse problems prior to becoming homeless for the first time, meaning that for most people in the inner Melbourne sample, other factors caused them to become homeless for the first time [71].

The literature covered in this section highlights the fact that there is a high prevalence of mental health problems amongst those who experience homelessness. There is evidence to suggest that PTSD rates are much higher amongst those who experience homelessness than the general population, however this is an area that requires further research. As such, in the quantitative study (stage IV), the prevalence of PTSD amongst those who experience homelessness is assessed.

What are the risk factors that contribute to recurring homelessness after the experience of trauma?

Many people experiencing homelessness have also experienced trauma, and people with histories of trauma and mental illness are often at increased risk of losing housing or never gaining adequate stable

housing [72]. There is a large body of literature that has examined vulnerability to developing PTSD after trauma exposure, and, quite independently, research has also examined the risk factors associated with homelessness. These two bodies of literature, and any relationships observed between the two, are explored below.

Risk factors for developing PTSD following exposure to trauma

Meta-analyses of studies investigating risk factors for PTSD have identified a number of consistent predictors of the development of PTSD following exposure to trauma. While these meta-analyses include a wide range of traumatic experiences and trauma survivors, their findings are relevant to those who experience trauma and homelessness.

There are a number of individual characteristics that increase the risk for developing PTSD. These include previous psychiatric history, prior trauma history, family history of mental illness, and early childhood adversity [73, 74]. Other individual factors such as a low level of education, female gender, and personality traits have also been identified as increasing the risk of PTSD [73, 74]. One of the most important and modifiable risk factors is social support [75]. The extensive literature on risk factors for PTSD suggests that effective social support, including access to supportive family, friends and work colleagues, can lessen the risk of PTSD [73, 74].

Risk factors for experiencing homelessness

The body of research exploring risk factors for homelessness is not well developed, but there is growing consensus that many interrelated factors may contribute to homelessness [76]. At a macro level, risk factors include poverty, lack of affordable housing, poor education, and long-term unemployment. Familial factors may include family dysfunction (i.e., divorce, mental illness within the family, or conflict), family violence and sexual abuse, childhood institutionalisation, and poor family and social support [6, 77, 78]. Individual attributes such as mental health problems (including substance abuse), physical or mental disability, and coping ability, also play a key role. On a practical level, poor availability of low cost housing, the complexity of the housing system, and the failure of government and community services to provide an adequate safety net for individuals sliding into homelessness may also increase risk [79]. Social exclusion, a term used to refer to the complex compound of disadvantages which can act to marginalise a person in terms of their access to resources and their capacity to be involved in their community [18], also plays an important role. These streams of sequelae interact with each other, so it is not possible to identify a single cause of, or pathway to, homelessness for any individual.

Poverty has been identified as a core risk factor for homelessness, because welfare benefits and the typically insufficient wages provided by marginal jobs force people to rely on a limited pool of subsidised housing or else experience homelessness [77]. An Australian government report found that of couples with and without children seeking accommodation due to homelessness, most commonly cited eviction or being asked to leave their housing as the main reason for doing so [80]. Being unable to pay the rent is a primary cause of eviction, and risk factors associated with being unable to pay the rent include lack of education, lack of work skills, physical or mental disability, substance abuse, minority status, and sole support parent status [6, 77].

However, a US survey found that the most common reasons for homelessness reported by men and women living on the street were family related problems such as marital break-up, family care-givers becoming unwilling or unable to care for a mentally ill or substance abusing family member, escape from a dysfunctional family, or not having a family to turn to for support [78]. Similarly, in Australia, domestic and family violence is a major driver of homelessness, with escaping violence being the most common reason provided by people who seek help from specialist homelessness services [80]. Amongst Australian women who seek assistance from specialist homelessness services, domestic and family violence is the principal cause of homelessness. Fifty-five per cent of women with children and 37% of young single women seek help from specialist homelessness services to escape violence [80]. In a case-control study of female-headed families experiencing homelessness and female-headed housed families, mothers experiencing homelessness were more likely to have been abused as children, battered as adults, and have fragmented support networks [81].

In addition to suffering from disadvantage, many people who experience homelessness also experience social exclusion. Along with exclusion from housing or employment, they experience exclusion from the fabric of social life [18]. Social exclusion may be understood in terms of two forms: cultural exclusion, that is, inadequate social participation, lack of social integration and a need for social cohesion

and solidarity; and income inequality and material exclusion, that is, poverty or lack of material resources, with exclusion seen as a product of social inequality derived from economic inequality [18].

Childhood experiences of out-of-home care may increase the risk for homelessness as an adult. Two studies of homeless adults have found that over 15% had experienced out-of-home placement during childhood [82, 83]. A further study found that 46% of adults who experienced homelessness lived in a non-parental placement during childhood, with 20% having lived in an institutional or group placement [84]. However, these results must be treated with caution, given that non-homeless comparison groups were not included in these studies. It is known that young people who have spent many of their childhood years in statutory care face significant challenges when making the transition to independent living [85]. It is also widely recognised that there is a need for services to assist young people to make the transition to independent living following leaving care [86], to mitigate the risk of them experiencing homelessness.

At present however, it is not possible to discern from the literature the extent to which out-of-home placement, in and of itself, leads to increased risk for later homelessness. Factors that lead to out-of-home placement and the nature of the child's experience during out-of-home placement are likely to be of critical importance. In one of the only studies to specifically examine adverse childhood experiences as risk factors for adult homelessness, it was found that these experiences are powerful risk factors for adult homelessness [47]. Specifically, lack of care from a parent during childhood sharply increased the likelihood of subsequent homelessness, as did physical abuse. Perhaps surprisingly, sexual abuse in childhood was not found to have a significant impact in this study. The risk of subsequent homelessness among those who experienced both lack of care and either physical or sexual abuse was dramatically increased compared with people who reported neither of these adversities [47].

A substantial body of literature provides evidence that childhood experiences of physical or sexual assault, and inadequate parental care are also risk factors for negative psychiatric outcomes in adulthood [87-89]. Thus, early childhood adversity may contribute independently to homelessness and poor mental health, but there is also reason to believe that there is an interaction between the two, with each compounding the impact of the other [84, 90].

Risk factors for long-term homelessness

Very few longitudinal studies of people experiencing long-term homelessness have been published, meaning that the course of homelessness is poorly understood. In one of the only longitudinal studies to examine risk factors for long-term homelessness, Caton [91] interviewed newly homeless single adults admitted to New York City shelters at six month intervals, over a period of 18 months. A longer duration of homelessness was found to be related to older age, past or current unemployment, a lack of earned income, poorer coping skills, less adequate family support, a history of substance abuse, and an arrest history. The most important predictors were older age and arrest history.

Further understanding of the risk of experiencing long-term homelessness can be gleaned from studies of homeless onset in which people experiencing homelessness are contrasted with people who have never experienced housing loss. In a study where people experiencing homelessness were matched to a never-homeless sample, North et al [92] found that length of time spent being homeless was associated with symptoms of alcohol use disorder, schizophrenia, antisocial personality disorder, and age of drug use disorder onset. This study identifies how the characteristics of people experiencing homelessness differ from the characteristics of people who have extremely low incomes but manage to stay housed, and highlights the importance of mental health issues in this regard.

As discussed earlier in the section *Types of traumatic events experienced by those who also experience long-term homelessness*, homeless people, particularly those with mental health problems, are frequently assaulted. Physical assault of people experiencing homelessness has been found to have consequences beyond physical and emotional injury. Although there has been little longitudinal research on people experiencing homelessness, it appears that violent assault may prolong homelessness, even more so than factors such as an individual's level of social support [30]. The reason for this has not been established, but the previously described relationship between the experience of mental health problems and physical assault raises the possibility that the relationship between physical assault and prolonged homelessness may be mediated by mental health problems. This highlights the importance of a focus on mental health problems and the establishment of a safe environment in efforts to mitigate the risk of violent assault and prolonged homelessness.

In summary, a review of the risk factors for PTSD and homelessness has highlighted a complex interactive relationship between the variables that may contribute to both, independently and in combination. Potentially traumatic experiences, particularly in childhood, that are risk factors for the development of PTSD, are an important subset of the risk factors for homelessness that also include economic and social disadvantage. Furthermore, there is evidence that the combined experience of mental health problems and homelessness is associated with an increased risk of further trauma exposure (assault) and poorer housing outcomes in the longer term. However, there is insufficient research evidence at this stage to establish causal relationships between these variables.

What is the impact of trauma exposure and resulting mental health problems upon homelessness?

Exposure to traumatic stressors is prevalent among homeless people, and homelessness is often associated with trauma, substance use and physical or mental illness, however, the nature and direction of causality is not clear. It appears likely to vary for different individuals or sub-populations [93]. Unfortunately, very little is known about the antecedents and consequences of homelessness, particularly among men, including the role of trauma, substance abuse, and physical and mental illness. The sparse literature suggests that trauma, PTSD, substance abuse, and physical and mental illness often occur before, during and after periods of homelessness, but the causal pathways and nature of the relationships among these factors remain in need of systematic empirical study [58].

This is particularly relevant because exposure to traumatic events occurs frequently among homeless adults, and many of the risk factors for homelessness are risk factors for PTSD [39]. For example, as was discussed in the previous sections, people who experience homelessness have a far greater risk of being exposed to a traumatic event than a housed person. Adults who experience homelessness seem to be at higher risk for further traumatic stressors, especially assault, than their housed counterparts, but what role this and the associated PTSD play in long-term homelessness is unknown. It has been suggested that exposure to violence may increase the likelihood of long-term homelessness [34]. Lam and Rosenheck [30] found that recent assault negatively impacted on both duration of homelessness and quality of life, suggesting a critically important role for trauma-informed services that aims to minimise further trauma exposure as well as provide appropriate support.

Very few studies have investigated the relationship between PTSD and homelessness within the context of time (i.e., which occurs first), but there is some evidence to suggest that the development of PTSD commonly precedes the onset of homelessness. In a study conducted in the US, North and Smith found that of those with a lifetime history of PTSD, 71% of men and 74% of women developed PTSD before the year that they first became homeless [25]. Similarly, in an Australian study of homeless youth, trauma preceded homelessness in 50% of cases and was the precipitant for homelessness in 30% of cases [94]. In the only study to examine this issue with Australian adults experiencing homelessness, Taylor and Sharpe [20] found that in 83% of cases the first trauma occurred before the first homeless episode, and in another 4% of cases the first trauma and homelessness coincided.

Given the scarcity of research on the nature and direction of the impact of exposure to trauma upon the experience of homelessness, this is an area that is in need of attention. Since the experience of trauma may be a risk factor for homelessness, it is important that this relationship be better understood, so that steps can be taken to prevent the onset of homelessness in those who have experienced trauma. These issues are examined in stage IV of the THI (the quantitative study).

What are the barriers experienced by people who experience homelessness in receiving mental health interventions?

Many people who experience homelessness also have diagnoses of serious mental illness. In the general community, approximately two thirds of all people with mental illness do not receive treatment in any given year [95], and this proportion is likely to be far higher for those experiencing homelessness, who frequently report difficulties in accessing care [18]. Systemic barriers including deinstitutionalisation and the subsequent failure of the community mental healthcare system to respond to the multitude of needs of people with severe mental illness, the general inaccessibility of healthcare to people who experience homelessness, and the pressures of

extreme poverty – such as the necessity to obtain food over healthcare – have all been cited in the international literature as factors that contribute to the problem of experiencing homelessness and mental illness [67, 96-99].

Many efforts have been made to develop useful treatment programs and facilities for people who experience homelessness and mental illness. These services, however, are often not utilised to an extent that would be desirable. Studies have shown that people who experience homelessness report more psychiatric hospitalisations than their housed counterparts [51, 100]. The experience of trauma increases the need to access mental health services, and as we have previously discussed, the majority of people who experience homelessness have also experienced trauma. However, despite high levels of need, many homeless people do not receive adequate or appropriate physical [101] or mental health care [102].

Researchers have defined various types of barriers (e.g., financial, bureaucratic, programmatic and personal) and their potential impact on the extent of service usage for people experiencing homelessness [103]. Mental health service-seeking among those experiencing homelessness tends to be related to their level of need [104], education, residential stability, and having a usual place to sleep [105].

Some barriers come from service providers who are reluctant to treat clients experiencing homelessness [106, 107]. Some of the reasons that service providers are reluctant to treat these clients include, feeling overwhelmed by the clinical problems, being unprepared to deal with social and economic needs, and feeling too demoralised to pursue what they perceive as improbable goals or "lost causes" [106]. Many people experiencing homelessness have not traditionally been well cared for and may be reluctant to engage in services. As such, further barriers may come from the people themselves, who are distrustful about the providers and authorities [108]. Simple practical problems can hamper efforts to engage with mental health services. For example, the lack of transportation to treatment and the cost of using public transport can prevent people from engaging with services [18, 109]. For people who live in remote areas, there is often a lack of services, which can result in feelings of isolation and inadequate support [18]. Little is known however, about the barriers to specific kinds of care and the individualised ways in which interventions can target those barriers to promote preventative and regular service utilisation [110]. In a study which examined barriers to mental healthcare, stigma was found to be the most important barrier, with those reporting the highest level of psychiatric symptoms also more likely to report perceived stigma and fear of social rejection [111]. Interestingly, over half of the respondents in this study reported that they could solve their mental health problems on their own. Importantly, this study did not involve people experiencing homelessness, and the findings may not generalise to this group.

While individuals who experience long-term homelessness have high rates of emergency service utilisation, they are generally unable to access and engage in ongoing outpatient treatment for mental illness, chronic health conditions and substance use disorders. A study by Fortney [112] found that people experiencing homelessness with mental illness are less likely than other mental health consumers to experience continuity of care. This was measured by longer duration between encounters for mental health services, lower volume of service encounters, fewer types of services received, lower likelihood of receiving continuous care from the same facility/provider, and lower likelihood of having a case manager. The authors note that low continuity of outpatient care over time puts people who experience homelessness and mental health problems at risk for encounters with other elements of the service system such as hospitals and emergency departments which are less likely to meet their needs, as well as placing them at risk for encounters with the criminal justice system [112].

These findings are consistent with other studies which have documented inefficient patterns of service utilisation among people experiencing homelessness and mental health problems – more days of acute psychiatric hospitalisation, greater utilisation of services in the psychiatric emergency units of hospitals, and more infrequent use of outpatient mental health services [51, 113, 114]. In one examination of an outreach program for homeless mentally ill veterans, only 24% were still in contact with services after three months [115]. In another study, 40% of a sample of people experiencing homelessness with a dual diagnosis of mental health problems and substance use disorder failed to commit to at least one day of treatment [116]. Individuals experiencing homelessness are also more likely to cycle in and out of emergency and residential substance abuse treatment services and often find it difficult to maintain participation in outpatient settings [79]. People experiencing homelessness who participate in substance abuse treatment services are more likely than other participants to have had multiple episodes prior to the current treatment episode [117]. Individuals who enter substance abuse treatment programs are often unable or unwilling to complete the program. Studies of a range of treatment interventions have found that only about one-fourth

[118] to one-third [119] of participants complete substance abuse treatment programs, even when the programs are specifically designed for homeless people with serious substance use problems.

Difficult client behaviour associated with client conditions can sometimes hamper efforts by workers to engage clients in treatment and promote recovery. For example, behaviours associated with active substance use were seen as difficult to manage in a review of services designed to serve individuals with co-occurring disorders as they transition to permanent supported housing [120]. The time needed for change to occur was cited as another barrier, with staff reporting that they needed more time and patience than they had expected, in order to build trust and address clients' myriad of issues. In some cases, clients were unable to acknowledge that they had mental health problems, and required months of relationship building and education before accepting any form of counselling or treatment. Lack of agreement or insight into mental illness issues, a lack of awareness of available services, and a reluctance to access services due to past negative experiences, are all common barriers to receiving treatment for mental illness [121].

By developing a better understanding of, and addressing these barriers to mental health care, it may be possible to develop strategies for improving mental health services for this population. These issues are therefore examined in more detail in stage III of the THI (the qualitative study).

Working with people experiencing homelessness: A trauma-informed practice model

Research shows that people who experience homelessness experience high rates of exposure to traumatic events that occur prior to, and after losing, secure accommodation. Currently, few programs serving individuals experiencing homelessness directly address the specialised needs of trauma survivors [122]. However, in an effort to respond to the needs of those who have experienced trauma, some programs that service clients who experience homelessness are developing trauma-informed services. These services recognise the significance of violence and trauma exposure in understanding client problems. The critical need to deliver services that are trauma-informed has been recently recognised [5, 123, 124], however the wider adoption across the Australian homelessness service is still in its infancy [125].

Trauma-informed care (TIC)

At a minimum, trauma-informed services aim to provide an increased sense of safety, and strive to avoid any re-traumatisation of their service users [3]. In the past, the nature of trauma-informed care (TIC) was ill-defined. Recently, however, in a seminal peer-reviewed article by Hopper, Bassuk and Oliver [122], a consensus-based definition of TIC within homelessness service settings was developed:

> *Trauma-informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment ([122], p.82).*

Within the practice literature, being trauma-informed requires that the whole approach to service delivery is aware of the trauma history an individual presents with. The themes encompassed by this consensus based definition can be broken down into some greater detail. The key themes include:

- **Trauma awareness:** Trauma-informed service providers incorporate an understanding of trauma into their work. This may mean that it is necessary to alter staff perspectives on how to understand various symptoms and behaviours. This can occur through *staff training, consultation,* and *supervision*. Organisational changes may also be made, such as routine screening for histories of trauma and assessment of safety. The self-care of staff is also an essential element of trauma-informed services [122].
- **Emphasis on safety:** Trauma survivors can feel unsafe and at times may actually be in danger (e.g., victims of domestic violence), therefore TIC works towards building *physical and emotional safety* for both *service users and providers*. Because interpersonal trauma often involves boundary violations and abuse of power, systems must be developed that take into account trauma dynamics, and *clear roles, responsibilities and boundaries* must be delineated. *Privacy, confidentiality and mutual respect* must be maintained to develop an emotionally safe atmosphere, and *cultural differences and diversity* (e.g., gender, ethnicity, sexual orientation) must be respected [122].
- **Opportunities to rebuild control:** Control is often taken away in traumatic situations, and homelessness itself is disempowering, therefore TIC emphasises the *importance of choice* for service users. Trauma-informed services create *predictable environments* and allow individuals to rebuild a sense of *efficacy and personal control*

over their lives. This includes involving service users in the design and evaluation of services [122].

- **Strengths-based approach:** Finally, TIC is *strengths-based*, rather than deficit-orientated. Individuals are assisted by the service in identifying their own strengths and developing their own coping skills. TIC service settings are *focussed on the future* and utilise *skills-building* to further develop resiliency [122].

The scientific evidence related to TIC

A small number of studies have examined TIC in relation to psychiatric symptoms and substance use, which provide evidence on the *outcomes* for TIC [e.g., 126]. A meta-analysis of a nine-site quasi-experimental study of comprehensive trauma-informed and consumer-involved service for women with mental health problems [127], found that sites which provided more integrated counselling produced more favourable results for mental health symptoms six months post-program. Early indications also suggest that TIC may have a positive effect on housing stability. A multi-site descriptive evaluation of trauma-informed services for homeless families found that almost 90% of participants had either remained in government subsidised housing or moved to permanent housing [128] 18 months after engaging with the program. Although this research suggests that TIC may be effective for those who experience homelessness, there have yet to be any rigorous quantitative studies exploring outcomes within homelessness service settings [122].

From this review of both quantitative and qualitative studies, there is evidence to suggest TIC is generally viewed favourably by service users and providers and there is some evidence linking it to more effective outcomes across several areas including increased rates of housing stability [122]. There are, however, significant gaps in current knowledge for homelessness-specific models and further research is necessary to examine its effectiveness [122].

Corroborative evidence related to TIC

Due to the fact that the area of TIC is still in its infancy, a review of the grey literature in this area yields a wealth of information about current practices and policy initiatives. Many of the models of TIC that are currently in use in the "real-world" emphasise staff education, involving consumers and transforming systems to be responsive to the needs of trauma survivors, for example, A Long Journey Home [129] and Phoenix Rising [130]. Organisational self-assessments can be a starting point for system change, indicating how a service delivery model might be adapted to an organisation's unique needs. A number of trauma-informed organisational self-assessments are currently available including the 'Trauma-informed Organisational Self-Assessment for Programs Serving Homeless Families' [131], and the 'Trauma-Informed Facility Assessment' [132]. The development of these models and self-assessment tools has facilitated the development of a number of TIC programs within the homelessness service system in the US [122].

Given that the majority of people who experience homelessness have also experienced trauma, it is of critical importance to provide a service response that is trauma-informed. There is currently a scarcity of rigorous research in the area of TIC, however this is an area that shows great promise. Future research investigating attitudes, implementation and outcomes of TIC will shed light on this under-researched area.

Discussion

In this review, the literature on the nature of the relationship between traumatic events in people's lives and homelessness, and the literature on service issues such as barriers to care and trauma-informed care, have both been examined. The content of this review was used to assist in the development of a series of research projects that investigated the nature of the relationship between traumatic events in people's lives and their state of homelessness. It also assisted in the development of a trauma and homelessness service framework that will guide practice and service delivery of agencies who work with people who are homeless. The results of the studies are presented in the following sections.

STAGE II: SERVICE USER QUALITATIVE INTERVIEWS

Introduction

The aim of this qualitative study was to investigate the relationship between a history of homelessness, exposure to traumatic experiences, and mental health. The results of this study informed the design of the larger quantitative investigation of the experience of trauma in people experiencing homelessness.

The study involved gathering information from participants from the four agencies to understand their history of homelessness, exposure to traumatic experiences, mental health issues, treatment and support. Through qualitative interviews, the researchers sought to explore the types of traumatic events participants had experienced, the prevalence of exposure to Type II trauma, the emotional, psychological and social experiences of these participants, and the impact these experiences had on individuals.

Method

Qualitative interview

General background

Participants were asked several background questions which covered age, gender, marital status, income/financial support, and whether the participant had children or not.

Current and past accommodation

Participants were also asked a series of open-ended questions about their current and past accommodation situations. They were asked to describe their current living situation and their past accommodation experiences (including the experience of being homeless), their perceptions of what needed to happen for them to be able to get/maintain long-term housing, and what it meant to them to be identified as someone who has experienced homelessness.

Trauma experiences

Participants were asked to look at a list of traumatic events [133] and note which of the events (if any) had either happened to them, or had been witnessed by them. They were also asked to describe the impact of these events on their lives now.

Mental health issues

Participants were asked a number of open-ended questions about several mental health issues that can follow trauma and may drive long-term psychological and social difficulties. The constructs we were investigating were emotional regulation difficulties, difficulty maintaining social relationships, dissociation, risk taking and putting self in danger, and negative views of self and world.

Emotional regulation difficulties: Participants were asked whether they have had intense emotions or feelings that were hard to manage. They were asked to identify which emotions were particularly difficult to regulate. Those who had experienced these difficulties were asked to comment on how this had impacted on their life.

Difficulty maintaining social relationships: Participants were asked how they felt about their relationships.

Dissociation: Participants were asked whether there had been times when they felt like they were not really part of what was happening around them, for example, blanking out, or feeling like they were in a dream. Those who had experienced this were asked to describe their experiences and how they had impacted on their life.

Risk taking and putting self in danger: Participants were asked whether they had put themselves or others in dangerous situations without necessarily realising it. If they responded affirmatively to this question they were asked to describe these experiences.

Perceptions of self: Participants were asked to describe how they felt about themselves.

Perceptions of the world: Participants were asked about their views of the world and their future.

General health: Participants were asked to describe their physical health.

Treatment and support

Past experiences with treatment and support were assessed with a series of questions. Participants were asked if they had ever been assessed by a doctor or a psychologist for a mental health issue, and those who had were asked what kind of mental health issue the doctor or psychologist said that they had. Participants were asked whether a mental health issue(s) had impacted on their housing, and if so, how it impacted. They were also asked whether they had ever wanted to get some professional help for a mental health issue, but then did not end up getting help. If this had occurred, they were asked to describe this. This question tapped into the construct of barriers to care.

Procedure

The study was approved by the University of Melbourne Human Research Ethics Committee. Potential participants who were eligible for the study were identified by case/support workers at each agency. Each agency was asked to identify at least five service users, with the aim of achieving a total of 20 participants in the study. Agencies were requested to identify service users who had experienced enduring or persistent homelessness, which included people with repeated experiences of unstable housing. Where agencies found it difficult to identify someone who had experienced long-term homelessness, those who were vulnerable to repeated episodes of homelessness were included. Vulnerability to homelessness included factors such as having a mental health difficulty, an acquired brain injury or psychological disability, where the condition had a detrimental impact on the capacity to maintain housing. Service users were required to be over the age of 18 years.

The interviewer spent time at each agency to facilitate familiarity with the service users and to allow time for questions about the research project. Participants were seen in a quiet location at each service. Information about the research was provided by a Plain Language Statement and their agency contact worker. Consent from each participant was obtained prior to the commencement of the interview. In recognition of the potential distress associated with the interview, after each interview the researcher provided feedback to the team leader. The scope of this feedback was limited to how the participant coped with the interview. The content of the interview was not discussed. Each participant received $20 (either in the form of a food voucher or cash, depending on the policy of each agency) in recognition of the time taken to complete the interview.

Data analysis

Open questions were analysed using a Thematic Analysis methodology. To complete the thematic analysis, responses were reviewed by two members of the research team. Responses to each question were grouped into initial themes in order to categorise the data [134]. These initial themes were reviewed and, where appropriate, one theme was subsumed into another, or themes were combined to form a new theme. At the completion of the thematic analysis the research team met to confirm agreement about the themes that were identified [135], and to identify quotes that exemplified each theme [134].

Closed questions were analysed using descriptives and frequencies procedures, using the IBM SPSS Statistical Software package [136].

For the purpose of this report, Type II trauma was defined as the instance where a participant identified: (a) suffering or witnessing interpersonal trauma before the age of 16; (b) that the perpetrator was a caregiver; and (c) that the traumatic event was prolonged and repetitive, as defined as occurring on five or more occasions. As Type II trauma may also occur for persons who were exposed to wartime environments as civilians, Type II trauma was also defined as occurring in adulthood if the exposure was prolonged and repetitive, and of an interpersonal nature, such as torture and kidnapping.

Findings

In the section below, the key findings from the service user qualitative interviews are summarised.

General background

A total of 20 participants was interviewed for the study. The sample comprised 11 males (55%) and nine females (45%), with an average age of 42.35 years (range 22 to 61). Participants described their marital status as single (n=13, 65%), separated or divorced (n=6, 30%), or widowed (n=1, 5%). Nine participants (45%) reported having children (an average of 2.11 children each), with none of the children currently under the care of the participant. When asked to describe the source of any income or financial support that they received, 14 participants reported being on a disability support pension (70%), six received Newstart Allowance (30%), and one reported sex work (5%) (in addition to disability support pension).

Current and past accommodation

Participants identified living in a range of accommodation, including: supported accommodation (n=6, 30%); public housing (n=5, 25%); traditional housing (n=3, 15%); community housing (n=3, 15%); rooming house (n=1, 5%); van (n=1, 5%); and in a hotel (n=1, 5%). On average, participants had been in their current living situation for 20 months.

Participants were asked how long they thought that they would be in their current housing situation. The most common response was, the *"hope that the current accommodation would be permanent"* (n=11, 55%), followed by, "I don't know" (n=4, 20%), and *"less than six months"* (n=3, 15%).

Participants reported first experiencing homelessness in the range from birth to 50 years of age (average first experience at 17.2 years of age). They reported that on average they had experienced difficulty finding somewhere to live for an aggregate of 256 months or 21.3 years of their life. Fifteen (75%) participants reported having previously had secure housing at some time during their life.

Meaning of homelessness

Participants were asked to identify what homelessness meant to them. Two themes were identified from their responses. The first theme was a **practical, definitional response** (n=10, 50%). Examples of these responses included:

- *"not having somewhere to live"*
- *"not having a roof over your head"*
- *"lack of stable accommodation".*

The second theme concerned the **consequence of being homeless** (n=12, 60%). These consequences impacted participants in both physical and emotional domains. Physical consequences included food and safety, and an example is:

- *"You think to yourself, what are you going to do next, how are you going to survive?"*

Emotional consequences were predominantly negative, such as anger and feelings of helplessness:

- *"I'm not necessarily angry towards people, I'm just angry towards the situation, you know, the injustice of it all … and that makes me anxious too, when I go out to meet people, or talk to people, ... the using [heroin] helps … but, people judge me, then the drugs come into it …"*
- *"… you feel helpless, you know, it's a feature for me, you know, yeah … can't get things done."*

One service user reported the benefit of freedom:

- *"It was a little bit hard some of the time, but a lot of the time is was really good, 'cause I felt really free, I had a lot of freedom, fresh air and space, you know, and that makes me feel good."*

Housing in the long term

Participants were asked about what needed to happen for them to be housed in the long term. Responses to this question fell into two main themes. The first theme concerned **changes that needed to occur that were external to the participant**. These included the need to find employment (n=7, 35%), the need to find suitable housing (n=7, 35%), and the need for increased financial support (n=5, 25%).

Issues of employment centred around finding employment. For example:

- *"We need increased programs implemented by the government, we need employers that will be patient and apply compassion and understanding."*

Suitable housing concerned the view that there was not accommodation available that could be accessed. For example:

- *"We need more houses to be built. Basically, Melbourne runs at occupancy [implied meaning, "vacancy"] rate of 2% which is the lowest in the western world."*

Financial support concerned not only the lack of money, but the difficulty participants found in managing their finances. For example:

- *"Now I have my rent taken out direct debit, so I've got all that sorted out. I don't have to worry about that … to get gas and electricity direct debited it makes a big difference, so then you don't, you get your pay and you don't have to worry about it … you don't have to manage the bills and you don't have to worry about where you are going to get the rent money from because it's already been deducted."*

The second theme concerned **internal changes** (n=7, 35%). These changes referred to personal changes in behaviours that would be required to maintain long-term housing.

- *"… as long as my [grown] kids don't ruin it for me … I'm doing a course, it's called 'who's the boss - parenting difficult teenagers', because my daughter's found herself using Ice, got herself into a heap of trouble and she's got a warrant out for her arrest, she's got all these different things, so goes back to court tomorrow, so there's that issue that I need to get a hold of…"*

Events that led to first experience of homelessness

Participants were asked about the events that led to their first experience of homelessness. They reported a range of circumstances, which were categorised under four themes: **childhood trauma** (n=8, 40%), **disintegration or absence of the family unit** (n=6, 30%), **mental health issues** (n=4, 20%), and **accumulation of stressful life events** (n=3, 15%).

Childhood trauma included events such as child sexual abuse or being involved in an incident which led to severe injury or the death of another. Homelessness in these situations occurred as a consequence of trying to escape these situations.

- *"I was being sexually and physically abused, in foster homes, you know, these things I've been seeing lately with the Brotherhood things, what is it? Boystown, ... I went through all of that."*

Disintegration or absence of the family unit included a parent moving out of home, caregiver relationship break-ups, being abandoned by a primary caregiver, being born into a family of substance users, and being born into homelessness.

- *"Simply because … my biological mother lived four streets away with my other two brothers and my youngest, older sister, … and I couldn't work out why they were living with my biological mother and I wasn't, so I ran away [from uncle and aunt's – called Mum and Dad]."*

Mental health issues included a psychotic episode or an undefined mental health breakdown. Homelessness occurred in these situations because the individual was too unwell to maintain the accommodation environment. For many people, admission to psychiatric care caused problems with maintaining accommodation.

- *"… yeah, I kept going in and out of hospital, in the psych wards and stuff, I've been in and out of hospital stacks of times, then me(sic) ankles, then me asthma again…" ("Then that would stuff up your housing?") "Yeah."*

Accumulation of stressful life events referred to when the participant could not recall a specific trigger, but recalled a series of stressful life events that preceded homelessness. Most commonly, a series of events occurred, often in relatively quick succession, which exceeded the participant's ability to cope and drove them to homelessness.

- *"At the time I was working … my marriage had broken down, that devastated me more than anything else … and I just ended up putting my social life, like wellbeing, everything into my job... Then [the daughter of the personal care client, where the participant worked] moved in and she was on heroin … that was all chaotic … it just got to the stage where I mentally broke down [and left her job and accommodation]."*

Difficulties in finding somewhere permanent to live

Participants were asked about what made it hard for them to find somewhere permanent to live. Three themes were identified: **employment** (n=3, 15%), **housing affordability and availability** (n=4, 20%), and **personal experiences and attitudes of others** (n=15, 75%).

Employment included difficulties in finding appropriate employment that suited the participant's skills or abilities. For example:

- *"I was recently put into a warehousing situation and after four hours I was deemed not to be up to speed and kicked out the door, so I mean that, we need those sorts of things."*

Housing affordability and availability included difficulties in finding rental properties that were affordable, and a lack of government and community housing. For example:

- *"It was just hard to find somewhere to live and it's hard to find help to find somewhere to live... I didn't have money, I wasn't working, so I didn't have money to get private rental, and there was just no [affordable] housing available, yeah, there just wasn't any help."*

Personal experiences and attitudes of others included being used to being homeless, and being socially excluded. For example:

- *"Well, obviously my situation, being unemployed and having a sarcastic and cynical outlook on life…"*
- *"We've got real estate agents that don't look at us, you know, if we put in applications and we are up against a doctor, for instance."*

What helped to staying in secure housing

Participants were asked about what helped them to stay in secure housing in the past. The clearest theme to emerge was **the family unit** (n=13, 65%), followed by **employment** (n=3, 15%).

Family unit referred to either having an adult caregiver who took responsibility for the participant as a minor, or the participant having their own family responsibilities (i.e., children and/or a partner).

- *"Yeah, children, family unity, that's what it was, that was the stableness of our lives."*

Employment was identified as an important contributor to previous experiences of permanent housing, both in terms of having permanent work, and in terms of being able to work, or having the capacity to do what was required.

- *"Well in the past I had work, or my business. I also had a partner, so we were able to share cost which was a big thing."*

What got in the way of staying in secure housing

Participants were also asked about what had got in the way of staying in secure housing in the past. Four key themes were identified: **disintegration of the family** (n=7, 35%), **problematic interpersonal relationships** (n=5, 25%), **drug use** (n=3, 15%), and **psychological difficulties** (n=3, 15%).

Disintegration or absence of the family unit included a parent moving out of home, caregiver relationship break-ups, being abandoned by a primary caregiver, being born into a family of substance users, and being born into homelessness.

- *"My mum died of alcohol poisoning when I was nine, and I was sent to the boys' home. I went home for a bit, but Dad kicked me out when I was 14."*

Problematic interpersonal relationships included problematic intimate relationships, share accommodation relationships, and relationships with neighbours.

- *"No money, nowhere to stay, no friends, family can't help you, type thing … stayed at Mum's for about a year, but I wanted to leave, we started fighting and stuff."*
- *"I lived in my girlfriend's for 5 months prior to that and we broke up and I had to get out so I ended up [in emergency accommodation]."*

Drug and alcohol use referred to the need to obtain and use substances, subsuming any other responsibility (i.e., drugs were the priority). This meant that money was spent on substances, rather than being spent on rent or other housing costs.

- *"When I was living in the city in a squat, I could just go and get money from [family member] for food and somewhere to stay, but of course I didn't spend any of it on that of course [it all went on heroin]."*

Mental health issues included experiencing a psychotic episode or an undefined mental health breakdown. Participants were unable to stay in secure housing because they were too unwell to maintain the accommodation. For many people, admission to psychiatric care caused problems with maintaining accommodation.

- *"Well, a lot of it was psychological, with the very bad year I had."*

Traumatic experiences

All 20 participants reported experiencing at least one traumatic event in their lifetime, with 16 (80%) seeking assistance for dealing with these experiences. Of those who sought assistance (n=16), they most commonly visited a GP (n=12 out of the16 people who sought assistance, 75%) or a support/case worker (n=12, 75%), followed by a psychologist (n= 8, 50%), a psychiatrist (n=6, 37.5%), or a counsellor (n=5, 31%). Furthermore, some participants who sought assistance accessed drug and alcohol counselling (n=4 out of 16, 25%), some visited Centres Against Sexual Assault (CASA) (n=2, 12.5%), one (6%) sought professional assistance to reconnect with family, and one (6%) tried a parenting support group. Six participants (37.5%) who sought help described the assistance that they received as beneficial, while three participants reported having had a mixed experience, with some help that they had received being perceived as helpful, while other help that they had received was perceived as unhelpful.

For those that found the professional assistance beneficial, examples of responses included:

- *"Talking changed me altogether."*
- *"Got therapy and it helped me to learn about me."*

For those that found the professional assistance unhelpful, an example response was:

- *"No one could understand."*

Table 1 lists the frequency with which participants experienced given traumatic events. The table also lists the mean age at which participants either experienced or witnessed a traumatic event, and the mean number of times the event occurred to the entire sample of participants.

For some participants, the number of times they experienced or witnessed an event was too high to count. The number of service users who reported that they had experienced or witnessed an event too many times to count is provided in the final column.

Table 1. Trauma events experienced or witnessed by service users (n=20).

Event	Happened to me (n, %)	Witness event (n, %)	Age first occurred (Mean)	How often (mean number of times)	Too many to count (n, %)
Direct combat experience in a war	0	0	n/a	n/a	n/a
Direct experience in a war, as a civilian	2 (10%)	3 (15%)	2.5	2.0	1 (5%)
Life-threatening accident	12 (60%)	9 (45%)	16.4	10.4	1 (5%)
Fire, flood or natural disaster	11 (55%)	0	13.5	2.5	1 (5%)
Witnessed someone being badly injured or killed	n/a	17 (85%)	14.2	6.9	3 (15%)
Rape	9 (45%)	3 (15%)	18.3	2.5	4 (20%)
Sexual molestation	9 (45%)	2 (10%)	18.7	3.0	3 (15%)
Physical assault	14 (70%)	12 (60%)	18.2	16.7	7 (35%)
Threatened with a weapon, held captive or kidnapped	15 (75%)	11 (55%)	21.3	3.1	6 (30%)
Tortured or the victim of terrorism	5 (25%)	3 (15%)	23.0	3.0	4 (20%)
Suffered a great shock because one of the events on the list happened to someone close to you	17 (85%)	n/a	19.9	5.6	1 (5%)
Any other extremely stressful or upsetting event	13 (65%)	6 (30%)	25.1	1.1	2 (10%)
Childhood events (used to identify Type II trauma)					
Childhood physical assault	13 (65%)	9 (45%)	6.9	9.7	8 (40%)
Childhood sexual molestation	10 (50%)	4 (20%)	8.7	3.6	5 (25%)
Childhood rape	10 (50%)	3 (15%)	9.2	2.0	5 (25%)
Tortured or the victim of terrorism as a child	5 (25%)	4 (20%)	5.8	6.0	4 (20%)
Threatened with a weapon, held captive or kidnapped as a child	10 (50%)	6 (30%)	9.4	5.1	4 (20%)

Note: Childhood was defined as occurring before age 16 years.

Type I and Type II trauma

Applying the above criteria, it was found that 15 participants (75%) reported a personal history that included the experience of Type II trauma, while 100% (n=20) of participants had experienced Type I trauma.

When participants were asked about how the traumatic events that they had experienced had impacted on their life, the areas that were impacted were, mental health (n=8, 40%), physical health (n=2, 10%), relationships (8, 40%), and personal risk (i.e., drug and alcohol use) (n=3, 15%).

Mental health issues

Emotion regulation issues

Participants were asked whether they have had really strong emotions or feelings that were hard to manage.

In response to this question, service users reported: feeling down or hopeless (n=20, 100%), anger (n=16, 80%), anxiety (n=18, 90%), experiencing panic attacks (n=15, 75%), hypervigilance (n=14, 70%), and strong cravings or urges (n=15, 75%).

When participants were asked about how the emotional regulation difficulties impacted on their

lives, four themes emerged: **no perceived impact** (n=8, 40%), **perceptions of being unable to cope** (n=5, 25%), **interpersonal and relationship difficulties** (n=5, 25%), and **impulsive, illegal and dangerous behaviours** (n=3, 15%).

No perceived impact referred to when the participants identified the experience of emotional regulation difficulties, but could not identify an impact on their life. Examples include:

- *"They don't [affect me], I just go for a walk, read, think of my kids. At times I have been suicidal, I want my kids back."*

Perceptions of being unable to cope included identifying reduced feelings of self-worth and being overwhelmed.

- *"Sometimes I think I'm not going to make it, things are never going to get better."*

Interpersonal and relationship difficulties referred to a common experience of conflict with people either known or unknown to the participant.

- *"I'm always thinking, I can't handle these people, I can't trust these people. My biggest enemy is myself."*

Impulsive and risk taking behaviours referred to behaviours that were impulsive or dangerous, such as substance use, or sexual risk. Examples include:

- *"I can't give up heroin, and that ruins everything."*
- *"The risky sexual stuff and the substance abuse are sort of interconnected, but the sexual stuff bothers me the most. I have to avoid those people."*

Dissociation

Two participants (10%) reported having dissociative experiences. For example:

- *"Oh yeah! It's like my head is not even connected to my body, it's like I'm here, or my body's here, but I'm over there, completely disconnected … like I'm behind a pane of glass watching everything. The first time I ever felt anything like that and could identify it as that was when I was 13 [age indicated as when participant was first raped]." ("And how often does that happen?") "It depends on what I'm going through at the time. Sometimes it's just a constant state and I can't break out of it, sometimes it's … I only get like that a few times a week, but it's a pretty constant thing."*

When the two participants who had experienced dissociation were asked about how this had impacted on their lives, one replied that it had not happened very often:

- *"…dissociation has only happened on a few occasions recently, in the past few years."*

The other participant said that the dissociation made it hard to connect with other people:

- *"It makes it really hard to connect with people, might lead me to doing some pretty stupid things."*

Difficult social relationships

Most service users described difficulty maintaining relationships (n=18, 90%). When those who said that they had difficulties were asked about what made their relationships difficult, four themes emerged: **trust** (n=9 out of the 18 people who reported difficulty maintaining their relationships, 50%), **nothing to offer** (n=4, 22%), **no perceived impact** (n=3, 16%), and **poor communication skills** (n=1, 6%).

Trust included the common experience identified by participants where they did not feel that they could trust people, believing they would be deceived and hurt by them.

- *"I'm not interested in relationships. I like my own company. I don't like being touched. I don't like people touching me at all."*
- *"I don't trust anyone … I feel like there's just no point, because they're just going to hurt me anyway."*

Nothing to offer included participants feeling like they did not have anything of value that they could bring to a relationship, which was often associated with past relationship failures. Examples include:

- *"Yeah, well, yeah, I do understand relationships, but I … it's just so hard being with somebody who's had a really wonderful life, you know, and I just don't want to drag them down."*

No perceived impact referred to when the participants identified the experience of social difficulties, but could not identify how it impacted on their life.

- *"There are good things that happen, like my kids, I don't care about the kids' dads."*

Poor communication skills was drawn from participants describing that they could not understand their feelings or issues themselves, and had particular difficulty in articulating how they were feeling, or the issues that they were having, to their partners. This caused lots of misunderstanding, confusion and conflict within the relationship. Examples include:

- *"Yeah, yeah … because they get frustrated with me and I don't know why, I don't realise that I'm angry, or I'm upset ... lack of empathy as well, I don't really care that that's how I affect them."*

Views of self

The most common theme to occur was **negative views of self** (n=11 out of the 14 respondents, 78%), followed by **self as a survivor** (n=3, 22%), with six participants unable to provide a response to this question.

Negative view of self referred to thoughts or beliefs about the self that were critical or harsh. Examples include:

- *"Yeah, I sometimes see myself in a negative way, that's only the negativity of the old man [father] popping up: 'you're nothing, you've still got nothing'."*
- *"Yeah, sometimes when I'm belting myself up I say I'm not smart enough."*

Self as a survivor referred to examples where the participant identified past struggles but recognised their own strength.

- *"No, I know how to lift my spirits up [after talking about depression and suicide attempts]."*
- *"I can survive anything [after talking about being haunted by past]."*

World view

The most common themes to occur were **seeing the world as a dangerous place** (n= 6 out of the 14 respondents, 43%), and **there is good in the world** (n=8, , 57%), with six participants unable to provide a response to this question.

Seeing the world as a dangerous place was inclusive of a lack of trust of people in general (n=2), and feeling that the world is doomed or there is no future (n=4).

- *"The world is a very dangerous place, but I feel like I can handle it. There are just so many ugly people out there."*
- *"I see the world as being a dangerous place … I just see so, so much negativity in the world lately, just with a lot of things, you know, I just feel that way; 'damned if I do, damned it I don't', and I don't even like going to doctors, putting my life in doctors' hands now."*

There is good in the world was a theme that came through for people who had a belief system in place, with the majority of people having religious beliefs.

- *"I suppose the most important thing is, I'm lucky to be alive, that was my philosophy … I've always been a positive person, but not this positive, you know, that it will take me into the future."*

Risk taking and putting self in danger

Participants were asked about whether they had ever put themselves or others in a dangerous situation, possibly without even realising it. Participants reported having the following types of experiences: risky substance use (n=16, 80%), interpersonal risk (n=15, 75%), self-harm/suicide attempt (n=13, 65%), risk of physical harm (n=13, 65%), and risk of sexual harm (n=9, 45%).

Physical health

Responses fell into two main themes: **good or OK** (n=8, 40%), or **poor to very poor** (n=12, 60%).

Treatment and support

The service users were asked if they had ever been assessed by a doctor or a psychologist for a mental health issue, and 16 (80%) service users reported that they had. Fifteen (94%) of those assessed were diagnosed with a mental health disorder. This group of participants (n=15) received diagnoses that fit into the following categories: anxiety disorders (n=5, 33%), depressive disorders (n=5, 33%), bipolar disorder (n=7, 47%), schizophrenic disorders (n=4, 27%), and PTSD (n=3, 20%). Of those diagnosed with a mental health disorder, 14 (93%) believe it has impacted their housing situation through factors such as an inability to work and discrimination (i.e., people not wanting to house or employ someone with mental health problems).

Twelve service users (60%) reported that there had been a time when they did not get professional help for a mental health issue, despite wanting to do so. Examples of the reasons for this included:

- *"I had a terrible experience with a psychiatrist who yelled at me."*
- *"I just didn't care enough about myself."*
- *"I don't want to be judged or medicated."*

Discussion

The aim of this study was to gather information from participants to identify whether the domains that were identified in the literature review stage of this project were relevant to service users from the four agencies involved in this project. In particular, we wanted to identify the prevalence of traumatic experiences within this sample, and whether emotional constructs identified in the literature review were relevant to this group.

Traumatic events were experienced often by this group of participants. In addition to high levels of

Type I trauma, Type II trauma occurred frequently. While we cannot extrapolate prevalence rates to the wider homeless population (because of generalisability limitations described below), this study confirmed that it would be useful to assess both types of trauma types in the quantitative study.

Similarly, most of the emotional constructs explored by this study were relevant to this sample. This was particularly the case with emotional regulation difficulties, difficulty with social relationships, views about self and the world, and risk taking behaviours. We therefore assessed these constructs further in the quantitative study.

The construct of dissociation, however, did seem to elicit results that were unexpected. The research literature has identified that high levels of dissociation are frequently reported in populations with high levels of trauma exposure, especially Type II exposure. In this current study, dissociation was rarely reported. This may be due to the fact that the question was not clear enough (and therefore participants did not understand the type of experience we were asking about), or it may have been due to an issue with how we scored participants' responses to the question. It seemed that we were only able to detect people who had experienced severe dissociation, but not report on people who had experienced moderate or mild dissociation. Therefore, we used this information to inform the design of the quantitative study, and found dissociation questions that were clearer to participants.

Overall, the participants coped with the qualitative interviews very well, and without much distress. In addition, the practices that were put in place to ensure the wellbeing of both the participant and the researcher worked well.

It is important to note that the primary purpose of the study was to inform the larger, quantitative study. As such, there are characteristics about this study that will impact on the generalisability of the findings. Specifically, participants who were recruited to the study were identified by staff in each agency, and therefore the sample may not be representative of the larger population of service users for each agency. For example, most of the sample was in stable accommodation (although they had experienced long-term homelessness). Thus, study findings such as prevalence of trauma exposure, including Type II trauma, cannot be generalised to the larger population of service users. Furthermore, the methodology we used for the thematic analyses tends to allow for more subjectivity in interpreting results than would a quantitative designed study. Although we tried to minimise this by having two raters, there was still some degree of subjectivity to identifying key themes.

In conclusion, the findings from this study have helped to refine the focus of the various constructs proposed from the literature review to be explored in the larger quantitative study.

STAGE III: STAFF FOCUS GROUPS

Introduction

Focus groups were conducted with support/case workers from the four agencies: SHM, Mind Australia, ISCH, and VincentCare Victoria. The aim of the focus groups was to gather information from these support/case workers about their views on the relationship between trauma exposure and homelessness, and factors that help or hinder the provision of services to this population.

Method

The study was approved by the University of Melbourne Human Research Ethics Committee. One focus group was run at each of the agencies, with a total of 42 participants across all agencies. Participating support/case workers were chosen internally by each agency to be representative of that service. Each focus group was facilitated by the researchers, and lasted 1.5 hours.

Focus groups were run using a modified nominal group technique (NGT). This technique was developed by Delbecq and Van de Ven [137, 138] and can be thought of as a structured variation of small group discussion methods. This technique is useful for synthesising judgments where a diversity of opinions may exist on an issue. It prevents the domination of discussion by a single person or set of ideas, encourages the less active group members to participate, and results in a set of prioritised solutions or recommendations that reflect group consensus. The stages of NGT, as modified for the focus groups in this study, were as follows:

1. Generation: Each participant generated responses to the discussion questions and wrote them down.
2. Recording: Each response was shared by attaching it to the discussion question.
3. Clarification: Each recorded idea was checked for legibility and clarity of expression.
4. Voting: Participants individually endorsed the ideas or responses for each discussion question, and the overall group endorsement was made based on those votes (i.e., the idea with the most endorsements was ranked #1).

The key research questions that were asked of each group were:

1. On the basis of your experience, what is your hunch about the link between trauma and difficulties in maintaining secure housing?
2. In your experience, what works well in supporting people with trauma?
3. What tends to get in the way of effective work (i.e., clinically)?
4. In a perfect world, how would your agency respond more effectively to people with trauma?
5. In a perfect world, how would staff respond more effectively to people with trauma?
6. Do you have anything else that you would like to add in relation to either trauma or the experience of repeated homelessness?

Findings

The text below summarises the key findings of the focus groups. Similar themes emerged across the four agencies, with some minor differences in emphasis depending on the service users served.

What is the link between trauma and homelessness?

Staff who took part in the focus groups were asked to discuss their ideas about the link between trauma and difficulties in maintaining secure housing.

The comments that were endorsed the most frequently by the groups are listed below. The number of times they were endorsed is in brackets.

Participant comments:

- *"Trauma can lead to D&A [drug and alcohol] issues, which can affect housing security" (6)*
- *"Behaviours [that] have been developed to survive/adapt to trauma don't translate to maintaining housing" (5)*
- *"The trauma damages the individual's ability to maintain healthy relationships and this applies to housing relationships" (4)*
- *"Past unaddressed traumas – support" (4)*
- *"Trauma leads to behavioural, psychological, social issues, which impacts on their coping" (4)*

Analysis and interpretation

Psychosocial mediators: Across all groups, there was a view that trauma may result in the development of coping mechanisms designed to survive or adapt to trauma, such as substance use, self-harm, low trust, poor affect regulation, and poor attachment. These coping mechanisms, in turn, are related to behaviours not compatible with maintaining housing; for example, low engagement with services, reluctance to attend meetings or sign contracts, difficulties managing aggression, mental health problems, and substance abuse or dependence. One comment noted, for example, that people with a history of trauma may have problems with "confidence, life skills, hypersensitivity, trust issues, [which can] create planning [and] organising issues". A psychosocial mediation model of trauma and homelessness may be a way to describe these relationships, whereby trauma is seen to impact behaviour and relationships, which in turn is seen to impact on housing security. A comment that exemplified this was, "It is the link between trauma/mental illness/substance abuse and difficulties forming and maintaining positive relationships that impacts on the capacity to maintain housing".

Systemic issues: A number of staff raised the issue of the experience of homelessness or living in unsecure accommodation as being traumatic in itself. In this context, participants reported that an important systemic issue was being unable to provide secure housing for many of their clients. For example, one participant reported that their agency was "unable to provide secure housing 90% of the time". Obstacles included the lack of secure housing available and the limitations of shared facilities such as rooming houses; "shared facilities for people without the skills to do so". In addition to the problem of limited resources, focus group participants also felt that the way in which trauma is addressed within the system is often inadequate, meaning that people feel unsupported and past traumas continue to have an adverse effect on their current circumstances. As one support/case worker noted, "individuals who have experienced trauma have not addressed the trauma which causes them to continue the cycle of homelessness".

What works well in supporting people with trauma?

The staff were asked about what works well in supporting people who have been exposed to trauma.

The comments that were endorsed the most frequently by the groups are listed below. The number of times they were endorsed is in brackets.

Participant comments:

- *"Sitting with traumatic experiences. Not problem solving or being too instrumental. Clinicians need to be comfortable in this unpleasant space" (7)*
- *"Trauma-informed practise; not developing dependency, strengths-based" (5)*
- *"Validate trauma, build coping strategies, individual response, not my fault things happened, taking control, eat well, sleep well" (4)*

Analysis and interpretation

Characteristics and competencies of staff: In terms of supporting people with trauma, participants identified a range of factors that work well, falling under two main themes. The first related to characteristics and competencies of the case workers themselves. The ability of the worker to build a strong therapeutic relationship with the client was a theme identified by all four services. Trust, consistency, and clarity of boundaries were considered crucial in building good relationships with clients. Also falling under the theme of support/case worker factors that work well in supporting people with trauma, was the worker's interpersonal (or clinical) skills. Confidence and competence in employing a trauma-informed approach was seen to be important, as were more general client and interpersonal skills such as managing complexity, reflective listening, and self-care. In particular, participants felt that the ability to listen to and validate the client's experience of trauma was essential; as one participant put it, being "comfortable in this unpleasant space".

Service level factors: The second theme identified as relevant to supporting people with a history of trauma relates to service-level factors. All services discussed the importance of "being well-versed in what the system/service offers", and what the limits of a given service are, having good links with other services, and being able to refer clients on when appropriate while maintaining continuity of care. Flexible service delivery models, such as group work, and outreach and after hours services, were also mentioned as working well to support people with a history of trauma.

What tends to get in the way of effective work (i.e., clinically)?

The participant statements with the highest number of endorsements for what tends to get in the way of effective practice were:

- *"Structural factors: inflexibility of service system, resources – lack of, untimeliness – long wait lists, small window of access, lack of choice" (8)*

- *"Culture, gender, AOD (alcohol and other drugs)" (4)*
- *"Limitations of services: processes/referrals – inadequate/inflexible responses from specialist services" (4)*
- *"Drugs and alcohol, non-commitment, willingness, ability, resilience, insight, empowerment, ownership, control, shame, denial, psychological holds, ability to escape/get away, self-sabotage, S & M (sadism/masochism) IQ, ABI [Acquired Brain Injury], damage, independence, medication (not taking), media, pressure of society, finances" (4)*
- *"Services – crisis model, reactive not proactive, further perpetuates = Giving in to clients = unhelpful" (3)*
- *"Lack of safety for client, e.g., if housing not secure/on streets/instability, retraumatises – hard to stick to care plan" (3)*

Analysis and interpretation

Three main themes emerged when participants were asked to identify what tended to get in the way of working effectively with service users. There were service, practitioner and client-level factors.

Practitioner characteristics: All groups identified lack of confidence and relevant skills as an impediment to effective trauma-informed practice. Representative comments addressed the need for "confidence and experience for workers to be able to ask the questions and engage with clients around trauma", and the problem of "feeling overwhelmed; how do you make a difference?"

System characteristics: Participant endorsements indicated that system-level factors appeared to be the most substantial barriers to effective work for support/case workers across services. A number of issues were considered and strongly endorsed, including problems with the inflexibility of the system, long waiting lists, limited time for support/case workers to spend with clients, lack of funding, large caseloads, and limited options for referrals. There was a view that the mental health system remains inaccessible for many clients, creating a sense of hopelessness for both clients and staff.

Rigidity around mental health diagnosis and its consequences was seen to be a significant issue. Participants noted, for example, the "challenge to get services, particularly mental health to this client group, for example, if [there is] no diagnosis [it is] hard to engage services". Other issues relating to this topic included being turned away for having the wrong diagnosis, or the problem of a diagnosis resulting in reductionist thinking, with all subsequent issues attributed to, and interventions targeted at, symptoms of that disorder.

Client characteristics: Clients themselves were also seen to pose a barrier to the delivery of effective services, with many reluctant to engage, experiencing ongoing chaos or crisis, or presenting in denial or with a lack of insight about their mental health issues. In addition, some demographic characteristics, such as culture and gender, were noted to hamper effective practice.

In a perfect world, how would your agency respond more effectively to people with trauma?

The participant statements with the highest number of endorsements for how the agency can respond more effectively to people with trauma were:

- *"Work based culture that is trauma-informed, consistent approach" (6)*
- *"More time, more resources – unlimited resources/access. Know all services to access and assist clients – at our finger tips" (4)*
- *"Agency response: more resources, staffing specialists, trauma-informed counsellors located with the HUBS" (4)*
- *"Tailor response to need of client, e.g., work long-term if need be. More resources: in-house trauma counsellor – multidisciplinary staff" (4)*
- *"Trauma-focussed, recovery-focussed – integration of trauma and recovery models" (4)*
- *"Magic wand!! – trauma-informed practice peer workers – lived experience. Knowledge/collaboration. Brokerage for each client – create opportunities for clients" (3)*
- *"Trauma-informed service – training in trauma – multi-disciplined approach to working with people experiencing homelessness and trauma" (3)*
- *"Multi-disciplinary team, assertive engagement with skilled clinicians – applied and professional staff on same page" (3)*

Analysis and interpretation

Not surprisingly, when asked how their agency could respond more effectively to people with trauma, participants noted many of the issues they had previously identified as getting in the way of effective work, whilst offering a range of practical methods for addressing these issues.

Service factors: Participants identified that additional training and clinical supervision, increased flexibility and consistency, decreased case load, more time with clients and the capacity to work long-term would improve response to the difficulties experienced by staff and clients. Smoothing the transition between services was raised a number of times as a mechanism for improving agency

response; participants commented on the need for "better relationships with other services" and improved "referral pathways, communication", both internally and externally. A number of participants suggested that agencies should employ multidisciplinary teams in order to improve their response to people with trauma, including in-house trauma counsellors.

Across all groups, agency-wide implementation of trauma-informed policy and practice was highlighted as a key improvement. One highly ranked comment noted the need for a "work based culture that is trauma informed, consistent approach" while another suggested the introduction of "interview/assessment templates to identify trauma – training for all staff".

Several comments identified the need for additional funding, or suggested that changes to funding models would allow agencies to respond more effectively to people with trauma. For example, one participant noted that at present, the "funding model and service model don't allow for effective long-term engagement", particularly for clients who cycle in and out of the agencies.

In a perfect world, how would staff respond more effectively to people with trauma?

The three most frequently endorsed statements for how staff can respond more effectively to people with trauma were:

- *"Staff need to understand trauma and the link between behaviour and trauma" (8)*
- *"Better training – staff seeking specific training. Better training opportunities/targeted training. Staff more effectively create case plans responding to trauma. Access to resources to fulfil this plan" (5)*
- *"Staff well supported – supervision, etc. Staff aware/ respond to self-care. Staff deal with own personal issues/issues surrounding counter transference" (3)*

Analysis and interpretation

Staff training and supervision: Once again, many of the factors identified as precluding effective practice were raised here. All groups highlighted the need for staff to be well trained, and have a good understanding of trauma and trauma-informed practice. Relatedly, the importance of good supervision was raised by a number of case workers, although some supervision models were seen to be more useful than others. Specifically, support/case workers articulated a need for "external clinical supervision, as opposed to or in conjunction with line management supervision".

Another strongly endorsed component of improving staff response to trauma was the ability to build a strong therapeutic relationship with clients. Apparent from support/case workers' responses was the importance they placed on fostering empathy, non-judgemental listening, acknowledging the client's experience, and sensitive assessment practices; as expressed by one case worker, "not retraumatising a client through the assessment process".

Staff self-care: A key issue that emerged in relation to improving staff response was the need for staff to be aware of the impact of their work on themselves. Representative comments from support/case workers identified the importance of "staff knowing, understanding [the] limitations of their own practice", and "making sure staff take care of themselves – self-care". In the context of recognising their own limitations, case workers noted the value of knowing when to refer clients to more appropriate services. The need for staff to be "aware of their own responses" and "deal with [their] own personal issues [and] issues surrounding countertransference" were also considered crucial in improving staff's ability to respond effectively to people with trauma.

Do you have anything else that you would like to add in relation to either trauma or the experience of repeated homelessness?

The most frequently endorsed statements for anything else that the staff wanted to add were:

- *"Lack of diverse housing options for clients who have experienced trauma, e.g., rooming houses can re-traumatise" (4)*
- *"More funding for public housing" (4)*
- *"Some people will not have insight, coping strategies" (3)*
- *"Specialist staff training in order to provide secondary consults/information to workers in specific areas like trauma" (3)*
- *"Reconnect to community (give?) a sense of control: client centred approach" (3)*

A significant theme to emerge when support/ case workers were asked to contribute any other comments related to trauma or homelessness was the need for policy and service-delivery frameworks that more closely aligned with client needs. In particular, comments highlighted the need for a diverse range of housing options, and the importance of people with a history of trauma having access to safe accommodation (as opposed to rooming houses which were seen

to re-traumatise), given that these individuals are likely to feel constantly unsafe and live in a state of hyperarousal.

Across agencies, isolation was identified as a key issue for this client group and a suggested goal for staff was to support individuals in developing or maintaining social connections.

Another theme identified in response to the invitation for additional comments focussed on the cyclical and interwoven nature of trauma and homelessness. This theme encompassed the ideas that as much as trauma can lead to homelessness (as discussed in question 1, *What is the link between trauma and homelessness?*), homelessness also increases the risk of exposure to subsequent trauma, and for many clients, the experience of homelessness is traumatic in itself. One highly endorsed statement related to this theme stated that "People who are long-term homeless have commonly experienced a lifetime of trauma, that is, profound early childhood trauma [such as] sexual abuse, that is compounded by a lifetime of disadvantage, poverty, violence, and ongoing trauma".

Finally, a number of participants raised the issue of disparity between client and case worker expectations. It was noted that "not all outcomes can be measured … some people will not be able to get to a high level of functioning" and that culturally and linguistically diverse clients may have different expectations or be reluctant to change. Other case workers mentioned that some clients may not have insight, "occupy a different reality", or may not even consider themselves as experiencing homelessness due to their different notions of what homelessness means.

Discussion

Results of the focus groups conducted with these four agencies suggest that support/case workers consider trauma to be a significant issue among people experiencing homelessness, with a complex range of related behavioural and social issues making people who have experienced trauma a difficult group to effectively engage in services. In addition, there was a view that being resource and time poor, agencies and staff are often poorly equipped to provide optimal services to those who do engage. Support/case workers were keen for their agencies to support trauma-informed practice, and saw increased training and supervision as key opportunities for improving both agency and staff responses to people with trauma.

STAGE IV: SERVICE USER QUANTITATIVE STUDY

Introduction

As discussed in the previous sections of this report, given the relative dearth of literature related to the prevalence and correlates of trauma in adult Australians experiencing homelessness, it was considered to be vitally important to undertake research which provided a more complete picture of the relationship between these issues.

Study aims

The aim of this study was to quantitatively assess the history of homelessness, exposure to traumatic experiences (including type [Type I or Type II] and frequency of trauma exposure), mental health issues, treatment, and support in a representative sample of people presenting for assistance with homelessness. Of particular interest were the following key questions:

- What are the types of traumatic events that are experienced by people who experience homelessness or are at risk of homelessness?
  - What is the frequency with which traumatic events were experienced?
  - What is the prevalence of Type I and Type II trauma?
  - At what age did each traumatic event occur?
  - When did each traumatic event occur relative to becoming homeless?
- Does the experience of trauma contribute to homelessness (as measured by the length of time that someone has experienced homelessness to date)?
  - Does experiencing trauma prior to homelessness contribute to length of time spent homeless?
  - Does the experience of Type II trauma contribute to length of time spent homeless?
  - Does the number of traumatic events (lifetime) contribute to the time spent homeless?
  - Do people who develop PTSD after experiencing trauma spend more time homeless than those who do not develop PTSD?
- What is the prevalence of mental health disorders amongst people who experience homelessness?
  - What are the prevalence rates of PTSD, depression, psychosis and substance use disorders?
  - What are the prevalence rates of other mental health difficulties often associated with complex trauma presentations such as emotional regulation difficulties, risk taking, suicidal thoughts or behaviours, dissociation, and difficulties maintaining social relationships?
  - Are these difficulties more likely to be experienced by those who have a history of experiencing Type II trauma?
- What are the levels of social support, community connectedness and social exclusion that are experienced by those who experience homelessness?
- What are the barriers encountered by people who experience homelessness in seeking help for issues related to trauma or mental health?

By addressing these questions, this study aimed to provide valuable information for the final stage of the THI, the trauma and homelessness service framework development.

Method

Quantitative interview

General background

Participants were asked several background questions which covered age, gender, education level, cultural group, marital status, income/financial support, and whether the participant had children or not (and whether those children were in the participant's care).

Current and past accommodation

Participants were asked about their current and past accommodation arrangements, including the total period of time that they had experienced homelessness.

Trauma experiences

The World Health Organisation Composite International Diagnostic Interview (CIDI): traumatic events list [133] was used to identify the types of traumatic events participants had experienced and the frequency with which the event was experienced. The participant's age when the event first occurred and whether the event occurred in a repetitious and prolonged way were also noted.

Mental health issues

Participants were asked to respond to a number of structured questions about several mental health issues that can follow trauma and may drive long-

term psychological and social difficulties. A number of established and valid structured clinical interviews and self-report scales were used to collect data for this study.

The MINI International Neuropsychiatric Interview [139] is a structured clinical screening interview which is based on diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) and the International Classification of Diseases-10 (ICD-10), and indicates whether or not a person screens positive for a given disorder. The MINI has good reliability for all diagnoses when compared to similar interviews (e.g., the Composite International Diagnostic Interview). It is a short but accurate interview which is widely used in research and clinical settings. In this study the following modules were administered:

- Lifetime PTSD
- Current Major Depressive Episode (MDE)
- Current Alcohol Abuse
- Current Alcohol Dependence
- Current Substance Abuse
- Current Substance Dependence
- Current Psychotic Disorder
- Lifetime Psychotic Disorder

Current PTSD diagnosis, and level of symptom severity were attained using the **PTSD Symptom Scale Interview (PSS-I)** [140]. The PSS-I consists of 17 questions that correspond to the DSM-IV PTSD symptoms, and each rates on a 0 to 3 point scale for frequency and severity. Studies have shown that regardless of who the assessor is, the PSS-I results in the consistent diagnosis of PTSD and PTSD severity [140]. The overall severity scores can range from 0 (no signs or symptoms of PTSD) to 51 (experiencing all symptoms of PTSD).

The **Structured Interview of Disorders of Extreme Stress Not Otherwise Specified-Reviews (SIDES-R)** [141] was used to assess several domains associated with exposure to Type II trauma including emotional regulation difficulties, difficulty maintaining social relationships, dissociation (i.e., having experienced dissociation, depersonalisation or amnesia), risk taking and putting self in danger, and negative views of world and self [141]. The SIDES-R is a 45-item structured interview, and is the only instrument that has been validated as a diagnostic assessment tool for complex PTSD.

Depression and anxiety severity were assessed using the **Depression, Anxiety and Stress Scale (DASS)** [142]. The DASS is a 21-item self-report questionnaire designed to measure the severity of a range of symptoms common to both depression and anxiety [143]. This instrument has three subscales: depression, anxiety and stress. Individuals are required to indicate the presence of a symptom over the previous week. Each item is scored from 0 *('did not apply to me over the last week')* to 3 *('applied to me very much or most of the time over the past week')*, and the total score can range from 0 to 42 for each scale. The scales of the DASS have been shown to have high internal consistency and to yield meaningful discriminations in a variety of settings. In the current study, only the depression and anxiety scales were administered. Table 2 gives information about interpreting DASS scores [144].

Table 2. Scoring for interpretation of DASS scores.

	Depression	Anxiety
Normal	0-9	0-7
Mild	10-13	8-9
Moderate	14-20	10-14
Severe	21-27	15-19
Extremely severe	28+	20+

Social support and social connectedness

The level of social support experienced by the participants was measured by the 12-item **Interpersonal Support Evaluation List-12 (ISEL-12)**, which is a short form version of the 40-item Interpersonal Evaluation List (ISEL) [145]. The ISEL-12 provides an overall measure of perceived social support, and consists of three subscales (appraisal, belonging and tangible support). Appraisal is a measure of the availability of someone to talk to about one's problems. Belonging is the perceived availability of people that one can do things with. Tangible support is a measure of the availability of material aid. Scores for each subscale of the ISEL-12 can range from 4 (being low levels of perceived support) through to 16 (being high levels of perceived support).

Participants were also asked a series of questions related to their sense of community connectedness. These questions were based on those used to assess sense of community in the Household, Income and Labour Dynamics in Australia Survey (HILDA survey [146]). These questions, together

with those on social support, material resources (i.e., income), level of education, employment, and personal safety (i.e., whether the person has been a victim of violence), were used in combination to measure the construct of social exclusion. Social exclusion refers to the complex compound of disadvantages which can act to marginalise a person in terms of their access to resources and their capacity to be involved in their community [18].

To create a social exclusion composite score, each of the following domains was assigned a score of either '0' (meaning no difficulties), or '1' (meaning a difficulty/disadvantage):

1. community connectedness
2. income
3. education level
4. victim of violence (i.e., having direct experience with Type I or Type II trauma)
5. social support (total score).

These five individual scores were then tallied to create a total social exclusion score (ranging from 0, meaning no social exclusion, through to 5, meaning very high levels of social exclusion).

Access to health care

Past experiences with treatment and support were assessed with the following series of questions.

Participants who had experienced trauma were asked if they had ever been assessed by a mental health professional (e.g., GP, psychologist, psychiatrist, counsellor, support/case worker) for dealing with their prior trauma experience. Participants were asked about whether this had been helpful, and when participants reported that it had not been helpful the reasons for this were sought.

Participants were asked whether they had ever wanted to get some professional help for a mental health issue but then did not end up getting help. If this had occurred, they were asked about the main reasons for this. This question tapped into the construct of barriers to care, and contributes to our understanding of how specific barriers may negatively impact on people's access to, or use of health services.

Procedure

The study was approved by the University of Melbourne Human Research Ethics Committee. Participants were recruited from each of the four participating agencies. Participants who were eligible for the study were randomly selected by a researcher working together with a case worker or manager from each agency. A specific randomisation strategy was developed for each of the participating services. The most common form of randomisation procedure was to select every third person who arrived at a drop-in service, or every third person, starting at a different place in the line each day to account for any hierarchical system that may exist amongst the people waiting in the queue to enter the drop-in service. This is a randomisation process used by other studies in the area [20]. For services which did not have drop-in services, there was most commonly a case management model in place. In these situations, the most common randomisation procedure was to randomly select case managers, and then select every third person of the case manager's list of clients that they were due to see that day, starting at a different place in the list each day.

People were included in the trial if they were service users and over the age of 18 years. People were excluded from the trial if they were highly intoxicated, too mentally unwell, or threatening in a way that led to safety concerns for the interviewer.

The interviewer spent time at each agency to become familiar with the staff and service users and to address questions concerning the research project that staff may have had. Participants were seen in a quiet location at each service. Information about the research was provided in a Plain Language Statement by their agency contact worker or case manager. Informed consent was obtained from each participant prior to the commencement of the interview. De-identified age and gender information was collected for those service users who declined to participate in the study so that a refusal analysis could be conducted.

In recognition of the potential distress associated with the interview, after each interview the researcher provided feedback to the team leader. The scope of this feedback was limited to how the participant coped with the interview, and team leaders could alert case managers if a participant required additional support. The content of the interview was not discussed. Each participant received $20 (either in the form of a food voucher or cash, depending on the policy of each agency) in recognition of the time taken to complete the interview.

Data analysis

The data was analysed using descriptives and frequencies procedures and Chi-square and ANOVA significance tests, using the IBM SPSS Statistical Software package[136].

For the purpose of this report, Type II trauma was considered to involve:

1. the participant suffering or witnessing interpersonal trauma before the age of 16
2. the perpetrator being a caregiver
3. the traumatic event being prolonged and repetitive (defined as occurring on five or more occasions).

Type II trauma was also defined as occurring in adulthood if the trauma exposure was prolonged and repetitive, and of an interpersonal nature, such as torture and kidnapping.

In order to establish the generalisability of the results to all service users, a comparison on age and gender of those who agreed to participate in the study and who completed the interview (participants, n=115), and those who declined to participate or were unable to be recruited (refusers/missed, n=455), was undertaken. In a number of instances, people were randomised to be recruited to the study, but then needed to leave the area that the researcher was in before they could be approached to take part in the study. Reasons for this included having to attend another appointment, taking a shower, talking to a support worker. There was no difference between those who agreed to participate and those who refused/missed in terms of the gender.

Those who completed the interview, however, were found to be significantly younger (M=44.73 years, SD=11.97) than those who declined/missed (M=47.52 years, SD=12.77) (t(517)=-2.10, p=.04). There was a significant correlation between age and trauma exposure frequency in the study sample (r =-.19, p=.05), and this may suggest that those who participated in the study had less trauma exposure than those who did not, although we cannot test this hypothesis explicitly.

Findings

In the section below, the key findings from the service user quantitative interviews are summarised.

Demographics

A total of 115 participants were interviewed for the study, with 37 from SHM, 11 from Mind Australia, 45 from VincentCare Victoria and 22 from ISCH.

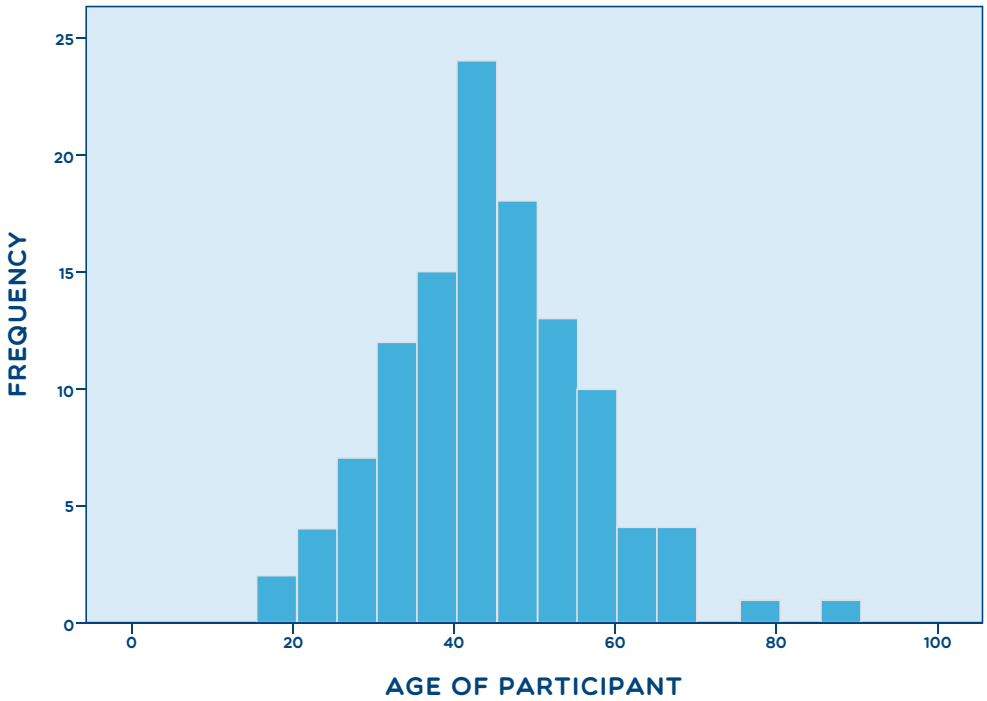
Gender

The sample comprised 77 males (67%) and 38 females (33%).

Age

The average age of the sample was 44 years (range 18 to 86). A graph demonstrating the distribution of participant age is shown below (Figure 1).

Figure 1: Bar graph representing distribution of participant age in the study.



Marital status

Participants described their marital status as single (61%), separated or divorced (27%), married or de facto (10%), or widow/widower (3%).

Cultural background

Participants were from a number of cultural backgrounds, with the majority of participants describing themselves as Anglo-Australian (59%). Of the remainder, 14 participants described themselves as Anglo-New Zealanders (12%), nine as Indigenous Australians (8%), six as European-Australian (5%), four as European (4%), four as Asian (4%), and three as African (3%). Two participants were from other backgrounds (i.e., Native American and El Salvadorian), and five people did not describe their cultural background.

Educational levels

Participants had varied educational backgrounds, with 12 participants having begun or completed tertiary education (10%), two of whom had completed PhDs. Fifteen participants had begun or completed TAFE courses or certificates (13%), and 22 participants had completed Year 12 (19%). Eight participants had finished their schooling at Year 11 (7%), 23 at Year 10 (20%), 18 at Year 9 (15%), seven at Year 8 (6%), seven at Year 7 (6%) and three at Grade 4, 5 or 6 (3%).

Children

Sixty-one participants (53%) reported having children (an average of three children each), with 87% of these respondents reporting that the children were not currently in their care.

Income

When asked to describe the source of any income or financial support that they received:

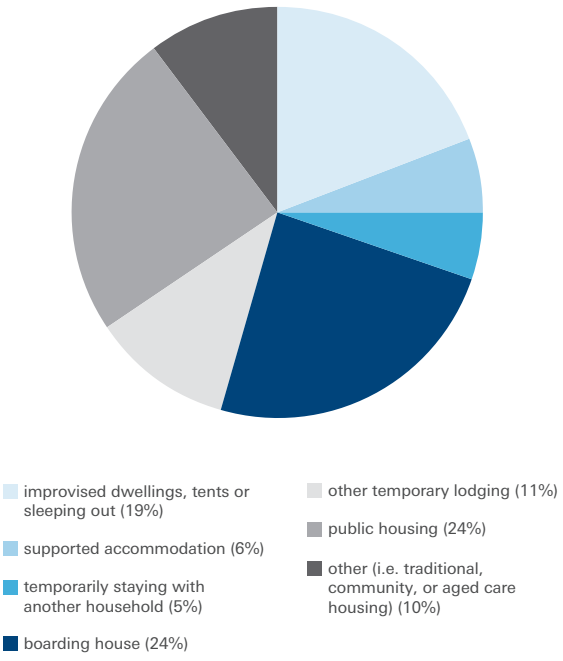
- 68 participants reported being on a disability support pension (59%)
- 27 received Newstart Allowance (24%)
- 5 received the Aged pension (4%)
- 2 received parenting payments (2%)
- 2 received the Youth Allowance (2%)
- 1 received the DVA disability pension (0.9%)
- 1 was working casually (1%)
- 1 was employed (1%)
- 8 participants reported having no income (7%)

Accommodation

Current accommodation

Participants were asked to report where they were currently living. The range of current accommodations included: improvised dwellings, tents or sleeping out (19%); supported accommodation (6%); temporarily staying with another household (5%); boarding house (24%); other temporary lodging (11%); public housing (24%); or other (i.e., traditional, community or aged care housing) (10%). On average, participants had been in their current living situation for 41 months. Figure 2 presents this information graphically.

Figure 2: Current accommodation reported by participants in this study.



First experience of homelessness

Participants reported first experiencing homelessness at an average age of 23 years (range: birth to 56 years of age). They reported that on average they had experienced difficulty finding somewhere to live for an aggregate of 203 months, or 17 years, of their life.

Participants were also asked about the main reason they started having difficulty in finding a place to live. Seventeen per cent of participants reported that childhood trauma was the main reason, while 26% reported that family disintegration was the main reason.

Fifteen per cent of participants reported that an accumulation of stressful life events was the main reason, with a series of events occurring in close proximity, such as a relationship breakdown, loss of a business, loss of a house, and death of a loved one, as examples. Ten per cent reported that mental health issues were the main reason. The remaining 31% of participants cited other reasons, which included: addiction, death of a partner, divorce, financial hardships including loss of a job, war, visa issues, domestic violence, feeling disconnected from the family, health problems/injury, and relationship problems.

Traumatic experiences

All participants reported experiencing at least one traumatic event in their lifetime, and the average total number of traumatic experiences reported by participants was 21. Table 3 lists the frequency with which the sample experienced each type of traumatic event (directly experiencing and witnessing the event). It is important to note that a single individual could have experienced more than one event in the table below. The table also lists the mean age at which participants experienced the traumatic event and the frequency with which the exposure occurred.

Table 3. Percentage of study participants directly experiencing or witnessing trauma, the age at which this first occurred, and the mean number of times the event occurred (n=115).

Event	Happened to me (n, %)	Witness event (n, %)	Age first occurred (Mean)	How often (mean number of times)	Too many to count (n, %)
Direct combat experience in a war	4 (4%)	6 (5%)	n/a	n/a	n/a
Life-threatening accident	39 (34%)	46 (40%)	18.5	4.25	10 (9%)
Fire, flood or natural disaster	42 (37%)	14 (12%)	18.2	2.3	1 (1%)
Witnessed someone being badly injured or killed	n/a	66 (57%)	17.7	4.15	21 (18%)
Rape (after age 16)	27 (24%)	11 (10%)	21.2	2.5	9 (8%)
Sexual molestation (after age 16)	19 (17%)	12 (10%)	21.7	2.1	9 (8%)
Physical assault (after age 16)	21 (18%)	64 (58%)	21.0	3.1	41 (36%)
Threatened with a weapon, held captive or kidnapped (after age 16)	24 (21%)	47 (41%)	22.0	3.0	23 (20%)
Tortured or the victim of terrorism (after age 16)	19 (17%)	17 (15%)	23.0	2.0	16 (14%)
Suffered a great shock because one of the events on the list happened to someone close to you	77 (67%)	n/a	19.8	3.0	15 (13%)
Any other extremely stressful or upsetting event	44 (38%)	51 (44%)	17.6	2.6	34 (30%)
Childhood events (used to identify Type II trauma)					
Childhood physical assault	26 (23%)	39 (34%)	7.8	1.6	46 (40%)
Childhood sexual molestation	34 (30%)	15 (30%)	8.3	3.0	21 (18%)
Childhood rape	27 (24%)	9 (8%)	8.2	2.6	18 (16%)
Tortured or the victim of terrorism as a child	14 (12%)	20 (17%)	7.8	2.7	25 (22%)
Threatened with a weapon, held captive or kidnapped as a child	17 (15%)	30 (26%)	9.5	2.3	23 (20%)

Applying the previously noted definitions of Type I and Type II trauma, it was found that 60% of the sample reported a personal history that included direct experience of Type II trauma, while 98% of participants had direct experience of Type I trauma. It was also found that 91% of participants first experienced trauma in childhood (either Type I or Type II trauma).

Table 4 provides the proportion (percentage) of the sample that experienced each type of traumatic event (including direct experience or witness) relative to Australian norms. This provides a comparison between the frequency with which events occurred in the sample relative to the frequency with which they are experienced within the general community. (Unfortunately Australian community norms are not available for the prevalence of Type II trauma or for prevalence of trauma first experienced in childhood.)

Table 4. Percentage of study participants experiencing lifetime trauma exposure compared with Australian norms (direct exposure or witnessed the event).

Event	Australian community average# (n=10,641)	Study participants (n=115) %
Direct combat experience in a war	3	9
Life-threatening accident	21	74
Fire, flood or natural disaster	17	49
Witnessed someone being badly injured or killed	26	57
Rape	4	50
Sexual molestation	8	52
Physical assault	10	82
Threatened with a weapon, held captive or kidnapped	12	70
Tortured or the victim of terrorism	n/a	47
Suffered a great shock because one of the events on the list happened to someone close to you	11	67
Any other extremely stressful or upsetting event	8	83

National survey of mental health and wellbeing [147]

The frequency with which the sample was exposed to traumatic events was compared to the general community in Table 5.

Table 5. Frequency of trauma events (i.e. any type) for sample participants compared to Australian community norms.

Frequency of traumatic events	Study participants (n=115) %	Australian community average (n=10,614) %
1	0	25.5
2	0	14.9
3	1.7	8.4
4	0.9	4.6
>4	97.4	3.9

The frequency with which the sample experienced specific types of trauma both before the experience of homelessness occurred and after homelessness occurred, was examined to gain a better understanding of their experience of trauma relative to their experience of homelessness (see Table 6).

Table 6. Frequency of specific types of trauma events before the experience of homelessness and after homelessness (n=115).

Frequency of traumatic events	Frequency of trauma before homelessness (n, %)	Frequency of trauma after homelessness (n, %)
Direct combat experience in war	3 (30%)	7 (70%)
Life-threatening accident	30 (35%)	55 (65%)
Fire, flood or natural disaster	18 (33%)	37 (67%)
Witnessed someone being badly injured or killed	23 (35%)	42 (65%)
Rape	28 (40%)	42 (60%)
Sexual molestation	20 (27%)	54 (73%)
Physical assault	46 (31%)	102 (69%)
Threatened with a weapon, held captive or kidnapped	51 (44%)	65 (56%)
Tortured or the victim of terrorism	49 (55%)	40 (45%)
Suffered a great shock because one of the events on the list happened to someone close to you	24 (34%)	46 (66%)
Any other extremely stressful or upsetting event	23 (26%)	66 (74%)

Seventy per cent of the sample experienced at least one trauma before experiencing homelessness. In general, a higher proportion of people experienced a particular type of trauma after becoming homeless. That is, people in the sample were significantly more likely to experience direct combat in war ($p<.001$), life-threatening accident ($p<.001$), fire, flood or natural disaster ($p<.001$), witnessing someone being badly injured or killed ($p<.001$), rape ($p=.009$), sexual molestation ($p<.001$), physical assault ($p<.001$), being threatened with a weapon ($p=.03$), suffering a great shock because one of the events happened to someone close ($p<.001$), and any other upsetting event ($p<.001$) *after* becoming homeless. This speaks to the accumulation of traumatic events that occur after becoming homeless.

Impact of trauma upon homelessness

People who experienced trauma prior to homelessness were significantly more likely to have longer periods of homelessness than those who experienced trauma after homelessness ($t(1,113)=2.86$, $p=.005$). In order to examine the relationship between trauma, mental health and homelessness in more detail, we tested whether characteristics about an individual's trauma history and whether they had developed PTSD at some time in their lifetime, contributed to the total length of time they spent homeless. Specifically, we tested whether the following variables contributed significantly to length of time spent experiencing homelessness: (i) first experience of trauma prior to becoming homeless; (ii) first experience of trauma after homelessness; (iii) Type II trauma; (iv) number of traumatic events experienced; and (v) lifetime PTSD. Age was entered as a control variable.

These variables were entered into a multiple linear regression analysis, the results of which are presented in Table 7. This analysis showed that once age was controlled for, the amount of time someone spent experiencing homelessness was not significantly associated with: (i) experiencing trauma prior to becoming homeless; (ii) first experience of trauma after homelessness; (iii) Type II trauma; (iv) total number of traumatic events experienced; and (v) lifetime PTSD. Length of time experiencing homelessness was associated with the age that an individual first experienced homelessness, with younger age being significantly related to the length of time spent homeless.

Table 7. Predictors of length of time experiencing homelessness (n=114).

Predictor variables	Odds Ratio, Exp (ß)	t	Significance (p)
Age	.67	10.41	<.001
Age first experienced homelessness	-.75	-9.79	<.001
Gender	-.03	-.42	ns
Lifetime PTSD diagnosis	.02	.35	ns
Experiencing trauma prior to homelessness	-.01	-.19	ns
Experiencing trauma after homelessness	-.02	-.27	ns
Type II trauma	-.08	-1.27	ns
Total number of traumatic events	-.05	-.86	ns

Screening positive for mental health disorders

Participants in the study reported a large number of mental health issues. In Table 8, the prevalence rates of meeting criteria for PTSD, depression, alcohol use and abuse, substance use and abuse, and psychotic disorder are shown.

Given that PTSD was a primary outcome of interest, we examined whether there was a difference between men and women in terms of meeting criteria for current PTSD, and lifetime PTSD. This is particularly important, as was identified in the literature review; the prevalence of males meeting criteria for current PTSD has not been published and represents a gap in our understanding of PTSD in the homeless population.

It was found that 68% (n=52) of men and 82% (n=31) of women met criteria for current PTSD, however there was not a significant difference between the men and women in terms of current PTSD prevalence rates. It was found that 58% (n=44) of men and 74% (n=28) of women met criteria for lifetime PTSD, however there was also not a significant difference between these two prevalence rates.

We also examined whether there were any differences between the genders, in terms of meeting criteria for current depression, current alcohol abuse, current alcohol dependence, current substance abuse, current substance dependence, current psychotic disorder and lifetime psychotic disorder.

It was found that 47% (n=37) of men and 63% (n=24) of women met criteria for current depression, however there was not a significant difference between males and females in terms of current depression prevalence rate.

It was found that 47% (n=36) of men and 53% (n=20) of women met criteria for alcohol abuse diagnosis, but there was no significant difference between the genders. It was found that 43% (n=33) of men and 42% (n=16) of women met criteria for current alcohol dependence, but once again there was no significant difference between the genders.

It was found that 43% (n=36) of males and 42% (n=22) of females met criteria for substance abuse, although there was no significant difference between males and females. Similarly, it was found that 35% (n=27) of males and 29% (n=11) of females met criteria for substance dependence, but there was no significant difference between males and females.

Finally, it was found that 33% (n=25) of males and 32% (n=12) of females met criteria for current psychotic disorder, although there was no significant difference between males and females. It was found that 46% (n=35) of males and 53% (n=20) of females met criteria for lifetime psychotic disorder, with again, no significant difference between males and females.

Table 8. Number of participants who met criteria for psychiatric disorder diagnosis (n=114).

Disorder	Met criteria %
Current PTSD	73
Lifetime PTSD	63
Current Depression	54
Current Alcohol Abuse	49
Current Alcohol Dependence	43
Current Substance Abuse	51
Current Substance Dependence	44
Most frequently reported substance use was:	
- Marijuana	31
- Heroin	12
- Ice	7
Any Current Alcohol or Substance Abuse or Dependence	69
Current Psychotic disorder	33
Lifetime Psychotic disorder	48
Any current psychiatric disorder	88

Other mental health difficulties

The average current PTSD symptom severity score was 29.08 (*SD*=13.78) which is in the moderate to severe range. Participants also reported high levels of more complex symptoms in the form of emotional regulation difficulties (62%), difficulty maintaining social relationships (93%), risk taking and putting self in danger (41%), suicidal ideation (19%), dissociative experiences (72%), and negative perceptions of the world and self (66%).

The mean depression severity was 19.65 (*SD*=12.63) which is in the moderate range, and the mean anxiety symptom severity score was 17.39 (*SD*=12.63) which is in the severe range.

Mental health and Type II trauma exposure

To investigate the relationship between Type II trauma and mental health, we examined whether there was a significant difference in the prevalence and severity of mental health disorder between those who had experienced Type II trauma relative to those who had experienced only Type I trauma.

It was found that 82% of those who had experienced Type II trauma met criteria for current PTSD, while 59% of those who had not experienced Type II trauma met criteria for current PTSD, and this difference was statistically significant (X^2 (1, N=114) = 7.76, p=.005). Those who had experienced Type II trauma had PTSD severity scores that were significantly higher (i.e., M=31.71, *SD*= 12.84, versus M=25.20, *SD*=14.33) (t(112)=-2.53, *p*=.01). It was also found that 72% of those who had experienced Type II trauma met criteria for lifetime PTSD, while 50% of those who had not experienced Type II trauma met criteria for lifetime PTSD, and this difference was significant (X^2 (1, N=114) = 5.74, *p*=.017).

It was found that 74% of those who had experienced Type II trauma experienced emotion regulation difficulties, while 46% of those who had not experienced Type II trauma experienced emotion regulation difficulties, and this difference was significant (X^2 (1, N=114) = 9.08, *p*=.003). There was also a significant difference in the proportion of those reporting risk taking and self-endangering behaviour (Type II trauma - 53% versus non-Type II trauma - 33%; X^2 (1, N=114) = 4.59, *p*=.03). There were not, however, significant differences between those who had experienced Type II trauma relative to those who had not, on negative social relationships, dissociation, negative views of the world or themselves, or suicidal preoccupation. Those experiencing Type II trauma did not differ from those who experienced only Type I trauma in

terms of any other disorder measured in this study (including current major depressive episode, anxiety, alcohol and substance use disorder, psychotic disorder).

Comorbidity

As identified in the literature review, PTSD is often comorbid with other psychiatric disorders [148, 149]. We therefore explored PTSD comorbidity in this sample.

All participants with PTSD had at least one other mental health disorder. Those who met criteria for current PTSD also met criteria for current major depressive episode (67% of PTSD was comorbid with major depressive episode), current substance or alcohol abuse/dependence (57% of PTSD was comorbid with substance/alcohol use disorders), or current psychotic disorder (38% of PTSD was comorbid with psychotic disorder).

Further analyses

To further explore the relationship between homelessness, trauma and mental health, we considered whether those who were in public housing (potentially a more secure form of housing; n= 27) differed from those currently in more insecure housing in terms of exposure to trauma and mental health. We hypothesised that those in more secure housing may have less trauma exposure and have less mental health problems than those in more insecure housing. A series of Chi-square and t-test analyses were conducted to determine whether this group of participants differed from the rest of the sample. No significant differences were found between participants living in public housing and those who were not, in terms of the prevalence of mental health disorders and exposure to Type I or Type II trauma.

Social support, connectedness and exclusion

Participants had low to moderate levels of social support and social connectedness and moderate to high levels of social exclusion. Participants were found to have medium levels of access to someone to talk to about their problems (appraisal subscale of the ISEL: M=9.59, SD = 4.03), medium levels of perceived access to people they could do activities with (belonging subscale: M=9.85, SD = 3.85), and medium access to material aid (tangible subscale: M=8.77, SD=3.78).

Participants were also asked a series of questions related to their sense of community connectedness. Participants were asked to rate the quality of the neighbourhood in which they live on a scale from 0 ("very poor) to 4 ("very good"). The overall mean rating was 2.42 (SD=1.25). Participants were asked to rate their satisfaction with the neighbourhood in which they live on a scale from 0 ("very dissatisfied") to 4 ("very satisfied"). The overall mean satisfaction level was 2.58 (SD=1.22) which is in the satisfied range. Participants were also asked to rate the degree to which they felt part of their local community on a scale from 0 ("not at all") to 4 ("very much"). The overall mean score was 1.81 (SD=1.58). This score indicates that overall, participants felt that they are part of the local community to only a small degree.

Participants were also asked several questions about their level of participation in activities. Forty-one per cent of participants had participated in a community activity in the past 12 months; 24% of participants currently participate as a member of a sporting, hobby or community-based club or association; 23% of participants took part in a voluntary activity in a typical week. When those who were living in public housing were compared to those in less secure accommodation, Chi-square analyses revealed that there were no significant differences in the level of participation in community activities, sporting, hobby or community-based clubs, or voluntary activities.

Access to transportation was identified as a problem, with 42% of participants being unable to attend an important event in the past 12 months due to a lack of transportation.

The construct of social inclusion was based on the level of community connectedness together with the level of social support, material resources (i.e., income), level of education, employment, and personal safety (i.e., whether the person had been a victim of violence). It was found that the mean social exclusion score was 3.42 (SD=0.95), indicating moderate to high levels of social exclusion.

Contrary to expectation, those who had experienced Type I trauma only (and not Type II trauma) did not report higher levels of social support or social connectedness, or lower levels of social exclusion. Both groups experienced similar levels of social difficulties. This was despite the view that Type II trauma is particularly damaging to the ability to form and maintain healthy relationships [12].

Help-seeking

Help-seeking after trauma exposure

Of those who experienced at least one traumatic event, 67% sought assistance for dealing with these experiences at some time in their life.

Of those who sought assistance (n=77), most visited a psychologist (27%, n=21 out of the 77 people who sought assistance) or a GP (25%, n=19), followed by a psychiatrist (21%), a counsellor (14%), or a support/case worker (7%). Furthermore, some of the 67% of participants who sought assistance accessed drug and alcohol counselling (4%), one visited a Centre Against Sexual Assault (CASA), and one tried painting and attended church.

The 50 participants (65%) who sought help described the assistance that they received as beneficial, while 27 (35%) participants reported that the assistance was unhelpful.

A small number of participants identified reasons why they found the help unhelpful. Reasons included:

- The assistance was ordered (e.g., court-ordered or military-ordered), rather than being sought by the participant (n=3).
- It didn't work/wasn't targeted/there was no action plan (n=1).
- The participant did not want to be judged (n=1).
- The participant did not want to be medicated (n=1).
- The participant did not feel like they were ready (n=2).
- The participant felt like they were not heard or not believed (n=2).
- The therapist did not ask about past experiences (n=1).
- It was too expensive (n=1).

Help-seeking for mental health concerns

Fifty-six participants (50%) reported that there had been a time when they did not seek professional help for a mental health issue, despite wanting to do so. The most common reasons for this included: not knowing how to get help (35%, representing 20 out of the 56 participants who reported not getting professional help); not trusting anyone (11%); thinking that no one can understand (11%); being unable to afford the appointment (7%); not caring enough (5%); not feeling ready (4%); and system failure (4%). A further 25% of participants cited other reasons, which included:

- Being unsure of what the issue was
- Being concerned about medication
- Finding it hard to find the right person
- Never being asked (if they wanted support).

Discussion

The aim of this study was to conduct a randomised cross-sectional study of people who have experienced long-term homelessness to examine the intersect between trauma, mental health and homelessness. This study recognised that past research into this area has been limited and that a well-designed study was necessary to examine the relationship between trauma, mental health and homelessness. However, central to the questions asked in the study was the aim to inform the development of a trauma and homelessness service framework that will assist services' understanding and provide improved and targeted responses to the needs of people who have experienced homelessness. This section will focus on the findings of the study, and how they fit with past research findings.

Study design

Before we explore the findings of the study, some comments about the study design are required. A randomisation methodology for selecting participants for the study was utilised by this study. The aim of randomisation was to create a sample that was representative of the larger population of people experiencing homelessness who access the services within the four agencies involved in this study. Randomisation acts to minimise the risk of bias in sample selection and therefore increases the generalisability of the study findings. The refusal/missed rate in this study was high. Only one in four people who were randomised into the study actually participated in the study. Some of these people refused to participate and some were not available to participate in the study after being randomised. Those who did agree to participate, however, did not differ from those who did not, in terms of gender. They did differ in terms of age, in that younger people were more likely to participate than older people. Given older people were more likely not to participate in the study, and there was a significant positive correlation between age and trauma exposure, it may be that the study sample represents a group with less trauma exposure relative to the whole population of people experiencing homelessness, and these results need to be interpreted as such.

One of the strengths of the current study was the fact that participants were sampled from a diverse range of services that work with people experiencing homelessness. Every attempt was used to approximate random sampling to ensure a representative sample from across these agencies. The sample consisted of people with varying experiences of homelessness (in terms of nature of current accommodation, or lack thereof, and the duration of homelessness). This is particularly significant because past studies have typically drawn samples from agencies best characterised as emergency

accommodation – making it difficult to generalise the results to the full range of potential experiences of homelessness [150]. It is also noteworthy that the current study employed an extensive in-depth clinical interview that included measures with robust psychometric properties. This also adds to the strength of the study design and therefore the conclusions that can be drawn from our findings.

Exposure to trauma

This study identified an exceptionally high level of trauma exposure in this sample of people currently experiencing homelessness. Each type of traumatic event, in the main, was experienced by a higher proportion of study participants than Australian community norms. High numbers of participants experienced interpersonal violence, especially rape and sexual molestation, which are recognised as having particularly adverse social and mental health impacts on people [151]. Furthermore, the total number of traumatic events experienced was also significantly higher than community norms. All the 115 research participants had witnessed or directly experienced at least one traumatic event, and the average number of traumatic event exposures was 21 events. This rate of trauma exposure (witnessing or direct experience) was higher than rates found in similar studies. For example, Taylor and Sharpe [20] in their sample of homeless people in Sydney reported an average number of traumatic events of six. This difference may be accounted for by our detailed methodology in asking about both witnessing and directly experiencing events, and the frequency of each type of event. Taylor and Sharpe [20] only asked participants to nominate whether an event had occurred or not (i.e., 'yes/no'), rather than recording the frequency of each event. They also did not ask about witnessing a traumatic event. Almost all the participants (97%) had experienced more than four traumatic events in their lifetime, compared to only 4% of the general community.

This study is the first study to explicitly measure exposure to repeated and prolonged trauma (Type II trauma) in a homeless sample. In this study, 60% of participants reported direct exposure to Type II traumas. To date, national surveys of mental health in Australia have not assessed the prevalence of Type II trauma, so a comparison to community prevalence rates was not possible. However, it is reasonable to conclude that this rate is exceptionally high.

There was a strong relationship between homelessness and trauma. Trauma exposure was frequently prevalent before becoming homeless. Trauma was often a precipitant to becoming homeless, and trauma exposure was frequently prevalent after becoming homeless. The majority of participants were exposed to trauma during their childhood. For many participants this childhood trauma was prolonged and repeated, and constituted child abuse (Type II trauma). For others, it was exposure to other events such as motor vehicle accidents, natural disasters, and violence (Type I trauma). These data confirm that childhood for this sample was not a safe time and that usual protective factors that operate during childhood were failing. There was also much to suggest that trauma was a major factor contributing to an individual's first episode of homelessness. In many instances, participants identified a traumatic event as the precipitant to becoming homeless. In other circumstances, family breakdown, relationship problems and other social difficulties were identified. Given this frequency of interpersonal trauma such as abuse, violence and other interpersonal violence within this sample, there is much to suggest that trauma may be central to the relationship/family breakdown that led to homelessness. Finally, trauma exposure occurred after becoming homeless. In fact, most of the exposure to traumatic events occurred after becoming homeless. The homeless environment was very unsafe, with repeated experiences of trauma. Trauma exposure in this environment was both interpersonal (exposure to abuse and violence) and non-interpersonal (e.g., accidents).

Finding 1

Our sample of people experiencing homelessness reported an exceptionally high rate of trauma exposure. Trauma exposure generally occurred across the lifespan with very high rates of trauma being experienced in childhood. Trauma was often identified as a precipitant to becoming homeless, and exposure to traumatic events escalated upon becoming homeless.

Mental health

Given the high number of experiences of multiple and serious traumatic events among study participants it was unsurprising that there were such high rates of PTSD. Seventy-three per cent of the sample met diagnostic criteria for current PTSD. In comparison, in the only Australian peer-reviewed study to examine PTSD prevalence rates in homeless adults, the 12 month prevalence of PTSD was 41% [20]. The difference in rates may be due to methodological reasons. Although both studies utilised validated structured clinical interviews, the instrument utilised by the other study (CIDI) may have been more conservative. Of all the mental health disorders assessed in this study, PTSD was the most frequent.

The majority of participants in our study (88%) met diagnostic criteria for a psychiatric disorder. In addition to PTSD, these included depression (54% of the total sample; 47% of males and 64% of females, respectively), and current psychosis (33% of the total sample; 33% of males and 32% of females, respectively). Rates of participants meeting criteria for alcohol abuse were found to be 49% for the total sample (47% of men and 63% of women), while rates of alcohol dependence were found to be 43% of the total sample (43% of men and 42% of women). The rate of participants meeting criteria for substance abuse disorder was found to be 51% of the total sample, with 43% of males reporting substance abuse and 42% of women. The rate of participants meeting criteria for substance dependence disorder was found to be 44% of the total sample (35% of men and 29% of women).

The prevalence rates of these disorders within our homeless sample were generally higher than rates that have been reported in the Australian literature. A study of men and women experiencing homelessness in inner Sydney found that 73% of men and 81% of women met criteria for at least one mental disorder in the past year (12 month prevalence) [65]. The prevalence rate of schizophrenia among men and women was 23% and 46%, respectively. Gender differences were examined in the Sydney study, and it was found that for men, there was a prevalence of 49% for alcohol use disorder, 34% for drug use disorder, 28% for depressive disorder and 22% for anxiety disorder [65]. For women the rates were 15% for alcohol, 44% for drug use, 48% for depressive and 36% for anxiety disorder.

The psychiatric profile of the sample was highly complex. When PTSD occurred, it occurred with at least one other disorder, most commonly major depressive episode or a substance/alcohol use disorder. This is consistent with other Australian research. For example, in the Sydney study of adults experiencing homelessness, of those who met criteria for current PTSD, 55% screened positive for psychosis; 69% scored in the severe or extremely severe range for depression; 50% scored in the severe or extremely severe range for anxiety; 63% screened positive for harmful or hazardous drinking or alcohol dependence; and 88% screened positive for a substance use problem, abuse or dependence [20]. In addition to the complexity demonstrated by experiencing multiple psychiatric disorders, the sample also reported other mental health difficulties which increased the complexity of their mental health presentation. Participants also reported high levels of emotional regulation difficulties, difficulty maintaining social relationships, risk taking and putting self in danger, dissociative experiences, and negative perceptions of the world and self. It can be seen how these difficulties may contribute to the ongoing trauma exposure. For example, difficulties controlling anger and aggression (emotional regulation difficulties) may increase the risk of interpersonal violence; risk taking and putting self in danger may increase the risk of injury or accidents; and dissociative experience may increase the risk of trauma by impeding escape from a high risk situation. In addition to this, psychosis or substance use disorders may also contribute to the risk of ongoing trauma exposure.

Finding 2

The majority of people experiencing homelessness in this sample met criteria for at least one psychiatric disorder, and most met diagnostic criteria for PTSD. In addition to these disorders, many participants experienced complex difficulties in emotional regulation, maintaining social relationships, anticipating and avoiding risk, and dissociation. Taken together, it is likely that these difficulties contributed to ongoing trauma exposure.

Impact of type of trauma exposure on mental health

Our hypothesis that exposure to Type II trauma would be associated with more severe and complex mental health problems relative to those who experienced Type I trauma only was only partially supported. The impact of exposure to Type II trauma was significant in a number of areas of mental health. Those with Type II trauma exposure had significantly more current PTSD, lifetime PTSD, and higher PTSD severity than those who had experienced Type I trauma only. In addition, those experiencing Type II trauma had a more complex presentation of difficulties, including emotional regulation difficulties, and higher levels of risk taking. That is, Type II trauma was linked closely to PTSD and an increased complexity in symptom presentation.

However, our analyses revealed that the complexity of presentations usually seen in those who have been exposed to Type II trauma was also evident in those experiencing Type I trauma. Specifically, there were no significant differences between those who experienced Type II trauma relative to Type I trauma on the prevalence or severity of depression, prevalence of substance or alcohol use or dependence disorders, anxiety severity, suicidal thoughts or behaviours, negative beliefs about self and the world, or dissociation.

The explanation for this lack of difference may lie in the extremely high levels of exposure to trauma regardless of whether the trauma experienced was Type I or Type II. Of particular note was the frequency with which Type I trauma occurred. In many instances this Type I trauma occurred frequently, repeatedly and persistently. This is unusual – Type I trauma events are usually 'one-off' events such as disaster exposure, or motor vehicle accidents. However, in our sample, even 'one-off' events occurred frequently as can be seen in Table 3. For example, the average number of life-threatening accidents experienced was over four, as was witnessing someone being severely injured or killed. Those participants who had experienced Type I traumatic events (and not Type II trauma) experienced a complexity in their symptom presentation that was often similar to those who had experienced Type II trauma exposure. That is, in this sample of people experiencing homelessness, recurrent Type I trauma was also associated with complex trauma presentations at a level usually only seen in those who have experienced Type II trauma.

Finding 3
In our sample, people experiencing homelessness who reported being exposed to Type II trauma were at increased risk for developing PTSD and having a highly complex mental health presentation. However, those experiencing homelessness who had not experienced Type II trauma also presented with a highly complex mental health presentation.

Impact of trauma upon homelessness

Simple analyses identified a significant relationship between experiencing trauma prior to experiencing homelessness and the length of time spent homeless. That is, an individual who had experienced trauma before going into a homeless environment was less likely to be able to secure and/or maintain accommodation over time. However, more complex analyses showed that this relationship was relatively weak and the effect was lost when considering other factors such as current age, and age they first experienced homelessness. These more complex analyses showed that the frequency of trauma exposure, when the trauma first occurred, and gender, were not significantly related to the time that someone spent being homeless, over and above the significant effect of age and the age when homelessness first occurred. It is difficult to interpret these findings. These findings may reflect the recognition that the factors which influence the length of time people experience homelessness are very complex and multi-dimensional. Our analyses tested whether trauma had a direct relationship with length of time someone was homeless (which it would appear that it did not). However, it may be that trauma experienced played an indirect role on length of time spent homeless. For example, trauma may have impacted upon a person's mental health, or social relationships, which in turn may have impacted upon the amount of time spent experiencing homelessness. It would be useful for further research to explore these types of indirect relationships but to do this, larger samples would be required. It may also be useful to utilise qualitatively designed studies to explore the factors that contribute to people leaving the homelessness cycle.

Part of the difficulty in interpreting these findings is that our sample had such a high level of trauma exposure. Everyone in the sample had experienced multiple traumatic events so it was difficult to discriminate a specific effect of trauma exposure on length of time spent homeless. These findings should not be interpreted to mean that trauma exposure does not impact on the length of time spent experiencing homelessness. If we had a control group of people who experienced homelessness and who had not experienced trauma, we could test this conclusion. However, our findings would suggest that the experience of homelessness and trauma exposure are so closely linked, that such a control condition does not exist.

Finding 4
Trauma exposure and homelessness were so closely linked in this study that it is difficult to examine statistically how trauma exposure contributed to the length of time spent homeless.

Social support, connectedness and exclusion

Generally, there was a moderate to low level of social support and social connectedness across the sample. Contrary to expectation, those who had been exposed to Type I trauma only had similar levels of social support and connectedness, and social exclusion, as those exposed to Type II trauma. Again, this is consistent with the finding that those with high frequency exposure to Type I trauma are presenting with complex mental health and social difficulties that are usually only seen with those exposed to Type II trauma. This is also consistent with the finding that the majority of the sample indicated that they had difficulty in maintaining social relationships. Taken together, social difficulties represented a fundamental component of the relationship between trauma and homelessness.

Finding 5
Difficulties maintaining social relationships, low levels of social support and connectedness, and high levels of social exclusion represented social disadvantage in this group. Taken together, this social disadvantage represented an essential component of the trauma and homelessness equation in this sample.

Help-seeking

Help-seeking and service use was only a small focus of this study so the data tends to raise more questions than it addresses. Nearly 70% of the sample had sought some type of help, at some time in their life, for dealing with their trauma experience. In many cases people found this helpful. About a quarter of study participants noted that in many cases they did not receive the help that they were seeking. There were a number of barriers identified, such as cost, difficulty engaging with the provider, or the provider not addressing the trauma. From this data we could conclude that (at some time over their life) participants were interested in seeking help for dealing with their trauma experience. In the majority of cases, participants sought help outside the service agency in which they were recruited. They sought services from GPs, psychiatrists, and counsellors. This does highlight that opportunities exist for appropriate trauma support to be provided by the agency support staff, and supports the development of the trauma and homelessness service framework that is being developed as part of this project. It suggests that access to support for dealing with trauma experiences may be increased as a result of the implementation of such a framework.

Limitations

Despite careful attention to the methodology, the results of this study should be viewed with a number of limitations in mind. First, we did not use a control group of age-matched or low-income housed participants. Such a control group would have identified whether it was the homelessness that increased the risk for trauma exposure and mental health problems. However, given the incredibly high rates of trauma exposure and mental health difficulties in our sample, a housed controlled comparison group would have only accentuated our findings. Another limitation of the study was that due to the cross-sectional design, it was not possible to draw any conclusions regarding causality between trauma and homelessness. Additionally, we were unable to test whether trauma exposure increased risk for depression, anxiety, alcohol disorder, substance disorder and psychotic disorder, because the entire sample had been exposed to trauma. It should be also noted that, in the interest of minimising participant burden, we only assessed for a limited number of mental health problems. For example, we did not assess personality disorders or many of the anxiety disorders, and as such, the mental health problems that are identified in this study may only represent a part of the mental health difficulties experienced by this population. Finally, it is important to recognise that service users who refused to participate in the study were older than those who participated, which may impact on the generalisability of the findings. The significant correlation between current age and trauma exposure suggests that our sample may have lower levels of trauma exposure than those who refused. It may suggest that the homeless population may be exposed to even higher levels of trauma than that seen in this sample.

Conclusion

Findings from this study suggest that long-term homelessness, trauma exposure, social disadvantage and mental health difficulties represented a cluster of vulnerability. They occur together and drive each other with significant consequences across a lifetime. Trauma exposure usually begins in childhood, is a precipitant to becoming homeless, and then escalates upon becoming homeless.

INTEGRATION OF THE INITIATIVE'S KEY FINDINGS

The Trauma and Homelessness Initiative was a unique collaboration. The initiative brought together the trauma expertise of ACPMH with the expertise of the homeless sector of SHM, ISCH, Mind Australia and VincentCare Victoria. It represented a major commitment by the homeless sector to elevate the importance of trauma and trauma-related difficulties. Importantly, this was a well-designed initiative comprising a number of different stages, with each stage designed to build upon the other and incorporate the lessons learned. Importantly, the initiative involved over 100 people experiencing long-term homelessness who were willing to share their time, and in many cases, their most painful and distressing experiences, in order to contribute to a deeper understanding of the relationship between trauma and homelessness.

Overall, the findings from the THI present a picture of a cyclical interrelationship between trauma exposure, long-term homelessness, mental health difficulties and social disadvantage. The interrelationships between the elements of the cycle see them driving and influencing each other. This in turn produces an environment which presents multiple potential barriers to recovery. A diagram representing this relationship is presented below.

Figure 3. Explanatory maintenance model of the relationship between trauma exposure, mental health difficulties, social disadvantage, and long-term homelessness.

Trauma exposure in this model includes exposure to Type II trauma and/or frequent exposure to Type I trauma, exposure to high levels of interpersonal violence, and high levels of trauma in childhood (which may or may not be Type II trauma). Mental health difficulties may include the psychiatric disorders measured in this study (PTSD, depression, substance use disorders, psychosis) as well as other Axis I disorders (such as panic disorders, agoraphobia, bipolar disorder) and Axis II disorders (personality disorders such as borderline personality disorder). Importantly, the scope of mental health difficulties goes beyond specific psychiatric disorders. Other mental health difficulties include emotional regulation difficulties, dissociation, dangerous risk taking (including not avoiding health and safety hazards), negative views about the world and self, and suicidal ideation and self-harming behaviours. Social disadvantage encompasses the spectrum of social difficulties including difficulties in forming and maintaining close interpersonal relationships, lack of social connectedness and social exclusion. In the explanation below we focus on difficulties maintaining close interpersonal relationships and an informal support network as these contribute to the foundation and maintenance of social disadvantage.

As the focus of this project is on the role trauma plays in maintaining long-term homelessness, exploration of the model will examine the reciprocal relationship between trauma and homelessness, trauma and social disadvantage, and trauma and mental health.

The link between trauma and homelessness

As was seen in the THI research, traumatic events are often a precursor to becoming homeless. In many cases people left their home to avoid ongoing trauma in the form of physical or sexual assault, child abuse, and other forms of interpersonal violence. In addition to this, the experience of trauma maintains long-term homelessness through its impact on mental health and social disadvantage. This is discussed further below.

It is also the case that being homeless is a risk for experiencing further trauma. In the THI research, the frequency of trauma exposure escalated when people lost their secure accommodation. Homelessness deprives individuals of a safe place for everyday activities and exposes them to risky, unpredictable environments. That is, homelessness is more than the absence of physical shelter. Homelessness is a stressful, dehumanising, and dangerous circumstance in which individuals are at high risk of being witness to or victims of a wide range of traumatic events [152].

The link between trauma exposure and social disadvantage

The early work of Bowlby [153] described the human need for intimate and long-lasting social attachments as a biological imperative. Trauma, especially that caused by the primary caregiver or other forms of interpersonal trauma, impacts on an individual's sense of safety and connection with other people, and therefore impacts on the ability to develop and maintain social relationships [154]. Much of the literature exploring the relationship between trauma exposure and social relationships has examined the impact of trauma exposure in childhood. The literature is very relevant to people experiencing homelessness given the high level of childhood trauma experienced by people in the THI research studies. Children exposed to high levels of trauma often experience difficulty negotiating relationships with caregivers, peers, and subsequently, marital partners [155]. Children exposed to high levels of trauma are at risk for impaired social-emotional development which is a foundation for healthy relationships [154]. They may lack the many skills required for social understanding which is the ability to understand feelings, beliefs and desires, and their role in social behaviour. Emotional knowledge, the ability to recognise emotional expressions in others and to understand the types of situations that can give rise to particular emotions [154], is often lacking. Difficulties with these skills can impair children's ability to predict and understand others' reactions to their behaviour and therefore impair the ability to form friendships [154]. Entering adulthood with impaired skills in social understanding may give rise to the high levels of relationship difficulties seen in the THI research.

Complicated social adaptations to severe and frequent trauma are not only limited to children. Research with rape survivors, women exposed to domestic violence, and concentration camp survivors show detrimental effects on self-identify, self-awareness, intimacy and communication, all of which are key elements in the maintenance of healthy interpersonal relationships [156, 157].

Difficulties forming healthy social relationships may also drive trauma exposure. Partner violence, which includes physical, emotional, and sexual violence, is the leading contributor to death, disability and ill health in Victorian women aged 15–44 [158]. Family violence has a profound and devastating impact on women, children, young people and communities, and is a significant contributor to homelessness among families [159]. This was very evident in the THI research where disintegration of the family unit was often a precursor to becoming homeless.

The link between trauma and mental health

Exposure to traumatic events in childhood is significantly associated with mental health problems in adulthood [160]. Childhood trauma increases risk for a complex presentation of psychological, social and behavioural disturbances, including (but not limited to) emotional dysregulation (difficulty regulating emotional responses), social dysregulation (including poor early and later attachment), negative perceptions of self and the world, dissociation, self-destructive behaviours, substance abuse, difficulty trusting people, and hopelessness [161-164]. Trauma exposure and its consequences are not limited to childhood trauma. While it is well-recognised that PTSD is a psychiatric disorder that may develop following trauma exposure, there is growing research that other problems develop following trauma exposure including depression and substance abuse [165]. In their research on homeless men, Kim et al [24] found that a history of trauma exposure in adulthood was significantly associated with mental health problems. Furthermore, PTSD itself is associated with an increased risk of developing other mental health problems such as substance use problems [166]. The findings from the THI research also support the relationship between trauma exposure and mental health. Not only were the prevalence rates of psychiatric disorders elevated in this population, but other adverse mental health experiences were also frequently reported. These experiences included difficulties such as emotional dysregulation, dissociation, suicidal thoughts or behaviours, negative views about the self and world, and risk taking. These adverse experiences were all frequently reported regardless of whether trauma had been experienced in childhood or adulthood.

These adverse experiences are important to note for several reasons. Difficulties such as these form the core of distressing and recovery-interfering aspects of exposure to trauma. In addition, dangerous risk taking (including not avoiding health and safety hazards), suicidal ideation and self-harming behaviours and dissociation also have important implications for safety. We also focus on these experiences because they suggest windows of opportunity for services to provide targeted assistance to people experiencing homelessness – to help lessen the impacts of trauma exposure, and make contributions towards the development of safety and psychosocial stability.

Emotional regulation difficulties have been identified as an outcome of persistent trauma exposure [167]. Emotional regulation difficulties include having difficulty distinguishing emotional responses in self and others, a low threshold for triggering strong emotional responses, high intensity emotional reactions, and difficulty calming down (and returning to equilibrium) [168]. These difficulties are often associated with a lack of skills for managing emotional reactions which includes compromised emotional recognition, poor distress tolerance [169], and difficulties controlling intensity and duration of emotional experiences [168]. Dissociation may be understood as a consequence of these emotional regulation difficulties. It can be characterised as a response to trauma exposure, which at first enables an individual to cope with the traumatic environment but over time becomes less helpful. Suicidal ideation and self-harming behaviours also can be seen in terms of diminished capability in regulation of emotion and problem solving skills.

Negative views of self and the world is a consequence of ongoing trauma exposure [170]. These beliefs can provide a lens through which future experience is understood [169]. Beliefs which carry unhelpful expectations of outcome or an individual's worth or capability can significantly impact on recovery after trauma. For example, a belief that bad outcomes are inevitable may underlie a person's feelings of hopelessness and helplessness, and a reluctance to seek or accept assistance.

Risk taking and self-destructive behaviours have long been associated with trauma exposure [155, 171]. Risk taking is the behavioural consequence of a compromised ability to identify risk in a situation. Risk taking is also an outcome of high levels of impulsivity whereby risk is not considered within a situation, thus exposing the person to health and safety hazards. It is also associated with difficulty using problem solving strategies. Often risk taking and emotional dysregulation are linked, so that risks are taken during high states of distress [169].

The maintaining relationship between trauma, homelessness, social disadvantage and mental health

Drawing together the individual pathways between trauma and homelessness, trauma and social disadvantage, and trauma and mental health leads to an explanatory model of reciprocal and interconnected relationships. Trauma may lead to mental health problems which leads to social and relationship difficulties which in turn maintain homelessness. For example, interpersonal violence may lead to posttraumatic stress responses including hypervigilance (high levels of physiological arousal), irritability, and avoidance, which in turn may lead a person to refuse accommodation that involves being with other people because they view other people as dangerous. Similarly, mental health difficulties might put stress on social relationship difficulties which increase the risk of relationship breakdown, trauma exposure and homelessness. For example, a person with a substance use disorder may experience a stress within their relationship which results in interpersonal violence, and homelessness is a consequence of avoiding the violence which in turn perpetuates the use of substances. And of course, there are cycles within this cycle. For example, research shows that traumatic experiences and resulting PTSD may lead to social difficulties which in turn maintains PTSD [172].

The THI research identified that the complex social and mental health outcomes associated with high trauma exposure were frequently reported. These included emotional dysregulation, difficulties maintaining close relationships, negative perceptions of self and the world, dissociation, and risk taking. It is easy to see how these outcomes may contribute to maintaining the cycle described above. For example, difficulties regulating emotions may lead to high levels of anger and aggression being expressed, which may lead to interpersonal violence which contributes to difficulties maintaining close relationships, and leads to negative perceptions about self and increased substance abuse, which in turn contributes to maintaining homelessness.

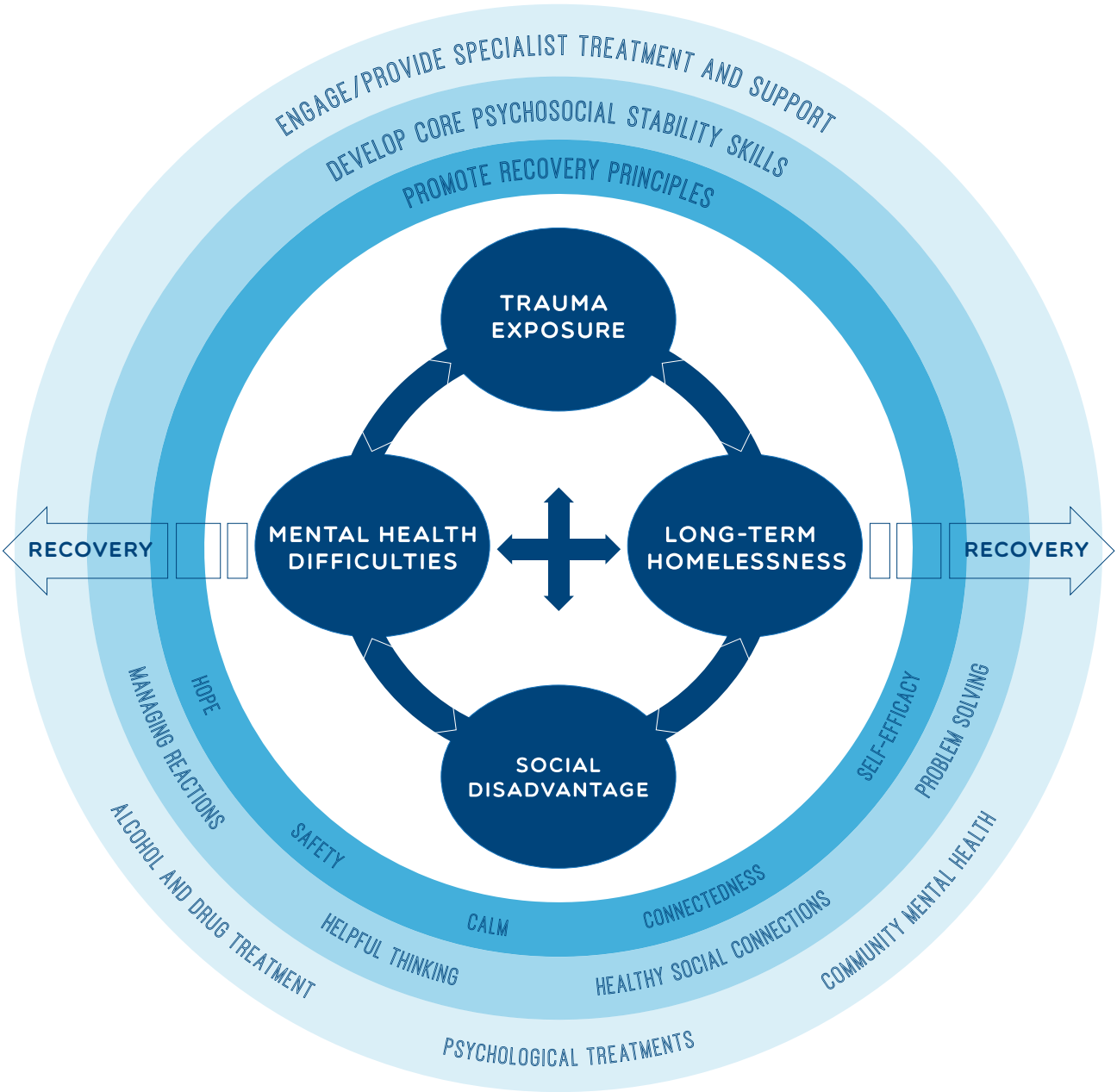
While the proposed explanatory model may be useful to understand the interconnectedness between trauma, homelessness, mental health difficulties, and social disadvantage, it is important to acknowledge that there are many more factors that contribute to the development and maintenance of homelessness. Other factors such as compromised access to resources (poverty, poor education, and long-term unemployment) and compromised health (such as chronic illness) also contribute to the cycle of chronic homelessness [1].

IMPLICATIONS FOR PRACTICE

A model of recovery must take into account this cyclical interrelationship between trauma exposure, long-term homelessness, mental health difficulties and social disadvantage. The findings from the THI research also articulate a number of principles and considerations for integrating trauma-informed principles and trauma-specific interventions.

This model articulates these principles and considerations, and identifies specific areas to focus on within homeless support agencies in order to develop psychosocial stability, and strengthen pathways to recovery. This model of recovery is depicted by Figure 4.

Figure 4: A model of recovery for people experiencing long-term homelessness.



The centre section of this model illustrates the previously described interrelationships between long-term homelessness, trauma exposure, mental health difficulties, and social disadvantage. Again, each component of this model serves to potentiate the others and ultimately this interaction prevents or delays recovery from trauma, improvement in mental health and social connectedness, and sustainable resolution of homelessness.

It is important to note that for the sake of simplicity and universality, the central factors identified in the recovery model serve as umbrella terms for a more complete set of factors which may or may not be present or significant for any given individual. For example, social disadvantage as an umbrella term incorporates systemic social exclusion, individual social isolation, and difficulties forming and maintaining relationships. Mental health difficulties incorporates experiences of symptoms associated with mental illness or mental health disorders, but also includes issues such as cognitive impairment and substance use difficulties.

When viewed as a model of recovery, the role of these central factors is to provide a basis for trauma understanding and awareness. The need for trauma awareness is a key aspect of trauma-informed practice, but trauma-informed care cannot be delivered in isolation from understandings of the impacts of social disadvantage and mental health difficulties. By looking at the interaction of these factors, this model allows for thinking and understanding that goes beyond categorising symptoms, disorders, and needs within unconnected domains or silos.

At an agency level, awareness of the interplay of these factors facilitates high-level planning. This includes considerations of what expertise, training and supervision of staff is required, which specific programs should be delivered, and what linkages with other services or sectors are necessary to address the factors contributing to long-term homelessness. At the level of individual work, an understanding of how these factors have manifested for an individual is key to developing deeper understandings and insights, demonstrating empathy, providing psycho-education, and planning for and resourcing recovery.

This model also describes the factors that support recovery from the nexus of trauma, long-term homelessness, mental health difficulties and social disadvantage. The innermost concentric circle describes principles that support recovery and resilience: promotion of hope, safety, calming, connectedness and self-efficacy. These principles serve as guides for practice at both the agency and individual worker level. They are relevant for responding to immediate crises, and recent and past experiences of trauma. These universal recovery principles also incorporate and to some extent subsume Hopper's consensus principles of trauma-informed care. They are also related to principles that have been developed in the personal recovery movement in mental health.

A focus on promoting hope communicates a strengths-based approach to recognising and managing the impacts of trauma. Hope carries an expectation of recovery and resilience in the future – that people affected by trauma can recover from and/or manage the impacts of trauma.

A focus on promoting safety involves reducing exposure to current risks and threats. It recognises and manages risk, works to prevent ongoing trauma, and seeks to minimise the risk of re-traumatisation within service settings. A focus on safety also involves providing a physically and emotionally safe space to engage and work with people.

A focus on promoting calm recognises the distressing and overwhelming nature of living with the impacts of trauma. It emphasises the importance of providing a predictable, stable and comfortable experience for people accessing help and support. It supports practices which respond to challenging and recovery-interfering behaviours with consistent and compassionate understandings and responses. A focus on promoting calm also recognises that there are supports and interventions that can directly support people's intrinsic abilities to self-soothe and gain a sense of control over their lives.

A focus on promoting connectedness recognises the key role that social connectedness and support play in mediating recovery from the impacts of trauma. The principle of connectedness also relates to the critical role of establishing and maintaining safe and strong relationships between service providers and service users, relationships that are characterised by well-defined roles and boundaries, and that are respectful of diversity.

Finally, a focus on promoting self-efficacy recognises the importance of fostering opportunities for people to rebuild self-control, empowerment and a sense of personal agency in dealing with the consequences of trauma exposure. This principle is readily operationalised at the individual level and emphasises locating control in the hands of the service user. It also applies at the organisational level by emphasising the importance of service user inclusion in service design, provision and evaluation.

The second concentric circle describes a set of foundational psychosocial stability skills that are thought to promote resilience and recovery from trauma. These are specific skill-based activities that a range of workers can offer across a variety of situations. The activities have been adapted from Skills for Psychological Recovery (SPR), an evidence-informed and modular package of brief interventions designed to be delivered to people in the aftermath of trauma exposure [173]. SPR has as its core goal the reduction of ongoing distress and promotion of recovery for people affected by trauma. The components of SPR are largely derived from cognitive behavioural therapy, although this is not a 'therapy' model per se, but rather a flexible and adaptable set of brief interventions that target areas of common difficulty for people who have been affected by trauma. The activities focus on the development and enhancement of skills relating to problem solving, managing emotional reactions, using helpful thinking, and maintaining healthy social connections.

These activities are explained in the accompanying Worker Guidebook, along with several supporting activities including a guide to how to approach and manage conversations about trauma experiences, and a method for prioritising which of the skill activities will be of most benefit.

Mindful of the resource limitations and realities of homelessness service settings, the guidebook provides a flexible approach to delivering these activities that allows for brief interactions of around five minutes, longer interactions of 15 minutes, and planned interactions where workers and service users are able to develop an overall plan for managing trauma impacts using whichever skills are most appropriate.

Finally, this model recognises that recovery occurs within a wider service system which can make critical contributions to the resolution of complex biopsychosocial difficulties. These service systems may hold specific knowledge, skills or expertise (e.g., access to psychiatry or specialist trauma-focussed psychological therapies), or may provide specific services (e.g., inpatient services or alcohol and drug specialist services). These specialist supports and treatments can have considerable barriers to entry and engagement for people who have been exposed to trauma, have compromised mental health, and experience social disadvantage and homelessness.

In contributing to psychosocial stability and the overall recovery from the impacts of trauma, homelessness services need to be engaged with and connected to this wider service system. At both the service and worker level it is critical to understand what specialist services can provide and how and when these services are best utilised. By supporting psychosocial stability with development of practical skills under a trauma-informed care approach, homelessness services may be more effective in supporting service users to access and get the most out of these specialist supports and treatments.

Conclusion

The factors in this model of recovery are strongly supported by the literature and the findings of the research conducted by the THI. Importantly, they are also consistent with the existing philosophical and practical orientations of the THI agencies. The consultations carried out within these agencies identified strong endorsement and incorporation of trauma-informed care principles. There was recognition that there was a unique opportunity for homelessness service providers to engage with and work with people for whom other pathways to recovery are denied. There was also a desire to go beyond existing trauma-informed care to provide targeted supports and services which contribute to the development of sustainable psychosocial stability and create pathways to resolve long-term homelessness.

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GLOSSARY OF TERMS

Term	Definition
Accumulation of stressful life events	A series of events occurring in close proximity, such as a relationship breakdown, loss of a business, loss of a house, or death of a loved one, for example.
Alcohol abuse disorder	A maladaptive pattern of drinking, leading to clinically significant impairment or distress. To meet diagnostic criteria, the individual must have experienced recurrent use of alcohol resulting in a failure to fulfil major obligations; use of alcohol in a situation which is dangerous; alcohol-related legal problems; or social problems which are exacerbated by alcohol.
Alcohol dependence disorder	A maladaptive pattern of drinking leading to physiological dependence on alcohol use and clinically significant impairment or distress. To meet diagnostic criteria, the individual must experience several of the following: (a) needing increased amounts of alcohol, or diminished effects with use of the same amount of alcohol; (b) drinking in larger amounts or over a longer period than intended; (c) desire to cut down or control drinking; (d) reduction of social or occupational activities because of drinking; (e) spending a great deal of time obtaining, using or recovering from drinking; and (f) continuing to drink despite knowing it is likely to cause problems.
Axis I	'Axis I' is part of the Diagnostic and Statistical Manual of Mental Disorders' multiaxial system for assessment. Axis I disorders are the most familiar and widely recognised disorders, and include anxiety disorders, mood disorders, eating disorders, psychotic disorders, dissociative disorders, substance use disorders .
Comorbid	The concurrence of two or more psychiatric disorders in the same individual.
Couch-surfing	A general term for moving from one temporary overnight arrangement to another, usually reliant on the goodwill of family, friends or acquaintances. Sometimes such arrangements may involve an exchange of sex. The term originally related to casual arrangements made by travellers to stay on someone's couch while touring, however, this term is now regularly used to describe a level of homelessness.
Depression	A period of two weeks or longer where the individual experiences persistent feelings of sadness or loss of pleasure, coupled with a range of other physical and psychological symptoms including fatigue, changes in sleep or appetite, feelings of guilt or worthlessness, difficulty concentrating, or thoughts of death.
Posttraumatic stress disorder (PTSD)	PTSD is a set of reactions that can develop in people who have experienced or witnessed an event which threatened their life or safety, or that of others around them, and led to feelings of intense fear, helplessness or horror. A person with PTSD has three main types of difficulties: (a) re-living the traumatic event; (b) being overly alert or wound up; (c) avoiding reminders of the event and feeling emotionally numb. **Current PTSD:** Means that the criteria for PTSD diagnosis has been met within the last 12 months **Lifetime PTSD:** Means that the criteria for PTSD diagnosis have been met at some time point during the person's lifetime.

Psychotic disorder	Psychotic disorders are severe mental disorders that cause abnormal thinking and perception. Two of the main active symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing or feeling something that is not there. **Current psychotic disorder:** Means that the criteria for psychotic disorder diagnosis has been met within the last 12 months. **Lifetime psychotic disorder:** Means that the criteria for psychotic disorder diagnosis have been met at some time point in time during the person's lifetime.
Substance abuse disorder	A maladaptive pattern of substance use, leading to clinically significant impairment or distress. To meet diagnostic criteria the individual must have experienced recurrent use of substance(s) resulting in a failure to fulfil major obligations; use of substance(s) in a situation which is dangerous; alcohol-related legal problems; or social problems which are exacerbated by substance(s).
Substance dependence disorder	A maladaptive pattern of substance use, leading to physiological dependence and clinically significant impairment or distress. To meet diagnostic criteria the individual must meet several of the following criteria: (a) needing increased amounts of the substance, or diminished effects with use of the same amount of substance; (b) taking the substance in larger amounts or over a longer period than intended; (c) desire to cut down or control substance use; (d) reduction of social or occupational activities because of substance use; (e) spending a great deal of time obtaining or using the substance or recovering from its effects; and (f) continuing to use the substance despite knowing it is likely to cause problems.
Type I trauma	Traumatic events include (but are not limited to) natural disasters, serious motor vehicle accidents, sudden death of a parent or child, and sexual assault. When the trauma involves a single incident, it is termed Type I trauma.
Type II trauma	Type II trauma involves prolonged and/or repeated trauma. In childhood, Type II trauma typically occurs within the child's primary caregiving system and/or social environment, and has the following characteristics: (i) trauma may involve direct harm and/or neglect by caregivers, or witnessing direct harm and/or neglect by caregivers; and (ii) trauma occurs at developmentally vulnerable times for a child. Exposure to this trauma occurs within an environment where escape is impossible (especially when the trauma is perpetrated by a primary caregiver). Type II trauma involving prolonged and repeated exposure to trauma where escape is impossible can also occur in adulthood, for example, in the case of political torture.
Sleeping on the streets or sleeping rough	Refers to sleeping outdoors where shelter from wind and rain is sought where possible. This may include sheltering between buildings, under bridges, in large clothing bins and rubbish bins, and in "squats." A squat is a vacant building or house used for sleeping in by a number of people experiencing homelessness.
Social exclusion	Refers to the complex compound of disadvantages which can act to marginalise a person in terms of their access to resources and their capacity to be involved in their community.


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