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THE USE OF TRAUMA-INFORMED CARE
IN PROGRAMS SERVING FAMILIES
EXPERIENCING HOMELESSNESS

by

Jeannine L. Lisitski

May, 2019

Submitted to the Faculty of
The Graduate School of Social Work and Social Research
of Bryn Mawr College in partial fulfillment of the requirements for the
Degree of Doctor of Philosophy

ABSTRACT

Using a qualitative research design, the purpose of this research was to explore practitioners understanding and utilization of trauma-informed care (TIC) as well as factors that facilitate or deter its' implementation within transitional housing programs for families experiencing homelessness. Directed content analysis was used with a theoretical framework including trauma theory, the Consolidated Framework for Implementation Research (CFIR), and the Bioecological Systems Theory (BST). Thirty-five practitioners from 23 programs participated. Participants primarily used the Sanctuary® Model of TIC. TIC practices identified were varied, general, and defied rigid proscriptions including mindfulness, motivational interviewing, and other social work practices. Programs faced many barriers related to TIC implementation with outer setting factors strongly influencing a programs ability to implement and sustain TIC. It is not enough for individual programs to practice TIC, TIC must be used in unison across social systems and public policies must be designed to be trauma-informed.

Keywords: Trauma-informed care, transitional housing, family homelessness, Sanctuary® Model, Consolidated Framework for Implementation Research, Bioecological Systems

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All glory, honor, and power to God, author of love, from which all things flow.

Trauma-informed care, the subject of this dissertation, is at its' core about love; or maybe I just see love everywhere. "Love is patient and kind; love does not envy or boast; it is not arrogant or rude. It does not insist on its own way; it is not irritable or resentful; it does not rejoice at wrongdoing but rejoices with the truth. Love bears all things, believes all things, hopes all things, endures all things. Love never ends." 1 Corinthians 13:4-7

There are many that had a part in this finished work that I want to acknowledge, but I must start with Dr. Sandra Bloom, the author of the Sanctuary® Model, without whom I would not understand the rippling impact of trauma within an organization and the importance of creating a culture to counter it. I am so grateful for Dr. Susan Sorenson, Dr. Judith Porter, and Michelle Ray, colleagues in the work to end gender-based violence, who encouraged me when I tried to give up! I am also deeply grateful to my Bryn Mawr College Graduate School of Social Work and Social Research (BMCGSSWSR) colleague, Dr. Kyra Turner Zogbekor, for showing up at my office on that fateful day and helping me to take the next step forward- God sent you that day- I am grateful you said "yes". I am grateful to all of my colleagues at Women Against Abuse, who live out trauma-informed care each day on the front lines of devastation: you inspire me.

I also want to acknowledge all of the people with lived experience of homelessness, from whom I've learned the most, especially, my friend Kat, who offered this wise advice: "Trauma-informed care should be implemented into the housing first model for the simple reason that homelessness is traumatic...chronic homelessness and

street homelessness are traumatic. Housing first is a model placing an individual who has two years or more of a documented homeless history into an apartment and providing various needed services. However, trauma-informed care isn't included in the services. For me, this meant that I had to find trauma-informed care in another system in order to meet my needs.” Written by Kat Delancey (“Identifying as transgender and who has experienced chronic street homelessness and is a current participant in a housing first program while separately enrolled in trauma-informed care”).

I dedicate this completed work to the memory of Dr. Raymond Albert, who saw something in me that I did not see in myself. I met Raymond during the 2005 inaugural class of Bryn Mawr College’s Graduate School of Social Work and Social Research Non-Profit Executive Leadership Institute (NELI) when I participated in the program. After completing the NELI program, I was asked by Raymond to co-facilitate the program. During the two years that I co-facilitated NELI, Raymond asked me if I had a Ph.D. in my future. I was a little shocked given that education had been a struggle for me. My early life was relatively chaotic, and I missed out on a solid foundation of education, culminating in dropping out of high school. I went to beauty school and ended up working my way through college as a cosmetologist. When Raymond asked me that very simple question, “Do you have a Ph.D. in your future?” I started to believe that maybe I did. On the Ph.D. journey, there were others at BMCGSSWSR that helped me to believe that I could succeed as well, including former Dean Dr. Darlyne Bailey, Dr. Leslie Alexander, Dr. Tom Vartanian, Dr. Julia Littell, and my dissertation Director of Work, the amazing, one-of-a-kind, Dr. Cindy Sousa. Cindy: Without the power of your encouraging words and all of your support and guidance, I surely would not have written

this, and this day would not have come. I am deeply grateful to have landed with the best dissertation coach imaginable! To all of the BMCGSSWSR faculty and staff that encouraged me and reflected back to me something that I did not always see in myself, you are bright lights, illuminating the path for students in pursuit of a more just world.

As I wind down this meandering 12-year journey to a Ph.D., I have profound gratitude to my husband, John, my family (Dad, Stepmom, Brother, Sister, Sisters-in-law, Brothers-in-law, Aunts, Uncles, Cousins, Nieces), my church family, and other souls that I love fiercely (that is a long list), for understanding my absences graciously (for the most part!) and still loving me nonetheless. I grieve for the time I lost with loved ones, precious moments forever lost.

“What has been is what will be, and what has been done is what will be done, and there is nothing new under the sun...there is no remembrance of former things, nor will there be any remembrance of later things yet to be among those who come after.” Ecclesiastes

1:9-11

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DEFINITIONS

Empowerment Model: The empowerment model is based on the empowerment theory, the idea that in order to improve one's life, one must have control over their environment (Busch & Valentine, 2000). Cattaneo & Goodman (2014), define empowerment as, "a meaningful shift in the experience of power attained through interaction in the social world" (p. 84). Cattaneo and Chapman (2010) developed the empowerment process model in which a person that is disempowered sets a goal related to increasing their own power, then takes steps to achieve the goal and makes progress towards their goal. Once progress is made towards the goal, the person reflects on their own actions in relation to the achievement of the goal (Cattaneo & Goodman, 2014).

Housing First Approach: Housing first is an approach to homelessness in which housing is the first priority, above addressing other issues such as behavioral health issues or a lack of education or life skills (National Alliance to End Homelessness, 2016). With the housing first approach, there are no pre-requisites to eligibility for housing nor are there mandates for service participation to retain housing. This approach locates stable housing as a foundation for health and wellbeing.

Social Work: The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients.

Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation, administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems (NASW, 2018).

Social Work Values: The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- Service
- Social justice
- Dignity and worth of the person
- Importance of human relationships
- Integrity
- Competence.

This constellation of core values reflects what is unique to the social work profession.

Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience (NASW, 2018).

Transitional Housing: Transitional housing (TH) combines up to 24 months of housing with accompanying support services in order to provide a foundation of stability to enable successful transition to independent living (HUD, 2017).

Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (SAMHSA, 2014a, p. 7).

Trauma-Informed Care: Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment (Hopper et al., 2010, p. 82).

A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization (SAMHSA, 2014, p. 9).

Trauma-Specific Services: Trauma-specific services are clinical interventions that treat specific trauma symptoms that are part of PTSD or another trauma-based disorder (DeCandia & Guarino, 2015).

CHAPTER 1: INTRODUCTION

The symptoms of trauma can have a debilitating effect on goal-directed and empowered behaviors that may help to mobilize families experiencing homelessness to

access and sustain stable housing. In this chapter, I provide an overview of the problem of family homelessness and the high levels of trauma experienced by these families as well as the impact of trauma on functioning. I then provide a brief review of the literature about the need for trauma-informed care (TIC) within residential programs for families experiencing homelessness. Next, I discuss transitional housing programs for families as an appropriate site for TIC implementation. Finally, I discuss the challenges in implementing TIC, related both to the construct of TIC as well as the program configuration of TH. The purpose of this research was to explore the current state of TIC understanding and utilization by staff within transitional housing programs for families experiencing homelessness as well as barriers and facilitative factors to the implementation of TIC.

Family Homelessness is on the Rise

Family homelessness has been increasing since the 1980s, with a sharper increase between 2007 and 2010 due to the Great Recession (Buckner, 2014). Although the most recent U.S. Department of Housing and Urban Development (2016-2017) point-in-time (PIT) count indicated a 21% decrease in the number of persons in families experiencing homelessness over the past decade, the U.S. Department of Education homeless student count for the same period, which requires schools to identify students lacking a “fixed, regular, and adequate nighttime residence,” indicates a 92% increase in child homelessness over the same decade (National Center for Homeless Education, 2018). The U.S. Department of Housing and Urban Development (HUD)’s point-in-time count for families is largely a function of the shelter housing inventory since shelters are usually at capacity (National Law Center on Homelessness and Poverty, 2017).

Furthermore, homeless families do not typically stay on the street for fear that they will be separated from their children by child welfare. Families experiencing homelessness that cannot access shelter are forced to stay in abandoned homes, cars, or doubled and tripled up in precarious and often unsafe situations (National Law Center on Homelessness and Poverty, 2017).

There are many factors that have contributed to this trend, the chief of which is the reduction in affordable housing opportunities nationwide. Specifically, the U. S. Department of Housing and Urban Development's (HUD) funding for low-income housing decreased by 48% from the beginning of the 1980s to 2004 (Nunez, 2010) with the reduction of approximately 570,000 units (Schwartz, 2015). The loss of affordable housing units has coincided with an increase in the need for affordable housing, an indicator of vulnerability to homelessness. One measure of this need is the indicator of *worst-case housing need*, defined as renters with incomes below 50% of the area median, facing severe cost burdens, or severely deficient housing (Schwartz, 2015). In 2011, 8.475 million very low-income renters had worst-case housing needs, a 43.5% increase from 2007 (Schwartz, 2015). At the same time, mainstream safety net social programs have been cut (Katz, 2013) and income inequality has increased (Grant, Gracy, Goldsmith, Shapiro, & Redlener, 2013). Today, families comprise approximately 38% of the homeless population (Hayes, Zonneville, & Bassuk, 2013) and 50% of the sheltered homeless population (Bassuk, DeCandia, Tsertsvadze, & Richard, 2014). The number of single, female-headed households has dramatically increased over the past 20 years, with more than four out of five homeless families now headed by single women (Bassuk,

2010). These families are 2.5 times as poor as other families and even poorer than individuals with a disability or senior citizens (Bassuk, 2010).

Factors that Lead to Family Homelessness

Many factors lead to family homelessness, including, of course, lack of affordable housing opportunities and extreme poverty. Other relevant factors include medical, mental health, and substance use problems, all of which are more common among the subpopulation of poor families that experience homelessness (Bassuk, 2010; Buckner, 2014; Hayes, et al., 2013). Importantly, researchers have consistently found that mothers who are homeless are more likely than their housed counterparts to have more extensive histories of traumatic stress including interpersonal violence both in childhood and as an adult (Guarino, Rubin, & Bassuk, 2007; Hayes et al., 2013; National Center for Family Homelessness [NCFH], 2011). In fact, research suggests that among poor, homeless mothers, more than nine out of ten have a history of some sort of interpersonal trauma in their lifetime ranging from childhood sexual abuse and/ or severe physical abuse, to adult intimate partner violence, as well as physical or sexual assault by a non-partner (Bassuk et al., 1996; DeCandia & Guarino, 2015). In addition to direct experiences of violence, mothers that experience homelessness are much more likely to have experienced out-of-home placement during childhood (NCFH, 2011) and approximately one in five children experiencing homelessness is separated from their family at some point (Kilmer, Cook, Crusto, Strater, & Haber, 2012). Foster care placement has been identified as a childhood risk factor that predicts family homelessness during adulthood (NCFH, 2011).

Homelessness and Trauma

Homelessness not only deprives families of their basic survival needs, but it also

exposes them to considerable hardship and danger (Fitzpatrick, LaGory, & Ritchey, 1999). Both the experience itself of homelessness as well as factors that lead to homelessness such as domestic violence, lack of a stable home and the sense of security that comes with it, and living doubled and tripled up with other families involve events that are experienced as traumatic for both adults and children (Goodman, Saxe, & Harvey, 1991; Guarino & Bassuk, 2010; U. S. Interagency Council on Homelessness [USICH], 2015). In *Opening Doors* (2015), HUD's strategic plan to prevent and end homelessness (USICH, 2015), federal officials concluded that homeless children have experienced high levels of adversity, poorer overall health, and poor school outcomes. Furthermore, DeCandia & Guarino (2015) found that children who have experienced homelessness have high rates of lifetime trauma, with 83% exposed to at least one serious violent event by age 12. Given the role of trauma within homelessness, we must attend to the urgent priority of understanding how practitioners understand (or do not) trauma and implement (or do not) TIC within residential programs for families experiencing homelessness.

What is Trauma?

There is no universal definition of trauma, although the most commonly referenced one was defined by the Substance Abuse and Mental Health Services Administration (Menscher & Maul, 2016) as "individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (Substance Abuse and Mental Health Services Administration [SAMSHA], 2014a, p. 7).

Traumatic stress can produce serious and chronic changes in physiological arousal, emotion, cognition, character, and memory as well as interfere with the connection between these functions (Herman, 1997; van der Kolk, McFarlane, & Weisaeth, 2007). Particularly when experienced in combination, traumatic events are likely to cause serious trauma-related sequelae such as Post Traumatic Stress Disorder (PTSD), depression, and even more complex trauma issues such as Disorders of Extreme Stress Not Otherwise Specified (DESNOS), also coined by Judith Herman (2015) as "Complex PTSD" (Brett, 2007).

Trauma Impacts Functioning

The symptoms of trauma can have a debilitating effect on goal-directed and empowered behaviors that help to mobilize families experiencing homelessness to secure and sustain stable housing. In a recent policy statement on meeting the needs of families experiencing homelessness, the U.S. Departments of Health and Human Services, Housing and Urban Development, and Department of Education asserted that “repeated traumatic events can serve as a barrier for families to participate in services and supports and form trusting relationships, and present serious risks to children’s and parents’ functioning and well-being” (HUD, 2016a, p. 4). Chronic abuse and trauma can overwhelm a person’s ability to adapt to life and can lead to serious psychological damage (Herman, 1997) including post-traumatic stress disorder (PTSD). There are three main categories of symptoms that comprise PTSD including hyperarousal, intrusion, and constriction (Herman, 1997). Hyperarousal is an overreaction to stimuli which interferes with normal functioning and can include symptoms such as startle reaction, sensitivity to noise, and frequent sleep disturbances. Intrusion refers to unwanted memories (i.e.

flashbacks) of the traumatic event often lacking a verbal narrative and context, but consisting primarily of sensations and images (Herman, 1997). Survivors have a tendency to reenact their traumas both in action as well as in thought, oftentimes trying to imagine a different outcome. The attempts by the survivor to control intrusive symptoms can lead to a "narrowing of consciousness, a withdrawal from engagement with others, and an impoverished life" (Herman, 1997, p. 42). Constriction refers to a detached state of consciousness that often presents as a trance or dissociative state with some evidence of endogenous impacts (Herman, 1997). These constrictive symptoms can interfere with planning for the future.

Van der Kolk (2007) identified factors that contribute to more serious impacts of trauma over a lifespan including occurrence at a young age, continuous or ongoing trauma, and trauma that occurs within an interpersonal situation. The cumulative impact of traumatic experiences on mothers can impact their ability to "form safe, trusting relationships, work consistently, and parent effectively" (Bassuk, 2010, p. 497; Goodman et al., 1991).

The Use of Trauma-Informed Care in Programs for Families Experiencing Homelessness

Various researchers have called for the use of TIC within programs serving families experiencing homelessness due to the high level of lifetime experience of trauma that these families have faced (Guarino & Bassuk, 2010; Hopper, Bassuk, & Oliver, 2010). However, there is little research on the use of TIC within these programs. Trauma-informed care (TIC) is a broad set of practices based on six key principles (Substance Abuse and Mental Health Administration [SAMHSA], 2014), not unlike

social work's core values, including safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice, and choice; and cultural, historical and gender inclusivity. TIC is meant to be used systemically throughout entire organizations to create a culture of safety and promote healing from trauma. Other TIC frameworks have included a provision of services that emphasize an individual's strengths, highlighting adaptability and resilience over a pathologized view of symptoms (Elliott, Bjelajac, Falot, Markoff, & Glover Reed, 2005). The idea of collaboration in TIC is akin to the "working alliance" in the field of psychology, which has been found to be one of the key active ingredients in successful psychotherapy (Herman, 1997; Knight, 2015). Hopper, Bassuk, and Oliver (2010) reviewed the sparse evidence base on the use of TIC with individuals and families experiencing homelessness and drafted a consensus-based definition of TIC: "Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper et al., 2010, p. 82). The focus of TIC is not to address the specific underlying sources of trauma but to provide support in managing symptoms of trauma and engaging in more effective daily functioning (Knight, 2015). TIC shifts the focus from a pathological framework of deficiency to one based on the impact of a person's lived experiences; in other words, a shift from "What's wrong with you" to "What happened to you" (Menscher & Maul, 2016, p. 2).

The Need for Trauma-Informed Care in Homeless Programs

The ways that providers understand and utilize trauma-informed approaches, both in policy and in practice, as it relates to housing and service interventions for families experiencing homelessness, has only recently begun to be explored with various authors calling for more research to gain a consensus on the definition, principles, and components of TIC to develop practice guidelines. In response to these needs, this study focuses on the use of TIC in transitional housing (TH) programs for families experiencing homelessness as experienced by the staff in these programs. There are various studies that have found high prevalence rates of trauma and depression among families experiencing homelessness. However, few studies exist that are relevant to understanding the impact of trauma on housing stability for families or the impact of the use of TIC on a families' future housing stability. Furthermore, it is not known to what degree programs for families experiencing homelessness utilize TIC and what that means to them.

The Homeless Families Program study, a descriptive evaluation of a large-scale demonstration project involving 924 families living in service-enriched housing programs for homeless, found a high prevalence of childhood and adult experiences of interpersonal violence and upheaval as well as of depression (Rog, McCombs-Thornton, Gilbert-Mongelli, Brito, & Holupka, 1995). Additionally, almost a third of the families had subsidized housing prior to entering the program and lost it for a variety of reasons with domestic violence being cited in one-third of these cases. The families' trajectory to homelessness was marked by years of instability beginning five years prior to entering the program. The authors concluded that there is a need for comprehensive interventions, one of the hallmarks of TIC (SAMHSA, 2014b), with this population since about a

quarter of the participant mothers had needs spanning all three broad areas assessed including human capital, health, and mental health/ substance abuse.

The Service and Housing Interventions for Families in Transition (SHIFT) Longitudinal Study evaluated the effectiveness of different models of supportive housing for families experiencing homelessness including emergency shelter, transitional housing, and permanent supportive housing (Hayes et al., 2013). The goals of the study were to identify the needs and characteristics of women experiencing homelessness and to understand the effectiveness of different models of housing plus service interventions on housing stability and family self-sufficiency (Hayes et al., 2013). Participating families were recruited in four cities in upstate New York when entering one of the three housing conditions with a total of 292 families at baseline. By the 30-month follow up, there were 184 families remaining in the study, a 29% attrition rate. The study found high rates of maternal trauma with 93% of participants having at least one trauma, 81% having experienced multiple traumas, 79% having experienced childhood trauma, and half meeting the DSM-IV diagnostic criteria for PTSD at baseline (Hayes, Zonneville, & Bassuk, 2013). At the 30-month follow up, low self-esteem and high PTSD symptoms were the only predictors of residential instability among a myriad of other variables including demographics, general health, mental health, substance use, parenting practices, and strengths and difficulties (Hayes et al., 2013). This is the first study to find that trauma has a direct impact on a family's ability to maintain residential stability (Hayes et al., 2013). At the final follow up, nearly half of the families remained unstable regardless of the program model the families received (Hayes et al., 2013). Although this study used data elements to measure trauma, trauma-informed care/ practice was not measured.

The authors conclude that because the mothers' trauma symptoms predict housing stability, that any program for families experiencing homelessness would need to address the mother's trauma for families to achieve stability (Hayes et al., 2013), specifically, programs should implement TIC as a cost-effective strategy.

Likewise, Brush, Gultekin, Dowdell, Saint Arnault, and Satterfield (2017) examined the stories of 29 homeless or unstably housed mothers within the broader literature on family trauma and violence and found a high level of lifelong interpersonal trauma and violence. The authors concluded that it is not enough that services to families be "trauma-informed" but that addressing trauma and violence is integral to housing stability. Another researcher (Sullivan, Lopez-Zeron, Bomsta, & Menard, 2018) conducted in-depth interviews with 11 advocates working with survivors of domestic violence that were also experiencing homelessness. Domestic violence is a leading cause of homelessness among parents, with "Forty-nine percent of all homeless parents having a history of domestic violence, and one in four citing such abuse as their primary reason for seeking shelter" (Nunez, 2010, p. 84). Each interview focused on a case in which the survivor was successfully housed (Sullivan et al., 2018). The major practice themes that emerged from this research were the need to continually address safety and trauma as well as multiple interrelated issues and not just housing. The authors conclude that "funding priorities should reward efforts that attend to the complex needs of survivors in order to attain long term success" (Sullivan et al., 2018, p. 7). The existing research, albeit sparse, points to a need for TIC within programs serving families experiencing homelessness. However, it is not known whether these programs utilize TIC and if so, what that means to them and what practices are used to deliver TIC.

Trauma-Informed Care in Programs for Families Experiencing Homelessness

In their literature review of the use of TIC in homeless service settings and behavioral health programs, Hopper et al. (2010) found that TIC may have a positive impact on housing stability among families experiencing homelessness. Furthermore, the results highlighted an increase in positive outcomes for children and reduced symptomatology for adults. This literature review included quantitative and qualitative studies as well as corroborative evidence such as program evaluations and unpublished pilot studies. However, the review synthesized findings across programs for singles and families experiencing homelessness as well as non-homeless mental health and substance abuse programs (Hopper et al., 2010). Several of the studies cited were from research based on the data set from the Women, Co-Occurring Disorders, and Violence Study (WCDVS) (Morrissey et al., 2005), a study conducted in nine sites ranging from residential to outpatient settings with 2,026 women, that found a small but statistically significant overall improvement in women's trauma and mental health symptoms with an intervention described as an integrated treatment approach to working with women with co-occurring disorders. The study also found that trauma-specific interventions can be thwarted if they are not delivered in a TIC context (Morrissey et al., 2005; Health Care for the Homeless [HCH], 2010).

Challenges in Implementing Trauma-Informed Care

Despite the connections between trauma and homelessness, programs serving families experiencing homelessness are often not utilizing TIC (Hopper et al., 2010). Furthermore, the available supportive housing program models either exclude families without a permanent disabling condition or they lack the supportive services needed to

develop a culture of TIC necessary to address the high levels of trauma experienced by families who encounter homelessness (Gubits et al., 2016; McKinney-Vento Homeless Assistance Act, 2009; USICH, 2015).

There are several interconnected challenges with implementing TIC within TH programs for families experiencing homelessness related to both policy and practice. First, the federal governments shift to funding shorter-term interventions with limited supportive services takes the focus off of creating a trauma-informed context for programs. Second, there is confusion about what TIC is including how it is unique from social work practice. Finally, there is a lack of comprehensive and accessible models of TIC designed for use in residential programs for people experiencing homelessness. Below, I briefly describe these three challenges.

Shifts in Federal Homeless Housing Policy

A major challenge to TIC implementation in programs serving families experiencing homelessness involves federal policy trends away from service-rich supportive housing models such as TH, in favor of housing-only interventions. After focusing on ending chronic homelessness for over a decade, HUD's Plan for ending homelessness, *Opening Doors* (USICH, 2015), has turned its attention to the aspirational goal of ending family homelessness nationally by 2020 without a clear pathway to accomplishing this goal including garnering the necessary resources. Although the federal government provides funding to address homelessness through the McKinney-Vento Homeless Assistance Act, it is not sufficient to meet the need for affordable and/or supportive housing for families experiencing homelessness (USICH, 2015). The increase in family homelessness puts pressure on the homeless assistance network,

leaving the federal government in a quandary of how to allocate scarce resources and which types of interventions to prioritize. HUD's primary interventions for homeless families include permanent supportive housing (PSH), reserved for those with a disability), rapid re-housing (RRH), transitional housing (TH), prevention and diversion, and brokered subsidized housing (typically with no supports) through collaboration with local housing authorities. The current HUD policy for families experiencing homelessness deprioritizes interventions that are better resourced to implement TIC, such as the Transitional Housing Program, and prioritizes short-term rental subsidies with very limited supportive services focused only on housing issues (i.e. rapid re-housing). TH has been reduced by more than 33% over the past few years, from 400 million in 2013 to 255 million in 2016 (HUD, 2016b).

The role of services for families experiencing homelessness has remained a hotly debated topic. Various studies have noted the detrimental effects of a myopic focus on rapid re-housing as a one-size-fits-all solution to family homelessness (Nunez & Adams, 2014; Kilmer et al., 2012; Bassuk, DeCandia, & Richard, 2015), primarily because the lack of appropriate supports and time-limited rental subsidies may actually perpetuate cycles of homelessness. Families often cannot effectively navigate the social services system without support due to the complexity of the systems combined with symptoms of trauma and other health issues (Nunez & Adams, 2014; Bassuk, DeCandia, & Richard, 2015). Whereas others, including USICH, contend that family homelessness should be treated as a time-limited crisis requiring short-term housing focused support without other services (USICH, 2015). This dialectic needs to be shifted with a focus on outcomes that will have long-term positive impacts on homeless families. By focusing

on immediate housing stability as the ultimate outcome, HUD has missed the opportunity to address traumatic stress and associated vulnerabilities which limit goal-directed and empowered behavior. In so doing, current policy risks exacerbating intergenerational cycles of homelessness and poverty.

Varied Models of Trauma-Informed Care

Although there are over a dozen models of TIC that can be used in a variety of health and human service settings (Jennings, 2008), the models vary widely in their thoroughness including whether they incorporate; 1) assessment and implementation curriculum, 2) comprehensive training guides and train-the-trainer modules, 3) technical assistance and support, and 4) tool kits (Jennings, 2008). Furthermore, there are few models designed for residential programs serving families experiencing homelessness. One of the most robust models of TIC is the Sanctuary® Model (Bloom, 2013), not only in terms of the wide range of available tools to support implementation, but also because it is the only model that is evidence-based according to the California Evidence-Based Clearinghouse for Child Welfare (California Evidence-Based Clearinghouse for Child Welfare [CEBC], 2018). Specifically, CEBC rates the Sanctuary® Model as a “3” for “promising research evidence” (CEBC, 2018). There are six other program models cataloged as part of the CEBC in the category of a system-level TIC program, but they are all “not able to be rated” because there is not enough scientific evidence (CEBC, 2018).

TIC models are not standardized interventions whose efficacy has been determined. TIC models vary in the intended audience and setting as well as the types of tools available (Jennings, 2008). Furthermore, there are few comprehensive models that

include assessment tools and implementation curriculum, comprehensive training guides and train-the-trainer modules, technical assistance and support, and tool kits to make the model accessible for users (Jennings, 2008).

Trauma-Informed Care Overlap with Social Work Practice

Related to the lack of robust and accessible TIC models, there is an overlap between TIC and general social work values and practices; this adds to the puzzlement around TIC. Indeed, social workers contributed to the development of trauma theory as they worked in the spheres of child protection, rape, crisis, and family violence, in which they witnessed extreme traumatic stress (Kimberly & Parsons, 2017, p. 554-555). Social workers were leaders in advocating for social change for those who were most oppressed, including through crisis intervention work (Kimberly & Parsons, 2017, p. 556). Some researchers have suggested that trauma should be an organizing principle for social work practice since it is a widespread experience that cuts across various groups and occurs regularly within populations served by social workers (Joseph & Murphy, 2014).

Solutions to family homelessness have historically focused on structural issues and/ or individual vulnerabilities. For example, lack of affordable housing and living wage jobs as well as behavioral health issues. However, what we know about the impact of trauma and what it takes for a family to achieve housing stability and wellbeing suggests that we will need to widen our focus to address trauma, shore up resilience, and provide the tools necessary for families to build a stronger economic future through developing programs and policies that are trauma-informed. The symptoms of trauma can have a debilitating effect on goal-directed and empowered behaviors that help to mobilize families experiencing homelessness to achieve stable housing. Despite the

importance of integrating trauma-informed care (TIC) into homeless services, various researchers and authors have called for a consensus on the definition, principles, and components of TIC to develop the lacking practice guidelines for the field (DeCandia & Guarino, 2015; Hopper, 2010). For these reasons, solutions to family homelessness must be crafted by combining the need for affordable housing and specific supportive services within a specialized context of TIC.

Purpose of this Study

Given the challenges outlined above, the purpose of this study, is to explore the current state of TIC understanding and utilization by practitioners within TH programs for families experiencing homelessness. I focused on TH because, among the varieties of supportive housing programs for families experiencing homelessness, TH programs are best resourced with staffing levels sufficient to practice TIC. TH combines up to 24 months of housing with accompanying support services in order to provide a foundation of stability to enable a successful transition to stable permanent housing (HUD, 2012c). Since the length of stay in TH is relatively long and those with a disability are prioritized for permanent supportive housing, trauma may be the most salient presenting issue in this population (Oliva, 2013).

My specific research questions were, 1) How do providers understand TIC? 2) What staff behaviors and program attributes are linked to TIC practice? 3) What are the barriers to implementing TIC? and 4) What are the factors that help to facilitate TIC? Using a qualitative research design, I gathered data through a 10-item short answer and multiple-choice survey and semi-structured telephone interviews with staff of TH

programs in the eight most southeastern counties of Pennsylvania. I then used qualitative directed content analysis to analyze the data.

Summary

In the following chapter, the literature review, I expand on some of the concepts outlined in this chapter including further illumination of TIC and the challenges associated with it such as the varied models of TIC and the overlap between TIC and social work practice. Additionally, I review the history and origins of TIC and the associated terminology as well as the specific practices and program attributes that are associated with TIC. I then review the practice and policy barriers to the implementation of TIC and summarize how TIC calls for an integrated approach to care, followed by a summary of my theoretical framework. Specifically, I review implementation science including the Consolidated Framework for Implementation Science (CFIR) (Damschroder et al., 2009), SAMHSA's TIC implementation domains (2014), and Bronfenbrenner's Bioecological Systems Theory (1992) as a framework for understanding the various barriers to and facilitative factors in implementing TIC. Following the literature review, I review the methods used in detail and then provide my findings organized into four chapters, one to summarize participant's understanding of TIC, one to discuss the practices reported by participants, and two to review the barriers and facilitative factors of TIC implementation broken out by factors internal to the program and factors related to external environmental issues.

CHAPTER 2: LITERATURE REVIEW

In this chapter, I provide an overview of the impact of trauma on psychosocial outcomes, a summary of trauma-informed care (TIC), including its history and origins as well as associated terminology and the specific practices and program attributes that are associated with TIC. I then review the challenges of TIC in more detail including defining TIC, distinguishing it from social work practice, and reviewing the competing TIC models. I provide a summary of the measurement of TIC as well as the policy and practice barriers to implementation of TIC in transitional housing (TH) programs serving families experiencing homelessness. I then review the gaps in research and end the chapter with a summary of the theoretical frames used in this study including SAMHSA's four TIC assumptions and six principles (SAMHSA, 2014), the Consolidated Framework for Implementation Science (Damschroder et al., 2009), SAMHSA's (2014) ten TIC implementation domains and Bronfenbrenner's (1992) Bioecological Systems Theory.

The Impact of Trauma

Trauma and its lasting impacts can have a lifelong effect on one's health, wellbeing, and even mortality as well as a debilitating effect on goal-directed and empowered behaviors that help to mobilize families experiencing homelessness to achieve stable housing. In one large-scale retrospective, self-report study, the correlation between several adverse childhood experiences (i.e. childhood risk factors) and health risk behaviors, health status and diseases in adulthood was identified (Felitti et al., 1998). The adverse childhood experiences study (ACE Study) was done by Kaiser Permanente, a large healthcare provider, along with the Centers for Disease Control and Prevention, to

assess the impact of exposure to toxic levels of stress in childhood across the lifespan.

This was the largest study of its kind examining the long-term health and social effects of adverse childhood experiences (ACE) with over 9,500 surveyed (Felitti et al., 1998).

Each participant was given an ACE score that reflected the number of categories of exposure to various adversities occurring before age 18. The categories included "severe physical or emotional abuse; contact sexual abuse; severe emotional or physical neglect; living as a child with a household member who was mentally ill, imprisoned, or a substance abuser; living with a mother who was being victimized by domestic violence; or parental separation/ divorce" (Bloom & Farragher, 2011, p. 64). ACE scores were then compared to each participants' adult risk behavior, health status, and disease.

Participants with higher ACE scores were much more likely to suffer from serious health and social issues such as alcoholism, drug abuse, depression, suicide attempt, smoking, sexually transmitted diseases, heart disease, diabetes, and obesity, among other outcomes related to health risk-taking behaviors. The authors concluded that there was a "strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults" (Felitti et al., 1998, p. 245). There were several limitations to this study, most importantly, the data about ACE's are based on retrospective self-report and can only demonstrate associations between childhood exposures and health risk behaviors, health status, and diseases in adulthood. Furthermore, the ACE study participants were primarily middle-aged, Caucasian and well-educated individuals.

Subsequently, the ACE study was replicated with various populations, including one that took place in Philadelphia and reflected a more diverse population. In an initial

report of the Philadelphia Urban ACE study that included descriptive and Chi Square statistics for a sample of 1,784 adults who responded to a retrospective self-report survey, a higher prevalence of ACES than had been found in previous studies was identified. Specifically, 33.2% of Philadelphia adults experienced emotional abuse and 35% experienced physical abuse during their childhood. Approximately 35% of adults grew up in a household with a substance-abusing member; 24.1% lived in a household with someone who was mentally ill, and 12.9% lived in a household with someone who served time or was sentenced to serve time in prison. In addition to examining ACES, the study examined stressors within the community in which respondents live. The findings paint a picture of the high level of trauma experienced by an urban population. A whopping 40.5% of Philadelphia adults witnessed serious violence while growing up and over one-third reported experiencing discrimination based on their race or ethnicity. Almost three of every ten respondents have felt unsafe in their neighborhoods. In all, over 37% of respondents reported four or more ACES. The findings from this study suggest the need for services that address the unique environmental stressors experienced in urban neighborhoods to mitigate their impact on individuals and prevent ACES (Public Health Management Corporation, 2013, p. i).

Trauma-Informed Care

Due to the lasting effects of trauma, there has been growing interest in systems of care that mitigate re-traumatization and focus on empowerment and client strengths. Trauma-informed care (TIC) is a whole systems and universal approach to client services and staff interactions used in a variety of health and human service systems. There are two levels of TIC (Elliott et al., 2005), the interaction between staff and participants and

the interaction among the larger organization (e.g. the administrators and supervisors with staff and staff to staff, etc.), the latter is an organizational-wide or whole system approach (Clervil, Guarino, DeCandia, & Beach, 2013). According to SAMHSA (2014), a program, organization, or system is using trauma-informed care, or a trauma-informed approach, when their practice exemplifies four main assumptions, “realize the widespread impact of trauma and understand potential paths for recovery; recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and respond by fully integrating knowledge about trauma into policies, procedures, and practices, and seek to actively resist re-traumatization” (SAMHSA, 2014, p. 9). TIC emphasizes the importance of supporting workers who may be indirectly traumatized through their work with survivors in three ways: 1) secondary traumatic stress with symptoms similar to PTSD, 2) vicarious trauma, which is a change in the worker's views of self and others similar to what occurs in survivors, and 3) compassion fatigue, where the worker is unable to show empathy for clients (Knight, 2015).

Trauma-informed care is not a prescribed set of practices, it is a set of assumptions and principles used to guide practice across unique settings and populations. In addition to the four assumptions of TIC, SAMHSA (2014) identified six key principles of TIC, not unlike social work's core values, including safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice, and choice; and cultural, historical and gender inclusivity (SAMHSA, 2014). The foundation of TIC is the creation of a physically, psychologically, socially and morally safe environment (Bloom, 2013). Without a sense of safety, clients will likely not progress and may experience re-traumatization (Wilson, Pence, & Conradi, 2013). Re-

traumatization occurs when something in the environment leads to clients' feeling that they are (re) experiencing trauma, such as adhering to rigid rules that do not meet the client's needs without any discussion of why and how the rules could be altered (SAMHSA, 2014). TIC helps to build client capacity to manage symptoms of trauma and engage in more effective functioning (Knight, 2015, p. 26).

Before the term "trauma-informed" emerged, the spirit of the model was being lived out in the 1970s by professionals and volunteers within the feminist movement and survivors of intimate partner violence and sexual assault (Wilson et al., 2013). A decade later child advocacy centers were established and further promoted the essence of TIC in practice. By the 1990s, the Substance Abuse and Mental Health Administration (SAMHSA), within the U.S. Department of Health and Human Services, turned their attention to the significant impact of trauma on women and the implications for gender-specific interventions (Wilson et al., 2013).

SAMHSA (2014) described three generations of approaches to trauma, healing, and recovery, in their Treatment Improvement Protocol (TIP- Series 57) on Trauma-Informed Care in Behavioral Health Services. The first generation focused on individual interventions to address PTSD in persons experiencing war, captivity, immigration, and asylum. The second focused on psychosocial educational and empowerment models of self-healing. The third generation of approaches is trauma-informed care, which focuses on a shift in the underlying organizational perspective from "what is wrong with you" to "what happened to you" (SAMHSA, 2014, pp. 267-269).

TIC took shape at the time of the 1998 landmark study, Women, Co-occurring Disorders, and Violence Study (WCDVS) (Moses, Huntington, & D'Ambrosio, 2004).

The WCDVS was a five-year study focused on women with alcohol, drug abuse and mental health disorders who have histories of violence. The main goal of this study was to analyze “the development of comprehensive, integrated service approaches, and the effectiveness of these approaches” (Moses et al., 2004). There were nine sites involved in this research ranging from residential and outpatient mental health and substance abuse service providers to hospitals, jails, public health agencies, universities, and other community groups. The research found that integrated, comprehensive and trauma-informed services for women victims of trauma with co-occurring disorders may be key to improved outcomes (Clark & Power, 2005). One of the core principles in TIC is integrated care (Guarino, 2014). The WCDVS also underscored the importance of having consumer/survivor/recovering women involved in designing and evaluating services (Moses et al., 2004). Some of the WCDVS sites also conducted a Children’s Subset Study (CSS) with 253 children (Finkelstein, Rechberger, Russell, VanDeMark, & Noether, 2005). The results of the CSS indicated that the majority of mothers (77%) believed that the groups positively impacted their child’s communication, attitude, behavior; and knowledge and skills related to safety, coping, addiction, and recovery. The authors recommended a more family-focused, TIC approach with children (Finkelstein et al., 2005).

By the early 2000s, professionals from the fields of psychiatry, psychology, social work, and addiction recovery were delineating models of TIC. In 1997, Dr. Sandra Bloom began outlining the Sanctuary® Model of TIC from experience utilizing TIC within in-patient psychiatric units starting in the 1980s (Bloom, 2013). The Sanctuary® Model would eventually become the only evidence-based, system-level model of TIC

(CEBC, 2018). Harris and Fallot (2001) were also among the seminal authors of using trauma-informed services with survivors of various forms of interpersonal violence. In 2005, SAMHSA formed The National Center for Trauma Informed Care and called TIC a “critical culture change” in the approach to healing necessary for all mental health service systems to comply with federal best practice standards (Wilson, Fauci, & Goodman, 2015, p. 587).

As TIC took root in various health and human service settings, many variations of the term started to be used including trauma-informed practice, treatments, systems, organizations, and approaches. These terms can be subsumed into two main categories: trauma-informed care and trauma-specific services. Trauma-specific services are clinical interventions that treat specific trauma symptoms that are part of PTSD or another trauma-based disorder (DeCandia & Guarino, 2015). SAMHSA defines trauma-specific services as “evidence-based and promising prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma” (DeCandia, Guarino, & Clervil, 2014). Some examples of trauma-specific services include interventions such as Trauma, Addiction, Mental Health, and Recovery (TAMAR), Seeking Safety, Trauma-Focused Cognitive Behavioral Therapy (TFCBT), and the Trauma, Recovery and Empowerment Model (TREM) (DeCandia, Guarino, & Clervil, 2014). Trauma-specific services may not be as effective in an environment that is not trauma-informed (Menschner & Maul, 2016). Another term related to TIC is “trauma-responsive,” which means that one deliberately works to minimize the risk of re-traumatizing clients and maximizes the opportunities for healing while promoting safety

(Bloom, 2018d).

Practices and Program Attributes Linked to Trauma-Informed Care

Practices and program attributes linked to TIC can vary widely with the aim of embodying the underlying assumptions and principles of TIC. Practices, therefore, range from staff's behavior to the organization's demonstration of an understanding of trauma in their policies, procedures and overall operations. SAMHSA's (2014) ten TIC implementation domains (p. 12), ranging from internal governance and policy issues to quality assurance and assessment, provide a useful framework for staff practices and program attributes that help in creating a trauma-informed environment. Creating TIC requires a multi-dimensional approach that comprehensively addresses all domains of a program. One example within the TIC implementation domain of "physical environment," is to address aspects of the physical environment in TH programs that contribute to TIC such as a clean and well-maintained facility; soothing colors, sounds and odors; clear signage, secure individual bathrooms and separation of seating in public spaces (Richardson, 2014). Another set of examples linked to the SAMHSA implementation domain of "screening, assessment and treatment" entail setting treatment goals that reflect consumer preferences (SAMHSA, 2014, p. 13), providing integrated treatment across disciplines (i.e. mental health, substance use disorders, and trauma) and incorporating clients' culture of origin into service planning (Hopper et al., 2010; Richardson, 2014). However, the literature on specific practices that help to increase levels of TIC within residential programs for families experiencing homelessness is limited.

Other Practices Related to Trauma-Informed Care

Additional specialized practices may fit into TIC, some of which originate in social work settings or related fields. These include mindfulness, empowerment counseling, and motivational interviewing.

Mindfulness

Mindfulness is a concept that has been defined in many ways by different types of practitioners. Jon Kabat Zinn defined it as “paying attention on purpose, without judgement, in the present moment” (Turner, 2017, p. 328). However, the operational, scientific definition, was delineated by a group of mindfulness researchers as, “the self-regulation of attention with an attitude of curiosity, openness, and acceptance” (Niemic, 2017). These definitions suggest a non-judgmental stance of being open to learning about what the client’s experience has been as well as an openness to what one is experiencing at the moment. Being non-judgmental is the hallmark of both social work and TIC (Hopper et al., 2010; Turner, 2017). The emphasis in the practice of mindfulness is on being purposeful (Niemic, 2017). In more recent years, mindfulness-based cognitive therapy (MBCT) was developed, with a focus on “relating to thoughts, feelings, body sensations and impulses as events passing in the mind and body, rather than identifying with them” (Turner, 2017, p. 326). Social workers have used mindfulness practice as a way to enhance their own listening skills, kindness, and levels of presence and connectedness with clients through a range of practices such as body movement, “body scan”, breath, observing feelings and emotion (Turner, 2017). Overall, the focus on mindfulness in clinical social work has been on the enhancement of the therapeutic relationship through enhancing one’s therapeutic presence and more closely

attending to the client's viewpoint as well as emphasizing the importance of client choices (Bindseil & Kitchen, 2017). Furthermore, enhanced empathy can be an outcome of mindfulness practice in social work (Bindseil & Kitchen, 2017). Menschner and Maul (2016), in their issue brief on key ingredients for successful TIC implementation, referred to mindfulness training as a "trauma-specific" treatment approach (p.7). Mindfulness converges with both TIC and general social work practice skills.

Empowerment Counseling

The empowerment model originated in social work with a focus on black empowerment that acknowledged the powerlessness of African-Americans and sought to increase power for this group in various contexts including in the economic and political realms (Busch & Valentine, 2000). Feminists were also a large part of advancing empowerment theory as a way of rejecting privileged truths (Busch & Valentine, 2000). The empowerment theory and counseling model has been utilized within domestic violence shelter programs for decades. Moreover, a central goal of the anti-domestic violence movement has been the empowerment of survivors (Cattaneo & Goodman, 2014). More recently, domestic violence programs have "applied TIC principles to reiterate and revitalize their long-standing commitment to survivor well-being." (Wilson et al., 2015).

The empowerment theory is based on the idea that in order to improve one's life, one must have control over their environment (Busch & Valentine, 2000). Cattaneo & Goodman (2014), define empowerment as, "a meaningful shift in the experience of power attained through interaction in the social world" (p. 84). There are three elements of the empowerment theory including power, powerlessness, and oppression (Busch &

Valentine, 2000). Empowerment counseling includes activities designed to reduce powerlessness and establish greater levels of control in the various domains of a person's life (Busch & Valentine, 2000). Empowerment includes establishing or regaining the power to speak for oneself, have opinions, define realities of one's own life, and make decisions (Busch & Valentine, 2000). According to Gutiérrez, DeLois, and GlenMaye (1995), empowerment practice requires a helping relationship based on collaboration, trust and power-sharing, building on the clients' strengths, increasing client consciousness, involving the client in change, teaching skills, modeling personal power within a helping relationship, and garnering resources on behalf of the client, similar to several components of TIC.

Lum (1996) identified four practice strategies to assist clients in empowerment including enabling, linking, catalyzing, and priming. Enabling entails identifying strengths of individuals and is akin to the TIC principle of empowerment, voice, and choice (Busch & Valentine, 2000). Linking entails making connections with others who have similar experiences and is akin to the TIC principles of peer support and collaboration/ mutuality (Busch & Valentine, 2000). Catalyzing entails garnering resources in order to assist clients in achieving independence and priming requires brokering with systems that have been barriers for clients in order to educate the professionals within the systems about the barriers and how they can make changes to support the empowerment of clients (Busch & Valentine, 2000). The concept of priming within the empowerment model has some overlap with the TIC principal of cultural, historical, and gender inclusivity in that the former seeks to broker with systems that have been barriers to many oppressed groups. These four strategies are theorized to result in

changes at the micro, meso, and macro levels. Cattaneo and Chapman (2010) developed the empowerment process model in which a person that is disempowered sets a goal related to increasing their own power, then takes steps to achieve the goal and makes progress towards their goal. Once progress is made towards the goal, the person reflects on their own actions in relation to the achievement of the goal (Cattaneo & Goodman, 2014).

There are four psychological changes that take place in individuals that are empowered including increased self-efficacy, development of group consciousness, a decrease in self-blame, and an awareness of personal responsibility (Busch & Valentine, 2000). Bandura (1982) defined self-efficacy as believing in one's own ability to enact and control events in one's life. Group consciousness involves membership in a historically oppressed group that connects around similar feelings and experiences and results in the knowledge that they are not alone (Busch & Valentine, 2000). The idea of personal responsibility is about taking responsibility for one's future by engaging in activities to change one's own circumstances (Busch & Valentine, 2000). These changes result in the development of values that motivate participation in broad life domains.

Empowerment resonates both with feminist and social justice ideals such as personal choice, finding voice, strengths-based practice, and overcoming oppression (Cattaneo & Goodman, 2014). There is some research support for utilization of empowerment model interventions to promote reductions in trauma-related symptoms and depression (Cattaneo & Goodman, 2014). Empowerment also promotes a greater quality of life and attainment of longer-term positive outcomes (Cattaneo & Goodman,

2014). There is considerable overlap between the empowerment model and TIC and also between the social work framework of strengths-based practice and empowerment.

Motivational Interviewing

SAMHSA (2014) identifies motivational interviewing as a client-centered, non-pathologizing counseling technique to improve engagement in treatment and commitment to change (p. 201). Motivational interviewing is a combination of supportive counseling (i.e. client-centered therapy) with a directive method for resolving ambivalence for change through eliciting the client's verbalization of their rationale for change (Hettema, Steele, & Miller, 2005, p. 92). The counselor reflects back to the client their understanding of what the client has verbalized as their motivation for making changes (Hettema, Steele & Miller, 2005, p. 92). By talking about motivation for change, the plan for change becomes more concrete and is more likely to be acted upon (Hettema, Steele & Miller, 2005, p. 92). Motivational interviewing has two phases, one to increase motivation for change and another for consolidating commitment for change (Hettema, Steele & Miller, 2005, p. 92). Menschner and Maul (2016), in their issue brief on key ingredients for successful TIC implementation, referred to motivational interviewing as a "trauma-specific" treatment approach (p.7).

The Challenges of Trauma-Informed Care

In addition to confusion related to the wide range of practices that can be linked with TIC and the dearth of research on the use of TIC within residential programs for families experiencing homelessness, there are several other challenges around the utilization of TIC within these settings. In the introduction chapter, I briefly introduced these challenges and here I provide more detail. First, there is not a universally accepted

definition of TIC or an understanding of how it is unique from social work practice.

There is also a lack of clearly delineated TIC practices and program attributes and no universal outcomes that reflect the extent of TIC implementation including the impact on clients and staff (Menscher & Maul, 2016; Hopper et al., 2010). Use of TIC within TH programs is further complicated by competing TIC models, few of which are specified for this particular setting. Furthermore, there are significant policy barriers to TIC implementation.

The Challenge of Defining Trauma-Informed Care

One of the key challenges of TIC implementation is related to clearly defining TIC in enough detail so that practitioners can enact behaviors to bring about a trauma-informed milieu (Hopper et al., 2010). Part of the difficulty in clearly defining TIC is that there is a wide range of settings in which TIC could be useful and therefore, any detailed definition of TIC would vary depending on the context. These settings are each equipped with differing levels of staff skill and education, types of services and interventions offered, as well as the structure of the programs (i.e. inpatient/ residential versus outpatient care). In the instance of TH housing programs for families experiencing homelessness, having staff that provide services in the setting of the clients home lends itself to a more intensive level of interaction and therefore, more opportunities to deliver TIC.

Controversy about the Differences and Similarities between Trauma-Informed Care and Social Work Practice

Some have described TIC as a “re-articulation of ethical best practices” in social work (Wilson et al., 2015, p. 587). TIC is a shift from pathologizing views of

intervention to one that incorporates person-centered and recovery-oriented care (Wilson et al., 2015, p. 587). The person-centered approach originated with the late psychologist, Carl Rogers, as “client-centered therapy”, and has been foundational to delivering effective interventions across a variety of health and human service settings including the social work profession (Turner, 2017). Person-centered practice is based on cultivating three “core conditions” within the working alliance, 1) unconditional positive regard, 2) empathic understanding, and 3) congruence (Kirschenbaum & Jourdan, 2005). Rogers (1957) argued that these conditions operated independently of the specific intervention being used except to the extent that the specific interventions serve as conduits for one of the conditions (Kirschenbaum & Jourdan, 2005, p. 41). Subsequent to Rogers’ development of the client-centered approach, various researchers have confirmed the connection between patient-perceived “common factors” in the therapy relationship and therapeutic change (Kirschenbaum & Jourdan, 2005). Common factors in the therapeutic alliance include provider warmth, respect, empathy, acceptance and genuineness, positive relationship, and trust with the client-perceived positive working alliance being a key factor (Kirschenbaum & Jourdan, 2005). The working alliance has been conceptualized as comprising provider engagement and collaboration while another conceptualization of the working alliance incorporates client-worker agreement on goals and tasks and the emotional bond that exists (Kirschenbaum & Jourdan, 2005). In the early 2000s, federal funding of research on psychotherapy was becoming increasingly focused on identifying specific evidence-based treatment approaches ignoring the long-established body of research finding that specific treatment approaches contributed minimally when compared with measures of the working alliance. In response, the American

Psychological Association formed a task-force at the end of the twentieth century to review and summarize the body of research that demonstrated that “treatment approaches made relatively little difference compared with the therapeutic relationship itself” (Kirschenbaum & Jourdan, 2005, p. 46). The task-force conclusions were published in 2001 and can be summarized in one slogan, “It is the relationship, stupid!” (Kirschenbaum & Jourdan, 2005, p. 47).

The values of the dignity and worth of the individual, self-determination, and the importance of social responsibility and reciprocity underlie the person-centered approach and are closely aligned with the TIC principles of “collaboration and mutuality” and “empowerment, voice, and choice” (Turner, 2017, p. 41). The field of social work is based on a set of six core values including service, social justice, the dignity and worth of the person, the importance of human relationships, integrity, and competence (National Association of Social Workers [NASW], 2017a). The importance of human relationships is central to effective social work. Similarly, TIC “requires the practitioner to understand how the working alliance, itself, can be used to address the long-term effects of the trauma” (Knight, 2015, p. 25), focusing on the use of relationships to enhance the client’s sense of emotional safety (Berman, 2016). Although the working alliance is core in all social work practice, it is instrumental in trauma-informed practice (Kimberly & Parsons, 2017, p. 563). One of the principles underlying TIC, “collaboration and mutuality,” defined by partnering, leveling of power, and healing within the context of relationships (SAMHSA, 2014), is aligned with various social work values as well as with key social work standards and practices including a person-centered approach (NASW, 2017a).

In addition to overlap in values and principles, there are many social work concepts and practices that overlap with TIC such as person-in-environment and strengths-based practice. Kimberly & Parsons (2017) summarize trauma-informed social work to include the following skill sets: relationship building, engagement; creating physical, emotional, and relational safety; and living in the moment (p. 563). Relational safety includes the pacing of the work based on the client's lead (Kimberly & Parsons, 2017, p. 563). Additional elements of trauma-informed social work practice include beginning where the client is and being empathetic as well as validating the client's experience of trauma (Kimberly & Parsons, 2017, p. 563). Furthermore, social work is a trauma-oriented profession and social workers are equipped with the skills to carry out trauma-informed practices and trauma treatment as well as to advocate to prevent further oppression and trauma (Kimberly & Parsons, 2017, p. 567).

Social work practitioners are aware of the importance of the integration of TIC principles into practice although, for the most part, this remains an ideal due to the lack of resources to implement TIC and the ongoing confusion around the application of TIC (Knight, 2015). TIC integrates trauma theory into existing programs, services and interventions in order to prevent re-traumatization and promote client engagement in services. Furthermore, when trauma goes un-identified, social workers may not understand a client's behaviors which could result in incorrect and potentially pathologizing diagnoses and re-traumatization (Richardson, 2014).

One of the major distinctions between social work practice and TIC is the emerging understanding of the impact of trauma on neurological functions including one's regulating systems such as memory and affect (Knight, 2018). TIC challenges

social workers to utilize their skill in compassion, caring and empathy to seek to understand and respond appropriately to clients' history of trauma (Richardson, 2004, p. 2). Clients also prefer providers that not only demonstrate empathy and compassion, but that offer emotional safety (Hopper et al., 2010, p. 85). Kawam & Martinez (2016) described TIC as a natural counterpart to the work that social workers are already doing and conclude that social work is in a preeminent position to lead in TIC implementation. TIC has been described as a shift in thinking about social workers' view of people and social problems that is additive to existing interventions or treatments and enhances the level of service on behalf of the most vulnerable (Kawam & Martinez, 2016).

The Challenge of Competing Trauma-Informed Care Models

In addition to the challenges of understanding what TIC is and how it is different from and similar to social work practice as outlined above, there are over a dozen models of TIC that can be used in a variety of health and human service settings (Jennings, 2008), not all of which would be appropriate for use in programs serving families experiencing homelessness. These models vary in the intended audience and setting as well as the types of tools available for implementation (Jennings, 2008). There are few comprehensive models that include assessment and implementation curriculum, comprehensive training guides, and train-the-trainer modules, technical assistance and support, and tool kits (Jennings, 2008). One of the most robust models is the Sanctuary® Model (Bloom, 2013). The Sanctuary® Model is an evidence-based, whole culture TIC model based on trauma theory with the goal of changing an organizational culture (Bloom, 2013). At the core of the Sanctuary® Model is trauma theory, a “shared knowledge” that serves as the foundation of the model. When people are traumatized,

their ability to learn from the past and predict the future is impaired, and they become more authoritarian and less thoughtful (Bloom, 2013). The Sanctuary® Model is based on a set of seven shared values called the “7 commitments”, which are a set of principles that guide implementation, including a commitment to nonviolence, democracy, open communication, social learning, social responsibility, emotional intelligence, and growth and change (Bloom, 2018b). The commitment to nonviolence encompasses physical, social, psychological and moral safety. The core of the Sanctuary® Model is “to more effectively provide a cohesive, innovative and creative context within which healing from psychological and social traumatic experiences and adversity can be addressed for all of us (Bloom, 2013).

In addition to the wide range of available tools to support implementation, called “shared practices”, the Sanctuary® Model is also the only systemic model of TIC that is evidence based according to the California Evidence-Based Clearinghouse for Child Welfare (CEBC, 2018). The specific evidence-base for the Sanctuary® Model consists of qualitative studies conducted in residential juvenile treatment and/ or justice facilities. One study that utilized a process evaluation with descriptive information gathered through retrospective qualitative interviews and focus groups with staff from a secure juvenile justice facility for girls that implemented the Sanctuary® Model, found positive changes in a number of aspects of institutional, staff, and resident functioning (Elwyn, Esaki, & Smith, 2015). In this study, there were two research questions: “(1) What changed at the facility in the period between the implementation of the Sanctuary® Model and two years after the facility received certification in the model, and (2), in addition to the model itself, what were critical factors in the change process?” (Elwyn et

al., 2015, p. 3). The results indicate that the Sanctuary® Model was necessary but not sufficient to account for the positive changes noted. Other important components of the change included implementation factors such as the commitment of leadership to cast the vision and fully implement the changes as well as the commitment of staff to make the long-term changes (Elwyn et al., 2015). A prior study that led to this research focused on the effectiveness of the Sanctuary® Model to change institutional safety in the same setting and found that the facility was a safer place after implementation of the model with a decrease in client restraints and assaults on staff and an overall decrease in client fear for their safety (Elwyn et al., 2015). Furthermore, there were reductions in staff turnover (Elwyn et al., 2015).

The vast majority of TIC models require a significant financial investment to purchase the materials, training, and consultation. There are only a few free models appropriate for use in TH for families that are not as comprehensive and do not offer consultation for implementation. One of these models, *A Long Journey Home: A Guide for Creating Trauma-Informed Services for Mothers and Children Experiencing Homelessness* (Prescott, Soares, Konnath, & Bassuk, 2008), is based on lessons learned from the WCDVS and offers guidelines for operationalizing TIC principles (Clark & Power, 2005).

The Challenge of Measuring Trauma-Informed Care

There are few measures of the impact of TIC although one group of researchers recently developed a set of Trauma-Informed Practice Scales (TIPS) to be administered as a client survey to measure the degree of trauma-informed practice within shelters for survivors of domestic violence (Sullivan et al., 2018). The TIPS assess several domains

of trauma-informed practice including the environment of the agency and mutual respect, access to information on trauma, opportunities for connection, emphasis on strengths, cultural responsiveness and inclusivity, and support for parenting (Sullivan et al., 2018, p. 2). Although this scale was developed for use with survivors of domestic violence, it could be applicable for families living in TH due to the considerable level of trauma that they have experienced. Bloom also outlines a range of expected outcomes for the Sanctuary® Model including reductions in various forms of violence, fewer incident reports, improvement in emotional management, less victim blaming, clearer boundaries, more open and direct communication, increased diversity, lower staff turnover and absenteeism, better outcomes for clients, staff and the organization; and an overall increase in knowledge and understanding of safety and the impact of trauma (Bloom, 2018d). However, programs would have to devise their own measures to capture the outcomes identified by the Sanctuary® Model.

Practice Barriers to Trauma-Informed Care Implementation in Transitional Housing Programs

In addition to the challenges with defining and measuring TIC and competing TIC models, there are several barriers to implementation of TIC related to policy and practice. The only systematic review of housing and service interventions for families experiencing homelessness was done by Bassuk, DeCandia, Tsertsvadze, and Richard (2014) and found that data-driven interventions within the field of family homelessness are not developed enough to guide practice. In particular, the interventions they gathered and studied were all housing based with an unspecified dosage of ill-defined services, none of which could be categorized as evidenced-based. Because the services were

poorly defined, it is impossible to decipher whether or not TIC or trauma-specific services were utilized and to what extent (Bassuk et al., 2014). It may not be the specific service components of a program that comprises the active ingredient that leads to positive outcomes for families experiencing homelessness. It may be that the underlying context of service provision (i.e. the culture of a program) is most salient in supporting families exit from homelessness.

Another barrier to staff practicing TIC in TH programs is what Bloom & Farragher (2011) refer to as “trauma organized” programs that are “fundamentally and unconsciously organized around the impact of chronic and toxic stress” (p. 154). These chronically stressed organizations experience symptoms that parallel the traumatic stress of their clients. Furthermore, staff also has personal trauma histories that may be exacerbated by exposure to the trauma that their clients have experienced (Menscher & Maul, 2016). Even without a personal experience of trauma, staff is prone to experiencing vicarious trauma from their role as witness to the trauma experienced by the families they serve (Knight, 2015). TIC utilization serves both to address clients’ needs and create a safe and supportive environment for staff to thrive in a difficult field.

Policy Barriers to Trauma-Informed Care Implementation in Transitional Housing Programs

The primary policy barrier to TIC implementation in TH Programs is related to federal homeless housing policy since TH has primarily been funded through federal sources (i.e. HUD). Although the federal government provides funding to address homelessness through the McKinney-Vento Homeless Assistance Act, it is not sufficient to meet the need for affordable and/ or supportive housing for families experiencing

homelessness (USICH, 2015). The increase in family homelessness put pressure on the homeless assistance network, leaving the federal government in a quandary of how to allocate scarce resources and which types of interventions to prioritize. The current HUD policy for families experiencing homelessness, deprioritizes temporary housing with more intensive supports, such as the Transitional Housing Program (TH), and prioritizes short-term rental subsidies with very limited supportive services primarily focused on housing issues (i.e. rapid re-housing). In one study involving domestic violence (DV) shelters, the authors found that due to the levels of trauma experienced by this population, there is a need to pause on working on housing related goals in order to address trauma-related issues (Sullivan et al., 2018). The authors conclude that a focus on brief interventions focused on housing support is short sighted for survivors of domestic violence, who have complex needs and are over-represented in the population of families experiencing homelessness (Sullivan et al., 2018).

The range of HUD interventions for families experiencing homelessness includes permanent supportive housing, rapid re-housing, transitional housing, prevention & diversion, and brokered subsidized housing through collaboration with local housing authorities (typically with no supportive services). Permanent supportive housing (PSH) is reserved for those with a disability that is "expected to be long-continuing or of indefinite duration, substantially impedes the individual's ability to live independently..." such as serious mental illness, addiction, or physical disability (HUD, 2012b). PSH pairs community-based subsidized housing without a limit on the length of stay with comprehensive supportive services (HUD, 2012b). The main goal of rapid re-housing (RRH), a model that provides a short to medium-term rental subsidy with limited services

focused primarily on housing-related issues (HUD, 2012b), is to move families into permanent housing as quickly as possible. The model assumes that families will avail themselves of mainstream services in their community as needed. However, people experiencing homelessness have often not been able to access mainstream service systems on their own and there hasn't been a change that would lead one to believe that the systems will now be more accessible and able to meet the needs of families experiencing homelessness. Transitional housing (TH) combines up to 24 months of housing with accompanying support services in order to provide a foundation of stability to enable a successful transition to independent living (HUD, 2017). However, TH, as an intervention has been deemed "terra incognita," in that little is known about the type and intensity of services provided and the impact on housing stability and wellbeing outcomes for families (Burt, 2010, p. 4). This is largely because TH is not a single standardized intervention with many program variations within the two overarching parameters of a time-limited length of stay and supportive services. By 2007, HUD had funded 7,300 transitional housing programs that could serve 211,000 people at any point in time, with just over half for families (Burt, 2010). Prevention and diversion may include housing relocation and stabilization services as well as short- and medium-term rental assistance to prevent families from becoming homeless (HUD, 2012c), hence these funds are available for families that are not literally homeless. There is no effective method for predicting which poor families will become homeless (Rog & Buckner, 2007; Shinn et al., 1998; Shinn, Baumohl, & Hopper, 2001). Therefore, prevention policies are difficult if not impossible to efficiently target due to the limited number of rental

subsidies available. Even facing eviction did not predict homelessness in one study, with only 20% of those facing eviction ending up literally homeless (Shinn et al., 2001).

After focusing on ending chronic homelessness for over a decade, HUD's Plan for ending homelessness, *Opening Doors* (USICH, 2015; "the Plan"), turned its attention to the aspirational goal of ending family homelessness by 2020 without a clear pathway to accomplish this goal including lack of identification of the necessary resources. The Plan offers four key areas for action including the development of a coordinated assessment process at intake for the homeless services network, connecting families to interventions appropriate to their needs, helping families connect to mainstream resources, and building on evidence-based practices for serving families experiencing homelessness (USICH, 2015, p. 40).

The one HUD defined homeless program with intensive supports that does not exclude families without a disability is TH. However, due in part to a recent research study, *Family Options* (Gubits et al., 2016), the funding for TH has been reduced by more than a 33% over the past few years, from 400 million in 2013 to 255 million in 2016 (HUD, 2016b). Other researchers saw the benefit of TH for subpopulations (Burt, 2007; Karnas, 2007), including people in early recovery from addiction, parents who are reuniting with children in child protective services and people who are leaving domestic violence situations. Burt (2007) provided support for the utility of "facility-based transitional housing" including building a community to support sobriety, protection of children in the case of reunification, and support in rebuilding a life after lengthy experiences of domestic violence.

At the same time, rapid re-housing, an intervention that includes low-intensity, time-limited housing-only related services, has been expanded, primarily because it is the least costly intervention. The recent Family Options study (Gubits et al., 2016) provided support for the national shift in supportive housing policy for families experiencing homelessness although there are several issues with the study that limit definitive conclusions. The Family Options study included 2,282 families and utilized a longitudinal experimental study with a randomized design comparing “priority access” to three housing interventions (rental subsidy without services or SUB, community based rapid re-housing or CBRR, and project-based transitional housing or TH) for homeless families to each other and to usual care (UC). Usual care consisted of emergency shelter without immediate referral to subsequent housing and/or service packages. Priority access did not mean actual utilization of the intervention but only that there was a designated slot available to the family. Families were free to utilize any intervention they preferred as long as they were able to access it on their own without prioritization although they were able to utilize the support available with UC. Take up rates of priority access, either due to client preference or program eligibility restrictions, varied across interventions with 88% for SUB, 59% for CBRR, and 35% for TH. The study considers the impact that each intervention had on the following five domains: housing stability, family preservation, adult well-being, child well-being, and self-sufficiency. The impact estimates that were used to test the policy emphasis of priority access included all the families in the priority access group, even those families that did not use the assigned intervention. The main results indicate that families given priority access to SUB in comparison to UC had improvements in housing stability, benefits to adult and

child wellbeing, and improved food security; there were no differences between CBRR and UC although CBRR has the lowest costs; and TH was linked only to reductions in use of emergency housing compared to UC. There are several threats to validity in this study, including the fact that the actual supportive services received by participants were not measured. For example, although the SUB group did not include supportive services as an element of the intervention, some of the SUB providers had on-site case management and participants were also able to access community-based services at will (Gubits et al., 2016). In a recent systematic review on family homelessness, Grant et al. (2013), concluded that the need for mainstream [comprehensive] health services in poverty communities does not preclude the need for services to improve health access within residential programs for families experiencing homelessness and these families often need concrete services facilitated by case managers. Furthermore, in a large-scale study of family shelter utilization patterns for 13,302 families experiencing homelessness in multiple cities (Culhane et al., 2007), 25 percent of the families had intensive health and human service system utilization histories, indicating a need for service-enriched housing options for these families. Nevertheless, the federal government is moving away from funding supportive housing models that are better equipped to implement TIC in favor of short-term housing-only interventions. This is a problem given that trauma is a major factor in housing stability (Hayes et al., 2013).

The Need to Address Trauma in Supportive Housing Programs

Findings from another major national survey of 907 community providers of homeless family services (The Services Matter Study) representing all 50 states revealed that only 14% believed that housing alone can end family homelessness (Bassuk,

DeCandia & Richard, 2015). Beyond housing, the report recommends eight components for addressing family homelessness, including the utilization of TIC in programs, as a universal precaution due to the prevalence of trauma as well as treatment for maternal depression since more than half of the mothers experienced depression (Bassuk, DeCandia & Richard, 2015).

Hopper et al. (2010) identified nine practices for use within residential programs for people experiencing homelessness that should be part of TIC, including: utilization of a theory-based model, universal systematic screening for trauma, assessment of client strengths and resources, integrated mental health, substance abuse and trauma services; avoiding practices that re-traumatize, trauma-informed services for children, availability of trauma-specific services, consumer/client involvement in programs and services to instill a sense of control and empowerment, and culturally competent services. In addition to practices, Hopper et al. (2010) identified various steps that need to be taken for provider organizations to move towards a TIC culture ranging from revising mission statements, instituting an organizational self-assessment, implementation of standardized staff training, designing trauma-informed physical environments, ensuring regular supervision and staff self-care, and ensuring that policies and procedures reflect TIC culture.

Various groups of stakeholders have identified strategies that are useful in working with families experiencing homelessness, all of which align with a TIC philosophy, such as respect and open communication, clear expectations and rules, allowing families to maintain their routines and rituals, working with families as a system, using motivational interviewing as a way to engage clients, facilitating parental

autonomy, and building trust; holding group meetings with families, establishing a formal complaint system, consumer advisory committees, and instituting after-school programs that include cultural and recreational activities (Menscher & Maul, 2016; Nunez & Adams, 2014).

Gaps in Research

Transitional housing (TH) is one setting in which the resources are available and the structure is such that TIC could be implemented. Furthermore, families entering into the homeless system experience high levels of trauma and therefore, TIC is indicated in this setting. Some TH programs purport to use TIC. Yet, as I discussed above, due to various challenges, TIC is loosely defined. Relatedly, there is little data that delves into the details surrounding how TH programs utilize TIC practices. For example, the Family Provider Services Network in Philadelphia surveyed 14 local TH providers about the use of trauma-informed services/ practices in the following categories: Sanctuary® Model “safety plans”, “self-care plans”, “red flag meetings”, “community meetings”, “S.E.L.F.” (Safety, Emotion, Loss, Future) groups; ongoing Sanctuary training, residential committees, and Trauma, Recovery, and Empowerment Model (TREM) groups (Family Provider Services Network [FSPN], 2016). TREM and SELF are trauma-specific services, whereas the remainder are TIC practices. The majority of respondents utilized one or more of the TIC practices, whereas less than half utilized the trauma-specific services. However, the utilization of a few practices is not indicative that the overall program provides a TIC environment. There is a lack of information in this survey to draw further conclusions about TH providers’ degree of TIC implementation. Although

various researchers and practitioners have identified practices that lead to TIC, none have been specified for use in TH for families experiencing homelessness.

After extensive literature searches on TIC within programs for families experiencing homelessness, it was evident that there is limited scholarship on this topic. There are numerous gaps in the research that have been identified including the nature of effective interventions; the relationship of affordable housing with and without services to housing stability and family wellbeing outcomes for a variety of subgroups; type, duration and dosage of services with a focus on contextual factors such as program culture including TIC and how this may impact implementation; long-term impacts of interventions, factors that increase family reunification, and the cost-effectiveness of different housing and service models (Bassuk et al., 2014). There are no recognized evidence-based practices for residential programs serving families experiencing homelessness in the behavioral health evidence-based programs and practices registries (Bassuk et al., 2014). Herbers and Cutuli (2014) reviewed evidence for effective solutions to family homelessness and concluded that there are “few studies that use rigorous research designs to evaluate Interventions” (p. 187), finding no conclusive evidence for effective interventions. Furthermore, examples of how to operationalize TIC in various settings are hard to find in the literature (Elliott et al., 2005, p. 464). Elliott et al. (2005) call for more research to further define and operationalize the principles of TIC and how they translate to specific practices and competencies; as well as to identify operational measurements to promote consistency (Elliott et al., 2005).

Bassuk et al. (2014) reflected on one of the most salient questions for research in the field, “Does homelessness represent the lack of a house.... or does homelessness also

represent disconnection from supportive relationships, opportunity, and participation in community life?” (p. 472). This question speaks to the lack of understanding of the type, quality, and intensity of interventions needed by various subgroups of families experiencing homelessness to achieve stability and wellbeing and is relevant to TIC practices, which are steeped in the principles of safety, empowerment, and peer support (Bassuk et al., 2014; Hayes et al., 2013). In particular, given the role of trauma within homelessness, we must attend to the urgent priority of understanding how practitioners understand (or don't) trauma and implement (or don't) TIC within homelessness programs. For instance, because there is an overlap between TIC and trauma-specific interventions, it is unknown how much of the difference in outcomes are based on a TIC environment verses trauma-specific interventions.

Other researchers have called for the provision of a TIC culture within programs for families experiencing homelessness (Goodman et al., 1991; Hayes et al., 2013). Hopper et al. (2010) suggest that due to the sequelae of traumatic experiences in the lives of homeless women/ mothers, “we will be unable to solve the issue of homelessness without addressing the underlying trauma (p. 81)”. Attempting to use trauma-specific interventions without a trauma-informed context may render the trauma-specific intervention ineffective (Menschner & Maul, 2016; DeCandia, Guarino, & Clervil, 2014), in part because an individual's experience of trauma can negatively impact their engagement with services and the quality of their interactions with staff and clients (SAMHSA, 2014). Programs for families experiencing homelessness may be an ideal setting to observe this distinction since it is uncommon for homeless providers to offer trauma-specific interventions directly. Homeless service providers rarely focus on the

specialized needs of trauma survivors and intervening into the traumatic sequelae.

Equally concerning is the potential for re-traumatization within supportive housing environments that do not practice TIC. There has not been sufficient emphasis on the role of trauma in rendering families more vulnerable to chronic and intergenerational homelessness and what types of changes to policy and practice are necessary to break this cycle.

As summarized above, there are several gaps in the understanding and utilization of TIC within TH programs for families experiencing homelessness. Namely, TIC is a loosely defined construct and the existing models lack guidance on how to operationalize TIC in these settings. There is also a lack of operational measures to promote consistency of use and gauge impact. Finally, the failure to utilize TIC models in these settings raises the potential for re-traumatization in an already highly-traumatized population. Therefore, the purpose of this study is to explore the current state of TIC understanding and utilization by practitioners within TH programs for families experiencing homelessness. My specific research questions are, 1) How do providers understand TIC? 2) What staff behaviors and program attributes are linked to TIC practice? 3) What are the barriers to implementing TIC? and 4) What are the factors that help to facilitate TIC?

Theoretical Framing: Implementation Science and Bioecological Systems

The implementation of TIC requires a cultural shift, engagement of leadership, comprehensive and ongoing training for staff, and supportive supervision for staff, all of which require a significant investment of time and resources by the organization (Wilson, Fauci, & Goodman, 2015). Implementation science is the study of the process of

implementing programs and practices and is the gateway between an organizational decision to adopt an intervention and the full utilization of that intervention (Damschroder et al, 2009). Implementation is defined as “a specified set of activities designed to put into practice an activity or program of known dimensions” (Fixsen, Naoom, Blasé, Friedman, & Wallace 2005, p. 5). It is important to attend to implementation processes since interventions demonstrated to be effective in research will fail if they are not implemented properly and one may falsely conclude that the intervention itself is ineffective. Interaction- based innovations are inherently complex to implement because they vary across practitioners, clients, and contexts (National Implementation Research Network, 2016), although the implementation processes are common across human service fields (Fixsen et al., 2005). There are two sets of processes and outcomes to attend to in implementation, one for using the intervention and one for the intervention implementation process.

Implementation is a social process enmeshed within the context in which it is being embedded. Contextual factors are dynamic and active, introducing a host of variables as implementation unfolds (Birken et al., 2017). Although implementation science is still in an embryonic stage (Proctor et al., 2009), there are over 60 conceptual frameworks to guide the work of innovation implementation research (Birken, et al., 2017). These frameworks differ in their specific purpose such as guiding an implementation process, identifying determinants of implementation, and evaluating implementation (Birken, et al., 2017). Damschroder et al. (2009) reviewed the literature on implementation science starting with Greenhalgh et al.'s (2004) synthesis of almost 500 publications from 13 fields of research on the determinants of innovation

implementation in health service delivery. The authors then utilized a snowball sample to identify additional studies of implementation frameworks. They then combined constructs that were overlapping and disentangled constructs that were conflated, resulting in the Consolidated Framework for Implementation Research (CFIR), a framework based on professional consensus within a scientific community. The CFIR has five major domains, each with several constructs for a total of 39 constructs and sub-constructs. The domains include the intervention characteristics, outer setting, inner setting, characteristics of individuals, and implementation processes. These domains can be viewed to fall into two broader domains including internal factors and external factors. Two of the constructs under the domain of outer setting, cosmopolitanism and external policy and incentives, relate to ecological factors. However, these two constructs do not fully capture the ecological factors that have an impact on the implementation of TIC. Therefore, I utilized Bronfenbrenner's Bioecological Systems Theory (1992) to expand the CFIR framework to highlight the ways that the various external factors impact TIC implementation. For information on the rest of the CFIR constructs under each domain, see Appendix J. The CFIR is the primary framework that I used to design this study and analyze the data along with trauma theory.

Urie Bronfenbrenner, in his Ecological Systems Theory (1979), theorized that human development occurs within the context of a nested set of systems that involve cultural, social, economic, and political elements, not merely psychological ones. These systems and their interactions can either support or hinder development over the lifespan. Policies and programs can play a major role in shaping these systems and therefore, it is

important to illuminate the influences of contexts on human development as we work to address some of the most complex social issues including family homelessness.

Ecological systems theory posits five systems or layers that shape human life outside of individual-level factors, starting with the most insular of systems, the microsystem. A person's microsystems consist of settings in which they experience life, for example, people and places that a person comes into contact with on a regular basis such as the home and immediate family, workplace, church, or homeless shelter where they live. Another layer in the ecological system, the mesosystem, is formed by the linkages or processes taking place between two or more microsystems containing the person. In other words, the mesosystem is created through the interaction between two microsystems. The exosystem is a layer that is comprised of places/groups that the individual has no direct contact with but that affect them nonetheless (i.e. a trickle-down effect). For example, various social and economic policies that impact families experiencing homelessness are part of the families' exosystem. Another layer in the theory is the macrosystem, which contains the values, attitudes, beliefs, and cultural background of an individual. The final layer in the theory is the chronosystem, which is indicative in each other layer and related to the passage of time. For example, a shift over time in family structures to more insular families or more single-female-headed households; changes over time in political structures and systems and phenomenon such as neoliberalism.

At the center of these layers is the individual with their own goal-directed behaviors, physical makeup, and experiences including a range of traumatic experiences. As Bronfenbrenner (1992, 2005) evolved his theory, adding a key element to reflect the

bi-directionality of development in which personal characteristics influence developmental outcomes, as well as the characteristics of the environment (p. 115), the name of the theory, shifted to bioecological systems theory.

TIC benefits from the well-developed bioecological systems theory to explain how there are multiple systems or layers that shape human life outside of the individual. SAMHSA (2014) also emphasizes that understanding trauma requires seeing trauma within a social-ecological context:

Trauma cannot be viewed narrowly; instead, it needs to be seen through a broader lens—a contextual lens integrating biopsychosocial, interpersonal, community, and societal (the degree of individualistic or collective cultural values) characteristics that are evident preceding and during the trauma, in the immediate and sustained response to the event(s), and in the short- and long-term effects of the traumatic event(s), which may include housing availability, community response, adherence to or maintenance of family routines and structure, and level of family support... Understanding trauma from this angle helps expand the focus beyond individual characteristics and effects to a broader systemic perspective that acknowledges the influences of social interactions, communities, governments, cultures, and so forth, while also examining the possible interactions among those various influences (p.14).

Trauma triggers or re-traumatization can exacerbate symptoms of PTSD and other trauma-based disorders, activating a disconnection from relationships and meaning that link individuals and community (Herman, 1997), hence weakening the micro and mesosystems within one's ecological context. This weakening of ecological connections

may result in the weakening of internal resources and external supports necessary to exit homelessness. Due to the disruption that trauma causes in families experiencing homelessness, an ecological systems approach, with a focus on strengthening relationships within families and between families and the social contexts in which they live, has been advanced by researchers and practitioners (Bassuk, 2010; Kilmer, et al, 2012). Therefore, the utilization of TIC practices in programs for families experiencing homelessness, such as developing a safe environment, safe relationships and enhancing social networks, may help programs support families to obtain and sustain stable housing and greater wellbeing.

SAMHSA's (2014) ten TIC implementation domains overlap with the CFIR (See Table 1) although the CFIR is more nuanced. SAMHSA's set of domains also overlaps with the conceptualization and principles of TIC. I considered the CFIR framework alongside principles of TIC to develop a framework that considers not just how any generic intervention might be integrated into practice, but how, specifically, TIC can be successfully implemented. Various clinicians and researchers note that organizational change is an ongoing process, therefore, staff training needs to be ongoing in order to sustain a TIC culture and to continue to grow in TIC (Healing Hands, a publication of the HCH Clinicians Network, 2010, p.6).

Table 1

SAMHSA's Ten TIC Implementation Domains that Overlap with CFIR

SAMHSA TIC Implementation Domain	Corresponding CFIR Categories
Governance and Leadership	Inner Setting- Readiness for Implementation: Leadership Engagement
Policy	Process- Planning
Physical Environment	Inner Setting- Culture, Structural Characteristics
Engagement & Involvement	Process- Planning, Engaging
Cross-Sector Collaboration	Outer Setting- Cosmopolitan, External Policy & Incentives
Screening, Assessment, Treatment Services	Intervention Characteristics- Evidence Strength & Quality; Characteristics of Individuals- Knowledge and Beliefs about Intervention
Training and Workforce Development	Inner Setting- Readiness for Implementation: Access to Knowledge & Information
Progress Monitoring and Quality Assurance	Process- Reflecting & Evaluating
Financing	Inner Setting- Readiness for Implementation: Available Resource
Evaluation	Process- Reflecting and Evaluating

Summary

In this chapter, I presented an overview of the impact of trauma on psychosocial outcomes, a summary of trauma-informed care (TIC), including its history and origins, as well as associated terminology and the specific practices and program attributes that are associated with TIC. I then reviewed the challenges of TIC including the policy and

practice barriers to the implementation of TIC in TH programs serving families

experiencing homelessness. Finally, I summarized the gaps in research and the

theoretical frames used in this study. The following chapter presents the methodology of

the study.

CHAPTER 3: METHODOLOGY

Rationale for Qualitative Approach

This study investigated exploratory questions about the understanding and utilization of trauma-informed care (TIC) in transitional housing (TH) programs for families experiencing homelessness, using a qualitative research design. I selected a qualitative design because my research questions are relatively new to the specific field and I wanted to understand how practitioners experience and engage with TIC (Padgett, 2008). Furthermore, TIC is not well defined as an approach and therefore, I wanted to “get inside the black box of practice” (Padgett, 2008, p. 17) with those that have lived experience in implementing TIC within TH programs for families experiencing homelessness. Finally, as a social worker and an activist, I wanted to illuminate these issues in order to support advocacy among practitioners and policy makers towards policy change that will promote policies that support the use of TIC in programs serving families experiencing homelessness.

Prior to data collection, I received IRB approval for all components of this research, including the planned procedures for recruitment, surveys, document review and interviews. There were no adverse events reported related to this study nor were there any concerns raised by study participants.

Reflexivity Statement

In a qualitative approach, the researcher acts as a key instrument in the data collection, bringing their own interpretive lens (Creswell, 2013; Padgett, 2008). Therefore, it is important to disclose elements of one’s own life that have a bearing on the interpretive lens. My career has spanned over 25 years in the human service sector,

specifically focused on family violence, poverty, and homelessness and the myriad of overlapping issues (e.g. addiction, mental health issues, un/under-employment, etc.), the majority of which has been in Philadelphia. I have been highly engaged at the state and local levels of government through coalitions, committees, and other forms of collaboration. For the past decade, I have served as the Executive Director and President for Women Against Abuse, Inc. (WAA), an organization that runs a transitional housing program for families experiencing homelessness and fleeing domestic violence, among several other programs. Over the past several years, the federal government and subsequently, local government, have been reducing resources for transitional housing programs in favor of less costly models such as rapid re-housing (Gubits et al., 2016). I have been at the forefront of advocacy to sustain transitional housing especially for survivors of domestic violence and other families that face complex trauma and special needs. I also led the implementation of the Sanctuary® Model of TIC in the organization that I currently lead. Through the process of implementation and certification in the model, I developed a professional relationship with the primary co-founder of the Sanctuary® Model, Dr. Sandra Bloom. Therefore, this research has personal and professional meaning for me. I have a strong opinion that transitional housing is an effective program model to deliver trauma-informed and trauma-specific services that lead to healing for families experiencing homelessness and other forms of trauma which in part motivated me to do this research. However, I was unsure about how and to what degree TH programs were using TIC. Because this study was not about whether or not TH works but about how TH programs understand TIC, what practices they use to bring about TIC, and the barriers and facilitative factors in the implementation of TIC, I don't

think that my affinity for TH programs would interfere with hearing what the participants had to share about use of TIC in these programs. In addition, I used several strategies to enhance rigor, such as an audit trail, as outlined below.

During my career, I have developed many professional relationships throughout the Commonwealth of PA. Therefore, one concern in doing this research was interviewing participants with whom I have an existing professional relationship. I have a well-developed sense of professional boundaries and work ethics and have been careful to maintain these boundaries by not mixing work relationships with my personal life. This background positioned me to proceed with the research without undue concern that these relationships would interfere with the rigor of my research. Nevertheless, I cautiously approached data collection with known participants by acknowledging all professional relationships at the beginning of the interview and offering participants the opportunity to share concerns about whether our relationship would impact their responses. Out of the 35 participants, I had a pre-existing relationship with eight of them and of the 23 participating programs, I had a pre-existing relationship with ten of them. Without exception, none of the participants that I had a professional relationship with voiced any concerns about their ability to be open in their responses during the interview. However, one participant did ask questions about whether the information provided would be kept confidential in terms of linking it to the specific program.

Sampling

The sampling frame included TH programs for families experiencing homelessness in the eight most southeastern counties of the Commonwealth of Pennsylvania (PA), including Berks, Bucks, Chester, Delaware, Lancaster, Lehigh,

Montgomery, and Philadelphia. Because transitional housing (TH) is a term used to denote a wide range of supportive housing programs for those experiencing homelessness, I utilized inclusion criteria linked to the specific parameters of the program rather than using the category of “transitional housing” as the primary inclusion criteria. Additionally, the national policy shift away from TH and the resultant disinvestment in TH units was evident in this sampling frame with approximately four of the programs recently closing or planning to close due to loss of government funding. The recent large-scale longitudinal study of housing for families experiencing homelessness, Family Options (Gubits et al., 2016), defined project based transitional housing as temporary housing for up to 24 months (the median stay for study families lasted 13 months), coupled with more intensive social services in supervised programs. Transitional housing inclusion criteria for this study were temporary housing with a maximum stay of greater than three months and some form of on-site supportive services such as life skills groups, case management, and counseling. Transitional housing that had a scattered site configuration was included either when there were clusters of units in one geographical location and/ or an element of on-site supportive services. Programs that were primarily drug and alcohol treatment programs were excluded.

I used a combination of criterion and snowball sampling techniques. Criterion sampling simply means “all cases that meet some criterion” (Creswell, 2013, p. 158) and in this case, I focused on TH programs for families experiencing homelessness. In order to develop the specific sampling frame (See Figure 1), I started with three sources that listed TH programs in Pennsylvania: 1) HUD-funded TH programs, 2) 211 listings (a telephone and website clearinghouse for information about health, human and social

service organizations), and 3) a website listing of TH programs

(<http://www.transitionalhousing.org/state/pennsylvania>). There was overlap in the different lists of TH programs, although I ultimately created one unduplicated list of TH programs within the included counties and this became the sampling frame. I attempted to contact all these programs. There were 23 programs that participated in this research with a total of 35 interviews.

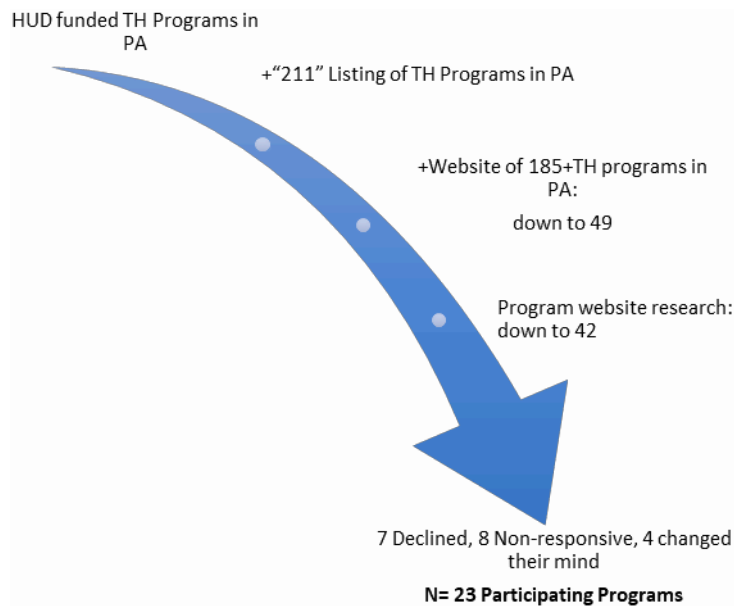


Figure 1. Process for developing specific sampling frame.

Pilot

Before beginning data collection, I piloted the survey and interview questions with an organization that operates residential programs for homeless families. I also asked the pilot participant to review the recruitment communications. Based on the feedback from the pilot participant, I changed the recruitment email to make it a bit more personal and I made some changes to the survey for clarity and to ensure that the answer choices were exhaustive. Furthermore, the pilot participant offered one recommendation

regarding the in-person interview, advising me to provide a written copy of the script that I read with the definition of TIC. I did not include the pilot interview as data for the study as the pilot was to assess feasibility of the study and streamline and clarify the data collection process.

Recruitment Process

I emailed all the program executive directors and included an attached copy of the informed consent form (See Appendix A) to introduce this study and invite them to participate commencing in August of 2017 (See Email Recruitment Script to Program Executive Directors in Appendix B). Once a program agreed to participate, signed and returned the informed consent, and completed the survey, they were scheduled for an interview (See Figure 2 below for the detailed process, as well as, the Checklist for Recruitment and Data Collection Process in Appendix C). Participants were also asked to forward an email invitation from me to the rest of the staff (See Staff Email Script in Appendix D). During the email and phone follow up and interviews, I asked participants about other TH programs in their county in order to confirm and/ or expand my sampling frame and learned about four additional programs.

Recruitment Process:	Email invitation to executive director
	Email reminder to invitees
	Phone follow up
	Informed consent
	Confirm main contact
	Ask about other local TH programs
	Complete survey & submit program description
	Reminders to complete survey
	Set up time for phone interview
	Send email invitation for point person to forward to staff
	Ask point persons to send reminder email to staff
	Set up time for phone interview with interested staff

Figure 2. Process of recruiting participants.

Procedures and Instrumentation

I gathered data through two methods: a survey and a semi-structured telephone interview (See Interview Guide in Appendix E). The 10-item short answer and multiple-choice survey (See Survey in Appendix F) was administered first, via Survey Monkey, and consisted of descriptive questions about the program that also helped to assess whether the program met inclusion criteria. Some of the responses for the survey questions did not conform to the specific question. For example, for average length of client stay, some programs provided a range of stay and some provided one length of stay, usually in month increments. Therefore, if the program provided a range of months for length of stay, I used the median number of months for the length of stay field. The document review involved a review of existing program descriptions and / or eligibility criteria. When programs did not have these documents, I used information from their

websites with the exception of three of the 23 programs, who did not submit the documents and whose websites did not contain the information. The document review was used to further verify inclusion criteria of the programs, specifically with respect to the parameters of transitional housing.

Initially, I was planning to do all of the interviews in person. However, the Bryn Mawr Institutional Review Board suggested that in-person interviews would risk confidentiality of staff participants in the research. Therefore, in order to protect the confidentiality of staff participants, I did the interviews by phone instead of in person so that staff had maximum control over when and where they participated in the interview. I also completed the executive director interviews via phone so that the methods did not vary based on staff role and impact the responses differentially. For example, in person interviews could have established a higher level of rapport but could also have created pressure to respond in a way that was desirable. Furthermore, in order to protect the confidentiality of participants, staff that were interested were asked to email me directly so that they did not have to disclose their interest to their supervisor or the management team. The risks of participation to programs are possible identification of the program or county by colleagues and the general public. I mitigated this risk by using geographical classifications (i.e. rural, urban, and suburban) or counties (e.g. Philadelphia, Chester) when discussing and writing up the results.

The interviews consisted of questions focused on the participants' understanding of TIC, practices that participants believe contributed to TIC, and factors that facilitate or are barriers to TIC implementation. After first asking questions about the participants' understanding of TIC, I reviewed a script defining TIC (See Appendix G for Interview

Guide with Script). After reviewing this script, I proceeded to ask questions about the ways that staff enact TIC. The semi-structured telephone interviews took place between August and November of 2017 and ranged from eight to 54 minutes with an average of 28 minutes, a median of 30 minutes, a mode of 16 minutes and the majority of interviews falling within the range of 16 to 40 minutes.

Interview Process

After the first interview, I concluded that I needed to shorten the script and clarify the difference between TIC and trauma-specific services within the script. In order to shorten and clarify the script, I removed the description of the four underlying assumptions of TIC (SAMHSA, 2014) and I added an explanation of the difference between TIC and trauma-specific services. Furthermore, to address ambiguity around the meaning of TIC, I shared this written script with participants in advance of their interviews. The script initially contained a consensus definition of TIC offered for use in homeless services (Hopper et al., 2010) as well as the SAMHSA (2014) assumptions and principles of TIC and a few examples of TIC models. However, after 16 of the 35 interviews, I discontinued sharing the written script due to some participants' references to the script when answering the question about how they understood TIC, which was always asked before I read the script aloud to the participant. I subsequently only read the script out loud and did not also share a copy of the written script. Asking participants to define TIC in advance of reading the script allowed for the participants own understanding of TIC to emerge while subsequently providing enough clarity about TIC for them to meaningfully engage in the rest of the interview. I coded all incidents where participants referenced an element of TIC from the script, whether or not they had

received a written script, in order to track the impact. The TIC script was referenced by seven participants, four of whom were in the group of 16 participants that were given the written script in advance and three from the group that did not receive the written script.

I made a few minor changes to the interview guide within the first few weeks of the data collection to address some of the issues that came up. First, I added a question about whether the program had implemented TIC immediately following the script that I read defining TIC. Second, I changed the question about sharing a story of how clients have been engaged in TIC because I was getting answers that focused on the outcomes of TIC but not about how clients themselves engaged with TIC practices and principles. I changed the question to, “can you share a story of how clients have been part of TIC at your agency?” and used some prompts to give participants examples of the types of things I was interested in such as whether clients participate in groups or meetings that include education about trauma or utilize tools or participate in activities that contribute to TIC environments. Finally, I expanded the question about how federal policy and/ or funding streams impact TIC implementation to encourage answers about all levels of government and not only the federal government.

In addition to the interview questions, I followed up on any confusing or incomplete information from the survey and missing information requested in earlier parts of the process (e.g. names of other local TH programs). The interviews were audio recorded and transcribed using *Trint*, an online service. I reviewed the transcripts and made substantial revisions as the online service is done electronically and different enunciations are not consistently accurately translated. However, because the *Trint*

service offers written transcription in tandem with the audio, it is easy to review and revise as needed.

Data Analysis

I used directed qualitative content analysis to analyze the data, a method for interpreting text data through a process of coding and identifying themes that emerge (Hsieh & Shannon, 2005). Content analysis is frequently used when trying to ascertain questions of what, why, and how (Cho & Lee, 2014). Since knowledge about the specific behaviors, attitudes, and experiences of staff that promote a TIC environment within TH for families experiencing homelessness is lacking and it is not known why these programs do not employ TIC practices more frequently, content analysis is indicated. Since existing theory (e.g. TIC, the Consolidated Framework for Implementation Research-CFIR, and Bioecological Systems Theory) was the foundation for the a-priori codes (See Appendix H for list of a-priori codes), I used directed content analysis (Hsieh & Shannon, 2005) as opposed to conventional or summative content analysis. The defining features of directed content analysis include starting with theory, defining codes before and during data analysis, and deriving codes from both theory and research findings (Hsieh & Shannon, 2005). The goal of directed content analysis “is to validate or extend conceptually a theoretical framework or theory” (Hsieh & Shannon, 2005, p. 1281). During data analysis, I also evaluated the need for new codes; in this way, I used both deductive and inductive approaches. One of the main strengths of the directed content analysis approach is that existing theory can be supported and extended. As part of my analysis, I created frequency charts of practice and implementation factor code-categories in order to understand the patterns of the data.

To store and organize the data, I used Atlas.ti 8 for MAC qualitative data analysis software (Atlas.ti 8, 2018). I reviewed and coded the transcripts twice in Atlas.ti. This added a measure of accuracy. There was some overlap among the a-priori coding categories especially in the TIC staff practices and program attributes and the CFIR codes. For example, in the TIC staff practices and program attributes codes, one quote could pertain to three codes, trustworthiness and transparency; collaboration and mutuality; and safety. Therefore, I selected the code that was most salient for each quote.

Rigor

In order to enhance the rigor of my research, I used various strategies such as triangulation, member checking, and use of memos to establish an audit trail (Creswell, 2013; Padgett, 2008). Triangulation was accomplished through the use of existing literature and theory as well as via interviews with multiple programs and across a variety of staff roles. After collecting and analyzing the data, I offered a web-based presentation to all participating programs about TIC and my preliminary findings and asked for feedback about the credibility of the results. In addition to general feedback, I asked some specific follow up questions including: what the difference was between TIC and good social work practice, how TIC was unique from social work and how it was not, examples of the use of “S.E.L.F.” as a tool, examples of peer support, examples of cultural, historical and gender inclusivity; and ways that the structure of nonprofits is a barrier to TIC implementation. There were 17 webinar participants who unanimously agreed on the preliminary findings. One participant provided clarification about one of the practices that I presented as a finding and also shared a new practice in response to one of the follow up questions I posed during the webinar.

I maintained memos throughout the research process to create an audit trail on key procedural decisions about the interview process, inclusion criteria, coding and other elements of the process. I also utilized memo writing to reflect on my thoughts about the interviews and record emerging themes. For example, there were many considerations in establishing the inclusion and exclusion criteria, some related to the ambiguity in the nomenclature of supportive housing programs.

Finally, before I started coding, I created a code book with brief descriptions, definitions, and inclusion and exclusion criteria for each code. I utilized the code book to make decisions about how to code the data and when to create new codes. I grouped my codes into categories aligned with my research questions as well as the theoretical frames that I used. With respect to understanding TIC, I utilized SAMHSA's (2014) assumptions of TIC as a code group category. For the research question about TIC practices, I used SAMHSA's (2014) six principles of TIC as an organizing category. Finally, for the research questions about facilitative factors and barriers to TIC implementation, I utilized the Consolidated Framework for Implementation Research (Damschroder et al., 2009) as a framework of code groups and codes along with Bronfenbrenner's (1992) Bioecological Systems Theory.

Summary

In this chapter, I presented the methodology for the research study including the rationale for the study, reflexivity, sampling, study design, process of data analysis, and information on rigor. The following four chapters will include findings organized by the participants' understanding of trauma-informed care, trauma-informed care practices, internal implementation factors, and external implementation factors.

**CHAPTER 4: FINDINGS – UNDERSTANDING OF TRAUMA-INFORMED
CARE**

Programs and Participants

First, I provide a summary of the descriptive information about the programs and participants that were part of this research, followed by the findings related to participants’ understanding of TIC. There were 35 participants from 23 different transitional housing (TH) programs. The majority of programs were in counties described as urban with a few in suburban counties and a few in counties with mixed geography (See Table 2 and Table 3). There was only one participating program from a rural county. The highest number of participating programs in one county occurred in Philadelphia with seven programs. The remaining 16 programs were from the seven other participating counties. The second highest number of programs came from Lancaster County with four participating programs.

Table 2

<i>Geographic Type for Participating Programs</i>	
GEOGRAPHIC TYPE	PROGRAMS
Mixed	4
Rural	1
Suburban	3
Urban	15
TOTAL:	23

Table 3

Counties for Participating Programs

COUNTY	PROGRAMS
Berks	3
Bucks	1
Chester	2
Lancaster	4
Lehigh	2
Northampton	2
Montgomery	2
Philadelphia	7
TOTAL:	23

The average length of stay for families in participating programs ranged from six to > 30 months (See Table 4). The majority of programs average length of stay fell between seven to twenty-four months. The maximum number of family units ranged from five to fifty with the majority having from five to twenty (See Table 5).

Table 4

Average Length of Stay for Participating Programs

PROGRAM AVERAGE LENGTH OF STAY	PROGRAMS
6 Months or Less	4
7-12 Months	5
13-18 Months	7
19-24 Months	5
25-30 Months	1
> 30 Months	1
TOTAL:	23

Table 5

Maximum Number of Family Units for Participating Programs

MAX # OF FAMILIES- PIT	PROGRAMS
1-10 Families	9
11-20 Families	7
21-30 Families	3
31-40 Families	3
41-50 Families	1
TOTAL:	23

The physical structure of the TH programs included single room occupancy, clustered/ scattered site units, congregate housing, and multi-unit apartments (See Table 6). The most frequent type of physical structure was multi-unit apartments and clustered/ scattered site units.

Table 6

Physical Structure Types for Participating Programs

PHYSICAL STRUCTURE	PROGRAMS
Stand Alone Program-Single Room Occupancy	4
Clustered or Scattered Site Apartments	8
Stand Alone Program- Congregate	1
Stand Alone Program-Multi-Unit Apartment	10
TOTAL:	23

Most programs had targeted subpopulations including people experiencing domestic violence, physical disabilities, re-entry, serious mental illness, substance use disorder, and youth head of household (See Table 7). The most frequent targeted subpopulation was people experiencing domestic violence. Over half (54%) of the total point-in-time units represented in this study were reserved for survivors of domestic violence. Only nine of the twenty-three programs did not have a specific subpopulation focus. There were only three programs that provided trauma-specific services.

Table 7

Sub-Populations for Participating Programs

TARGET SUBPOPULATION	PROGRAMS
Domestic Violence	10
Physical Disability	2
Re-Entry	1
Serious Mental Illness	2
Substance Use Disorder	3
Youth Head of Household (18-24 y/o)	4
None	9
*TOTAL:	31
*Some programs have multiple subpopulations	6

I interviewed a minimum of one person per program, although the overarching goal was to interview a variety of staff roles across the participating programs ranging from executive directors, to case managers and administrative staff. Most of the staff interviewed were either program directors/ managers, case managers or executive directors (See Table 8). Of the 35 participants, all but 10 were part of the management team (executive, senior or middle management). Of the ten-line staff, eight were case managers or counselors. There was very little representation of support staff or direct care para-professional staff with only one participant in each of these categories.

Table 8

Staff Positions of Study Participants

STAFF POSITION	PARTICIPANTS
Executive Director	6
Chief Officer/ Vice President	4
Program Director/ Manager	15
Case Manager/ Counselor	8
Para Professional/ Direct Care Staff	1
Support Staff	1
TOTAL:	35

Of the 23 participating programs, only six programs had more than one person participate, and four of these six programs had some level of professional association with me. Of these six programs with multiple participants, two of them had two participants, two of them had three participants and two of them had four participants. The majority of participants were full time staff with a range of tenure. The most frequent tenure ranges were 0-5 years and 16-20 years (See Table 9).

Table 9

Range of Tenure for Study Participants

TENURE WITH PROGRAM	PARTICIPANTS
0-5 Years	13
6-10 Years	5
11-15 Years	5
16-20 Years	8
21-25 Years	2
26 or More Years	1
Unknown	1
TOTAL:	35

There was a range of TIC implementation reported by the participants, with nine participants indicating a fuller level of implementation, 14 indicating partial implementation and 11 that did not believe that their agency had implemented TIC. TIC implementation was assessed by asking the participants whether their agency had implemented TIC and if so, how the decision was made to implement TIC. In addition to this specific question, I utilized the interview as a whole to determine whether TIC had been implemented and to what degree. Of the six programs with more than one person participating in this research, half had participants with slightly differing perspectives as to whether they had implemented TIC within the program. For example, in one program with four staff participating, two felt that they had implemented TIC, one was too new to

know but was able to describe TIC in action, and the other participant said that TIC had been partially implemented but attributed it to her own formal education. When there were differing opinions among staff within a program about whether TIC was implemented, the opinions were not entirely opposed. For example, when the majority of staff within a program said that they had not implemented TIC, the differing opinion was that they had partially implemented it. Similarly, for the programs in which most participants said they had implemented TIC, the differing opinion was that they had partially implemented TIC. Therefore, there was relative agreement within programs with multiple participants as to whether TIC had been implemented.

I included all data in the finding's chapters on understanding of TIC and barriers to TIC implementation, regardless of whether or not the specific participant had implemented TIC. However, I excluded those that had not implemented TIC from the finding's chapters on practices and facilitative factors in TIC implementation, as their responses would not have been relevant.

Defining Trauma-Informed Care (TIC)

One of the central questions of this research was, how do providers understand TIC? Participants defined TIC in response to questions about how they describe TIC as well as how their agency defines TIC. One non-management participant was only working at their program for a few weeks and although they were unable to articulate their understanding of TIC, they were able to describe a client story that exemplified TIC in action, specifically, their story demonstrated team work and offering options for support. When a mother became overwhelmed, the administrative assistant, resource specialist, intake person and case manager worked together to “meet the client where they

were” and offer options to support the client by providing care for her children without telling the client what to do. The team offered a tissue to the child that was crying, a snack for one of the children, and childcare for the baby while the client took time to de-escalate with one of the staff members.

Several participants in a range of roles did not know what TIC was and others did not have a clear understanding of TIC. For example, one senior manager noted that TIC was only for those that provide direct service to clients and therefore, others in the agency did not need to understand. Another management-level participant did not think it was part of their job to address trauma but that they would refer the client out for specific interventions. One management-level participant with 17 years’ tenure in an agency, did not know what TIC was although expressed a desire to learn about it.

Those that did not have an understanding of TIC tended to confuse TIC with trauma-specific services. One case manager noted, “I know we have people that suffer with post-traumatic stress disorder and we usually send them out, send them to another program...so we don't normally get involved with that.” Another participant, an executive, explained that they do not provide therapy, nor would they want to,

We would refer out to another agency, to a psychologist for them to explore the deeper issues that the individual or family may be dealing with, it has worked out really awesome for our program. So if they mention that they're dealing with some things or I see any behaviors, I will discuss or encourage them to seek counseling and to go for that psychological evaluation where people have gotten diagnosis and started medication and working on their self, where they were able

to deal with whatever was going on because there's a symptom behind the homelessness, in many of the cases.

The same participant defined TIC as,

Helping someone process a traumatic event in their life and allowing them to share their story and build some strength off of whatever trauma they went through and develop a plan to move forward in a positive way. Dealing with that. Whatever happened in their life.

This participant was describing an intervention to process specific trauma verses understanding TIC as a universal approach to creating an environment for healing. The participant went on to explain that TIC is not the work of homeless service provider programs since these programs are,

.... basically, trying to acknowledge their needs at that moment since their homeless. We want to provide stabilization for them. That is our goal. Remember we're a homeless provider program. We want to stabilize them, get them into a home, make sure they have all the material things they need to run their home.

Participants defined TIC in three primary ways, as a philosophical frame and a culture for healing, by describing the tensions inherent in TIC, and by describing the ways that TIC overlaps with social work values and practices.

Trauma-Informed Care as a Philosophical Framework & Culture for Healing

Overall, participants described TIC as a philosophical framework and a culture for healing. One case manager described TIC as,

A philosophy, a way of looking at the work of helping people improve their lives that takes into account the experiences that have brought them to where they are in their lives and experiences that affect where they'll be able to go next.

While another managerial-level participant regarded TIC as a culture,

I look at trauma-informed care more like a culture of treating trauma. So for me it's not only the interaction that staff have with clients but interaction that administrators have with staff and even the environment that we're working in.

Other common themes in defining TIC included having a nonjudgmental stance about who a client is and where they come from and showing empathy. One manager said that “anything that helps people feel like they have control...could be considered trauma-informed” care. One manager believed that direct service staff might not have a definition for TIC or might struggle to articulate it but that they have a working knowledge of it.

Providers view TIC as a philosophical framework that supports a shift from rigid programs to flexible programs. There were several participants that discussed this shift towards flexible programs, all of whom were either executive directors or part of the management team. For example, one participant talked about making “tremendous” program changes to be more flexible after being trained in TIC,

We had a lot of restrictions and requirements; and we had some restrictions around curfew that were really extreme. We changed our entire program and lightened it up, let me put it that way. So that they [clients] had more flexibility and freedom and they had a voice.

Another participant described flexibility in the agenda for client meetings,

...knowing how the client is doing that day should actually set the tone for the rest of the meeting. We don't plan for, 'definitely, oh this is what we're going to discuss, and this is what we're going to accomplish today'. We plan for, 'I don't know what you're going to be experiencing today, so when you come to the meeting, let's see how you're doing and let's see how the meeting goes and what challenges you are experiencing today.'

Other agencies had worked to do away with some of the program rules, to avoid making things mandatory, and to refrain from having "blanket policies."

Understanding trauma and the impact of trauma. Common elements of TIC as described by participants included having an understanding of trauma and complex trauma, how trauma can change a person and play a part in current functioning. One program manager pointed out that organizations have trauma histories as well that likewise need to be considered in developing a strategy to create a trauma-informed approach. A few participants had a good understanding of the impact of trauma including the coping skills used to survive adversity. One case manager emphasized the importance of understanding trauma and the impact of trauma,

We need to create space for working through trauma, both in communal settings and individually, while respecting how our experiences shape our lives. These are not intangible things that don't need to be paid attention to, these are the ways we experience trauma, the way we recover from it, and the way we move on and navigate the rest of our lives.

What happened to you versus what's wrong with you? One element of understanding trauma and the impact of trauma was a re-framing of the impact of trauma

as “what happened to you verses what’s wrong with you”. A few managerial-level participants described a person-first approach with clients as part of TIC and one that overlaps with thinking about clients’ experiences in a framework of “what happened to them verses what is wrong with them,” a central idea from the Sanctuary® Model (Yanosy, Harrison, & Bloom, 2011, p. 44). Another way that participants described this concept is that “clients are not the stuff that they’ve been through.” One participant described this way of approaching people as a much gentler approach then “what’s the matter with you.”

One senior manager described clients’ difficulty in following through on activities of daily living such as getting an identification. Rather than assuming something negative about the clients’ motives, the manager chose to talk about it as a need for support due to fear or perhaps never being taught. By taking a stance of “what happened to you”, workers situate themselves to “meet a person where they’re at” as they are already seeking to understand the impact of what happened to the person and the implications for working with the client.

“Meeting a person where they’re at”. Several managerial-level participants described TIC as “meeting people where they are.” One program manager described providing services “on a case-by-case basis so that we can really meet people where they're at rather than saying, the rules are the rules.” Another program manager noted that “good work doesn't happen outside of understanding where they’re at.” A few participants described prioritizing the needs and desires of the client above the program procedures. One program manager described the differing thought processes,

But instead of, here's a folder, here's all the papers we need to sign so you can get entered into our program. And here's the things that you must do. We're like OK, so why are you here in front of me and what's the most important thing on your mind right now? What is foremost in your mind?

One non-managerial staff person described this phenomenon as "...having knowledge about the different circumstances that people go through in life and how it can affect them...then base our services accordingly." Meeting people where they are also meant that programs "provide resources so if we're not meeting somebody's needs that they're able to find a place to meet their needs in a timely way."

One program manager told a client story that illustrates the importance of meeting a person where they're at instead of trying to fit them into a pre-set program structure, in essence, shifting from a program centric to a people centric focus. The client had one son with autism and during the intake interview, she was trembling as she shared that she was homeless, had no supports and recently tried to commit suicide. Due to high levels of anxiety, the client was not able to carry out basic activities of daily living so the staff, backed way off, like we weren't even talking about housing...piece by piece my case manager worked with her...and she ended up getting a part time job...and she's living in her own apartment now. But.... folks like this...if you push...too hard, she would've just been back at our local hospital on the...mental health unit and the boy, who knows where the boy would be.

Furthermore, one senior manager described the attitude of the repair people that they hire to do repairs in client apartments, who are also in recovery from alcohol or other drugs but are not educated in TIC, as

Coming to all of their interactions in life...going where the person is and understanding that everyone has a history and a story that can affect their behaviors. They're simply approaching life from that lens. So...if they're fixing something in one of my apartments and the resident happens to be home and there's interaction there, they're coming from that lens.

One program manager described their program as having a “constant mantra of trying to understand where a person is coming from and what they’ve been through.”

Compassionate and holistic care. Several participants viewed TIC as compassionate and holistic care, another element of a culture for healing. One executive summed up TIC as “a more human way of doing this work...the people that we're serving need to be met with compassion. And that is really what trauma-informed care is about. It's the best way to do it in a professional way.” One program manager viewed TIC as simply caring about what is really going on with the individual. A case manager described TIC as “a more holistic way of thinking about human behavior and change because you're taking into account what folks have been through and what they need to work through to get to their next step.” One program manager shared a story highlighting compassionate and holistic care in action,

...there is a client that recently was dealing with incarceration and drug addiction. And two of our staff...went to visit her when she was in rehab and also when she was in jail as a way of continuing our support of her. Staying in touch on the phone and just letting her know that we were there, and we cared. And I remember during the holiday season, she didn't have any toys for her children, and we made sure we got toys to her so that when her son came to visit, she

would have toys to give him. So, I think we constantly reinforced her strength as a mom and her love for her child as a strength. And recently, unfortunately she relapsed, and we had to ask her to leave our program. And even though we had to do that, we did that, from my perspective in a very trauma-informed kind of way. We would continue to provide her with services and support her through it and that this was not a punishment, this was really because we're concerned about her safety but more importantly there was a boundary that she had agreed to when she signed on. She understood and she was not angry with us because she did feel our compassion and empathy for her.

Several participants described the overall experience of using TIC as positive, a “metamorphosis” for the organization and “the most wonderful thing that has happened.” Another participant loves the whole approach and thinks it is a natural approach and the way that all humans should treat each other. However, TIC implementation was not without a struggle. One executive felt that no matter how hard they tried, they were not always fully able to adhere to TIC practices due to rules and regulations, which sometimes inadvertently result in issues for families.

Overlap between TIC and Social Work Values and Practices

Participants noted the overlap between “practicing strengths-based, empowering social work and trauma-informed” care. One program manager was not able to distinguish the differences between the two, “some of the things that you call trauma-informed are also essential social work values, strengths-based, inclusivity, empowerment, those are not, in my estimation exclusive to trauma-informed care, it’s just sort of social work's best practice.”

Overlap between social work values and TIC. Several participants from various staff categories described a range of social work values that undergird practices that overlap with TIC such as compassion and empathy, guarding against an institutional environment, listening, and overall caring. A few participants expressed a commitment to helping people work through trauma based on their social work background.

The most salient expression of social work values, described by many participants as part of TIC, were the importance of human relationships, the dignity and worth of the person and the importance of service. One case manager's client story best illustrated the social work value of the importance of human relationships:

Although the participant was not the primary case manager for a specific client, when the client relapsed, the participant was the first person that the client reached out to, ...for whatever reason we connected and...I was able to coordinate with the other members of her care team to help her articulate to them what was going on...I was always following up with her and she would call me at different times in the program to let me know how she was doing. When she came home, I greeted her and she ended up relapsing again and violating her probation, so she is now incarcerated but I let her know that she is always welcome here and that there's no judgment, there's no disappointment in her. There's only investment in seeing her be better.

One program manager underscored the importance of treating people with dignity and worth, especially in the context of working with traumatized individuals as the participant described advice given to the staff about client orientation,

When you come into the orientation, I want you to shake the hand of every single person around that table because I often find when people are traumatized...

(they) just don't think their important and who would want to talk to them, who would want to shake their hands.

While several managers described instilling in staff the importance of respect for their clients' time and energy as well as respectful communication. Participants noted that everyone deserves to have their basic needs of housing and food met.

Participants that used and understood TIC had a strong sense of social work values in general and described a deep commitment to service in their work. In describing staffs' attitude when answering the phone, one program manager noted, "they're not going to be real matter of fact, they're going to listen harder and they are careful to direct clients to the person who can most help them." Another program manager described her philosophy that clients are number one and should be treated with the same respect as board members. This participant felt that the biggest priority is to ensure that clients feel safe, listened to, and heard. Another managerial staff person summarized their commitment to the work,

We've had many barriers in our programs, but I've always said as one of my philosophies, I'm not letting anything stand in my way so I'm going to find my way around it. It may not be the right way, but I'm going to find my way around the barriers.

Several participants talked about the influence of social work education on their understanding and practice of TIC, highlighting the overlap between a strengths-based perspective and TIC. One non-managerial staff person reflected on their experience of social work education,

I am in college, going for social work, so I have the education and I'm always involved in school with things that, not necessarily have to do with trauma-informed care, but the entire education of social work focuses on the strengths perspective...I have seen the six...values that they use [referring to the six TIC principles summarized by SAMHSA] because of school.

One case manager shared that other staff at their organization had been trained in the Sanctuary® Model of TIC and although this case manager had not been trained, they learned a lot of the TIC principles and practices through their social work higher education experience. This same participant felt ethically and morally compelled to use TIC as a social worker because it is a best practice. While another case manager learned in social work school that you have to consider the unique needs of a client based on their history of traumatic experiences.

Even participants that did not know what TIC was were able to connect TIC with social work practice based on the TIC definitions script I read to them as part of the interview. One case manager noted,

I think with our casework that we basically try to do all of that [referring to TIC principles]. I mean we try to, in all our casework meetings, make sure that there's safety and trustworthiness and we have the peer support and we do inclusivity...we do all of that on a regular basis...I don't think I would say it was trauma-informed care. I just think when you describe it, we describe the nature of what we do, we tend to do all of that.

It may be the case that those that described an overlap between TIC and social work practice did not fully understand TIC. For one program manager, it was hard to convince

middle management that TIC was needed because they believed that they were already practicing it although in actuality, they only understood TIC in part.

Overlap between TIC and the empowerment model. Several of the participating programs work exclusively with people who have experienced domestic violence. Many of these participants described the overlap between TIC and the empowerment counseling model. One senior manager likened TIC to,

Our old...empowerment model. I mean a lot of the language is exactly the same...when I would describe it to people, say in our training, we do a module on [TIC in] our training...I would describe it to them as sort of a return [to] and with a higher level of understanding [of] the way the services were supposed to be delivered in the first place.

Some participants suggested that TIC was just new terminology for what they already practice, the empowerment counseling model.

Years ago, it was empowerment counseling and that was what everybody had to do, and everybody had to follow. And then it kind of molded into this trauma-informed care piece. So, we just kind of went with the ride.

One of the principles of TIC is empowerment, voice, and choice, which is directly aligned with the empowerment counseling model. One executive noted that even before the conversation about TIC, domestic violence organizations were built on trustworthiness and transparency, another principle of TIC.

Overlap between TIC and the housing first approach. One program manager described the overlap between TIC and the housing first approach outlined by HUD, which they described as setting low barriers to eligibility for supportive housing

programs. The housing first approach entails having few requirements for clients to participate in program activities in order to stay in the program. The purpose of this is to offer clients choice so that they are empowered. Participants also commented that both federal and city agencies charged with addressing homelessness have been shifting to a more client-centered approach with a focus on services tailored to client needs rather than having a pre-set rigid menu of program offerings.

Other models linked to TIC. A few programs provided examples of general social work models of practice as potential examples of TIC. For example, one program discussed the Bridges out of Poverty Model by Ruby Payne. This model focuses on building community support to address issues that perpetuate poverty on an individual level. Another participant discussed the overlap between TIC and a model of nonviolent communication developed by Marshall Rosenberg, “this whole mindset of trauma-informed care, it groups nicely with the mindset of nonviolent communication which I've been studying and doing work on for ten years now.” The Sanctuary® Model of TIC includes “non-violence” as one of the seven commitments of the model (Bloom, 2018b).

Trauma-Informed Care Assumption: Understanding Trauma Theory

It is common in health science research to use a priori theories as a framework for codes (Creswell, 2013). I started my analysis about the programs’ understanding of TIC with a framework of codes on the meaning of TIC from the literature. For the category of participants’ understanding of TIC, I started with the four assumptions underlying a trauma-informed approach: including understanding trauma theory, recognition of trauma symptoms, and systematic response to trauma and resistance to re-traumatization (SAMHSA, 2014) (see Table 10 below for detailed summary). However, the data coded

as systematic response to trauma and resistance to re-traumatization, were most illustrative of TIC practices. Therefore, I summarized those practices in the findings chapter about TIC practices.

Table 10

SAMHSA'S Four Key Assumptions in a Trauma-Informed Approach

Assumption	Description
Understanding of trauma theory	Having a basic realization about trauma and understanding the impact of trauma. People’s experience and behavior are understood in the context of coping strategies designed to survive adversity in the past or present including secondary traumatic stress experienced by direct care professionals. An understanding that trauma should be systematically addressed in prevention, treatment, and recovery settings because it can underlie various behavioral health issues and can serve as a barrier to success in other human service systems such as child welfare.
Recognition of trauma symptoms	Identifies or acknowledges “the signs and symptoms of trauma in clients, families, staff, and others involved with the system” (p. 9).
Systematic response to trauma	Full integration of knowledge about trauma into policies, procedures, and practices.
Resistance to re-traumatization	Seeks to actively resist re-traumatization of clients as well as staff. Staff who work within a trauma-informed environment are taught to recognize how organizational practices may trigger painful memories and re-traumatize clients with trauma histories.

A Basic Realization about Trauma

Understanding trauma theory is one element of a trauma-informed approach and includes having a basic realization about trauma and the impact of trauma. Most participants whose programs had either partially or fully implemented TIC were able to describe a basic realization about trauma and an understanding of the impact of trauma. Participants talked about the importance of recognizing trauma symptoms and the deeper impact that trauma has had on families and their ability to be successful. In their own words, managerial staff described this realization as,

An approach to care that takes into consideration the entire history of the person receiving care and being attuned to how those experiences have impacted them as an entire person including their bodies and their minds...and...working with individuals with the understanding that they've been traumatized...and being aware that their reactions may be trauma-responsive to either triggers or flashbacks.

While another participant described this realization as being aware of the kind of toxic stress that many participants have endured.

Awareness/ mindfulness of toxic stress experienced by clients. A few participants described their understanding of trauma as a “level of mindfulness in terms of what kind of environment people are coming into at what could be the worst moment of their lives.” Mindfulness of the clients’ experience of trauma was a frequent theme for how participants understood TIC. One manager felt that mindfulness was a key principle of TIC and described it as being “aware of what you're saying, doing, thinking and being really mindful of...people's experiences and what they've gone through and how what you're saying and doing...may affect them.”

Overall, many participants had an understanding of the high level of trauma experienced by their clients, whether it be as severe as PTSD, domestic violence or the environments that they are coming from. Participants frequently described both the experience of homelessness and poverty as forms of trauma. Poverty was described as “effecting every decision and everything.” One manager spoke about stereotyping people who are homeless without recognizing the role trauma plays both in creating and exacerbating the situation, while another non-managerial staff person talked about the trauma of failing in the homeless service system resulting in re-experiencing homelessness. One program manager talked about being stuck in shelter or TH due to the lack of affordable housing as a form of re-traumatization. One case manager explained that clients have experienced a lot of trauma throughout their lives and they experience the system as a revolving door due to the myopic focus on housing and employment without addressing the root causes. The same participant described the gap between the needs of clients and the criteria of the housing assistance program.

Trauma as a barrier to health, wellbeing and success. Trauma was identified as a barrier to health, wellbeing and success. A few participants identified that trauma can impact an individual’s ability to be successful in various life domains. When talking about how they define TIC, participants described various elements of this aspect of TIC including, “understanding and sensitivity to the impact of trauma on one's ability to live daily in life” and acknowledging “the wide variety of implications in the various roles that trauma can have in impacting a family’s ability to find success and meaning out of their lives.” Participants described trauma as interfering in a person’s ability to engage in

the workforce, to be successful in school, and as impacting mental health and physical safety.

Trauma as a universal experience. Furthermore, when working with families experiencing homelessness, trauma was recognized by several participants as so common as to be a universal experience that calls for a universal approach to service delivery. One program manager described the high levels of trauma experienced by families leading up to their homelessness. Others believed that trauma-informed care should be applied universally even if someone has not experienced trauma because we are all living in a world where we are watching people be traumatized by various systems, whether that is capitalism or racism or something else. One program described TIC as “...a strengths-based framework where one is aware that, I would say all of us have had some kind of trauma in our life, whether or not it's physical or emotional or psychological...”

Tensions Inherent in Trauma-Informed Care

Some of the organizations that utilized TIC described a tension between TIC, program structure and client accountability. One senior manager described concerns about the need for a little more structure while balancing the need for client choice. Clients may not appreciate the structure while they are in the program. However, after completing the program, some clients return to thank the staff for the structure because it allowed them to achieve things that they had not been able to in the past, such as saving a significant amount of money, completing higher education, and establishing a fulfilling career.

This is what makes this job to me, like one of the better jobs that I've ever had, is that you actually see where you've made a difference. I think we're helping lives here because you see it, they come back and tell you, you see them grow.

A program manager told a story about this balance between program structure and client choice that delineates this tension,

In addition to case management, we are providing housing. And so there are expectations because especially transitional, it is short-term. Expectations that people are going to pay rent or the expectations that people are going to save money and I think we can't just say, oh well you didn't, we're just gonna forget about that part. A couple of months ago, a participant told the case manager that she couldn't pay any money that particular month because her four-year-old, it was his birthday and she was having a big party. I'm not gonna pay my rent...this month because I'm going to spend \$250 on my four-year-old's birthday...do we say, gee, maybe she never had birthdays, or what does it mean to her? But nevertheless, it's still a problem. So, what happened? Why couldn't you pay the rent, let's talk about that. But to really help them to shape the conversation so that they could think about making other choices in the future.

One senior manager described confusion among staff about how to reconcile TIC with having program guidelines and allowing clients to experience the natural consequences of their actions. There was a misconception that in order to provide TIC, you cannot have any rules or guidelines, and everyone can do whatever they want, whenever they want, under any circumstance. The participant explained that it is difficult to identify and teach staff the balance between understanding that client behaviors may come as a result of

trauma and that there are still natural consequences of these behaviors. A program manager told a story of how a client was not able to react in a healthy way due to trauma but at the same time, they had to hold her accountable for the consequences of her decisions. The same program, one that had implemented TIC, noted that there was an evolution in staff's understanding of the balance between establishing boundaries that keep everyone safe, and being trauma-informed; the two are not mutually exclusive. Being trauma-informed does not mean that you throw out all guidelines and there is no safety.

Trauma-Informed Care Assumption: Recognition of Trauma Symptoms

Another TIC assumption according to SAMHSA (2014) is recognition of the signs and symptoms of trauma in both clients and staff as well as others involved with the system. Participants were able to articulate a recognition of trauma symptoms both in clients and staff and discuss prevention of secondary traumatic stress in staff.

Preventing and Addressing Vicarious Trauma in Staff

One program manager described her staff as sometimes “one step away from the same status as clients” in terms of being affected by trauma. Another participant provides constant reminders to staff not to take things personally since it can be overwhelming for staff to deal with client behaviors when the staff have their own issues and concerns.

A few participants were able to recognize the importance of addressing vicarious trauma in staff,

With our staff we talk a lot about vicarious trauma and just how things can affect them and how important it is for them to take care of themselves so they're doing the best work that they can with our clients.

One senior manager was particularly sensitive to their staffs' wellbeing and listens to staff for anything that does not sound right from staff or between staff and clients so that they can intervene to ask if the staff person needs support in interactions with their clients.

Supporting staff. A few managers placed a strong value on providing support for staff in order to deal with the level of trauma that they are witnessing in their work with clients. One manager described the need for a "total commitment of the agency because if you're truly trauma-informed you not only need to do it for your clients but for your staff as well." For some, this meant being sensitive to staff needs and suspending judgement about staff until getting more information.

Teamwork. Teamwork was another element of being trauma-informed that was identified by a few participants. One senior manager talked about the importance of how staff treat each other,

So, I think that whole concept that, it's all of us in it together, it's not just about how we interact with residents or people who come into the building for services. It's also about how we interact with one another, the consideration that we show one another, the empathy that we show for one another. Just the idea that we're all in this together and that all of those interactions are important.

Client Symptoms of Trauma

Several participants noted the importance of recognizing trauma symptoms in clients in order to deliver appropriate care. According to one executive, even when staff are in conflict with a client, they strive to understand the challenges that the client is going through that are contributing to client behaviors and responses.

Actions/ reactions impacted by trauma. Several participants expressed an understanding of the impact of trauma on clients. One executive explained that “the folks that we’re working with have experienced trauma or are currently experiencing trauma that causes actions and reactions that might be different than someone who might not have experienced trauma.” This included reactions that seem heightened because “trauma survivors are not [starting] at zero.” In addition, a program manager expressed an understanding of the permanent impact of trauma,

I know that people come with a whole lot of other stuff that has happened to them and that our body never goes back to neutral; our hearts, our minds never go back to neutral when things have happened to us.

Wearing a mask. One case manager told a story about a client who came from an extremely dysfunctional family as well as an unsafe part of the city, who felt that she needed to hide her personality in order to be safe,

.... she’s such a sweet girl, she's so nice, just bouncy and everything. She stated that she doesn't feel like she can be who she is. She's had to learn to mask herself and she's developed certain behaviors that she doesn't like but she does because of the environment that she was in. Every time she's out on the street, she's constantly guessing, is somebody going to hit me over the back? Do I have to respond in this way so that I don't get beat up? And she stated how tiring it was

and she continues to have little flare ups with other people that she tries to resolve but she ultimately gets frustrated and can act aggressively because of those instances. I didn't tell her she had PTSD but I did tell her that there is a type of fatigue that you develop from constantly having to defend what you see as normal responses to other people and then you wind up giving that fatigue to other people when you respond abnormally and then they see a threat. So, helping her to understand that helped her to kind of not be as angry with other people when they would get angry.

Summary

In summary, one of the central questions of this research was, how do providers understand TIC? Participants see TIC as a broad philosophical framework that shifts the emphasis from rigid to flexible programs and serves to structure a more compassionate and holistic way of providing services in TH programs. Several participants described TIC as “meeting people where they are” and using a strengths perspective to collaborate with clients, in essence utilizing a person-centered approach to services. These elements overlap with various social work practices and result in confusion about how TIC is unique from social work practice. Practitioners understanding of TIC was directly connected to practices or actions that they take in order to embody TIC. For example, participants often defined TIC as “meeting a person where they’re at” although in order to be able to do this, providers would have to begin to take action to embody the principle. In the next chapter, I explore the practices that participants attributed to TIC.

CHAPTER 5: FINDINGS – TRAUMA-INFORMED CARE PRACTICES

Trauma-Informed Care Practices

The second research question was about the practices providers use to deliver trauma-informed care (TIC). These practices ranged from systematic organizational to manualized staff-level practices and included practices that were used to try to prevent re-traumatization as well as engender the range of TIC principles (see Appendix K for TIC Practices Chart). I excluded the data from 11 participants, representing eight programs, from this chapter because they had not implemented TIC. Although some of these participants described general practices, they were not referring to TIC.

Systematic Response to Trauma

A systematic response to trauma is one of the underlying assumptions of TIC (SAMHSA, 2014) and means that there is an effort to fully integrate knowledge about trauma into policies, procedures, and practices within an organization. In answering the question about practices attributed to TIC, a few participants described this type of a comprehensive analysis of every aspect of services with an eye to adjusting practices to be trauma-informed including addressing anything that could re-traumatize clients. Another part of a systematic response to trauma was identifying accommodations needed based on a person's trauma experience and referring clients for more specific clinical intervention if it is not something the program can address directly.

A few participants described carrying out a comprehensive analysis of their policies, procedures, and practices to make changes that would promote TIC. Part of this analysis included assessing program rules to determine if they present challenges for clients with a goal of promoting flexibility by eliminating rules that are not tied to safety

issues. For example, one program historically had extreme restrictions and requirements, but after implementing TIC they changed their entire program to “lighten it up” so that clients had more flexibility, freedom, and a voice in the program. Subsequently, they used the monthly resident meetings as a forum to talk about concerns and changes clients would like to see in the program. These changes were implemented unless they posed a safety concern. One case manager felt that the flexibility in the program and the longer length of stay afforded in transitional housing helped in implementing TIC.

Systematic Approach to Policies and Procedures

In describing a systematic response to trauma, one topic that a handful of participants mentioned was the physical plant, ranging from installing peepholes in client unit doors, to having on-site security, to how a space looks and feels. Participants described assessing their space through the lens of TIC, which included ensuring that the space feels safe for individuals who are living there. For example, one organization was assessing their client waiting area for things like how close the chairs were together and how things were arranged with a goal of establishing safety. While another program was assessing their overall space to improve the first impression that clients get when they come into the building as well as the sense of safety and belonging. One of the goals of this assessment was to make the space less institutional. Part of the process included a redesign of the lobby and waiting area setup to create a safe and welcoming space. Another participant explained that they have changed the set-up of their offices as well in order to mitigate things that may trigger clients. One participant’s organization described hanging posters and leaving out educational materials and books on trauma to help clients to learn more about what they may be experiencing and how to get help. While another

organization talked about attending to the mix of clients that they admit to the program. For example, if there is already a certain number of clients with substance use disorders, they may try to limit admitting others with similar issues. One participant summed this up well, "...it starts in the understanding that the building is a giant family and in that giant family we don't want to create dysfunction." All of these practices contribute to a safe and trauma-informed physical environment.

Systematic Approach to Practice

There were some broad service-delivery practices that were common throughout organizations that practiced TIC. For example, one participant described taking a healing approach to every interaction whether it is with a client, a board member, or another stakeholder so that the culture of TIC permeates throughout the organization. One senior manager said that their first priority is to remember that client actions and reactions are often based upon either current trauma or previous trauma and therefore, they "try to wear that lens when interacting" with clients. Similarly, a program manager described "looking through the Sanctuary® Model lens" to apply the principles and tools to a situation before reacting. Another program manager viewed the client's behaviors as embedded in the environment that they are coming from when they described working with clients to revisit counterproductive decisions in order to understand why they are making those decisions. Although some of these ideas are also ways of understanding TIC, participants used these ideas as frames necessary to be able to practice TIC. In each interaction with clients, "looking through the lens of Sanctuary®" Model or some type of trauma-informed frame, seems to be the first step in taking action to engender TIC practices.

A few participants described a general approach to working with clients in a trauma-informed way. First and foremost, they set the tone for case management meetings by ascertaining how the client is doing and what challenges they may be facing. This information determines the plan and pace for the rest of the meeting. There is an openness to the structure and content of meetings. One program manager described observing the body language and speech patterns of clients to determine how to proceed. For example, if a client is anxious, the participant would start the discussion with less stressful topics and would continue to follow the lead of the client in determining when to shift to issues addressed as part of the client's goals associated with the program.

One participant, a program manager, discussed the importance of having flexible policies to accommodate each unique client; they do not have blanket policies. Another participant, an executive, placed importance on ensuring that their clients/families had private time outside of the purview of the program staff. In this case, because staff offices were in the same building as the residential program, they had a strict rule about making sure that staff are leaving in a timely fashion so that clients "don't have a staff member breathing down their throat" and would have time to just be families when they are home in the evening. In addition to offering flexibility to clients with respect to rules, one executive also talked about allowing staff flexibility in their schedule so that they are available to meet the needs of clients in the moment when clients need extra time even if it means that they are late for staff meetings. For this type of flexibility, management support is necessary.

Manualized Staff Level Practices

Participants described staff level practices that they used with clients and staff to deliver TIC, most of which are tools of the Sanctuary® Model of TIC. These manualized tools included the Safety, Emotions, Loss, Future (S.E.L.F.) framework and curriculum, the “family team meeting”, the “community meeting”, “safety plans”, and “self-care plans.” A few programs provide client groups about the effects of trauma on both adults and children.

One participant’s organization uses the Sanctuary® Model S.E.L.F. framework when staff present cases at internal case conferences. The underlying themes in the case conference are always safety and emotional management. The S.E.L.F. framework is used as a “compass” on the healing journey. Each letter in S.E.L.F. represents one of the key components of healing from trauma. Yanosy, Harrison, and Bloom (2011) referred to the S.E.L.F. framework as a “nonlinear, cognitive behavioral therapeutic approach for facilitating movement, regardless of whether we are talking about individual clients, families, staff problems, or whole organizational dilemmas (p. 43).” The S.E.L.F. framework can be used to process any dilemma or issue to assist the individual, group, or organization move to the envisioned future. The four key components of the framework represent the domains of disruption that can occur in a person’s life including 1) safety: achieving safety in its various forms; 2) emotional management: identifying and modulating emotions related to key events and people; 3) loss: experiencing grief and understanding that all change entails some sort of loss; and 4) future: experimenting with new roles made possible by healing (Bloom, Foderaro, & Ryan 2006).

The same organization also purchased the S.E.L.F. curriculum, which includes various modules, each serving as a workshop that can be presented to clients. The S.E.L.F. curriculum is a non-linear trauma-informed psychoeducational group format that provides one of the most essential elements of TIC, education on the impact of trauma (Bloom et al., 2006). As a non-linear model, each of the 36 lessons in the curriculum is designed to be able to stand-alone since the materials are typically delivered in settings that may have a short length of stay such as a homeless shelter or an inpatient psychiatric facility (Bloom et al., 2006). The authors note that although this is a trauma-informed curriculum, trauma is not what the focus is on, rather on the impact of exposure to trauma, specifically “loss of safety, inability to manage emotions, overwhelming emotions, and a paralyzed imagination” (Bloom et al., 2006, p. 6). The participants program offers these workshops regularly and because each module is stand-alone, they do not need to do a series. Each module is about 50 minutes in duration, and you do not need to be a therapist to facilitate the workshop, any staff person can lead the session. The same organization uses a variation of S.E.L.F. with both adults and children by having them create self-soothing boxes that they call “myS.E.L.F. boxes,” where tactiles, designed to help them understand how they are feeling and to create safety are placed in the “myS.E.L.F. boxes.” The materials to make these boxes are available in common areas of the program so that clients can create one at any time. Finally, the same organization formatted many of their forms, such as supervisory forms, using the S.E.L.F. format to address safety issues, emotional management, loss, and future related to a particular issue. Another program uses S.E.L.F. on a daily basis including in client meetings and for addressing program non-compliance.

The participant whose organization uses S.E.L.F. extensively, also discussed using the Sanctuary® Model “family team meeting” tool, noting that they used to have a pre-family team meeting with staff only, but they did away with it because they did not feel comfortable talking about families without them present. The “family team meeting” is a family goal planning conference to provide an opportunity for staff, clients, and families to reflect on the work that has been done in the residential program setting including progress and future goals. The structure of the meeting includes utilization of the S.E.L.F. framework as well.

One manager explained that the stress levels for the staff are high and therefore, the manager uses the Sanctuary® Model with staff as well as clients. One of the TIC tools that several participants use with both clients and staff is the Sanctuary® Model “community meeting.” The “community meeting” is a brief ritual that helps a group transition from one activity to another in which the focus is working together on a shared purpose (Community Meeting, 2018). The “community meeting” has its origins in the “therapeutic community” and it is one of the easiest ways of creating a non-violent environment since all community members can use it when there is an incident or when tension arises (Community Meeting, 2018). The “community meeting” gives everyone an opportunity to communicate in a safe environment and reinforces the importance of relationships and articulating feelings while conveying a sense of social responsibility. There are four questions that comprise a “community meeting” that are asked of all meeting participants including “Who are you? What are you feeling today? What is your goal for today? and Who can you ask for help?” (Community Meeting, 2018). Even for those that know each other, the question, “Who are you?” allows for the affirmation of

identity which can be an important issue for those that have been oppressed. Sharing feelings at the beginning of a meeting allows for the development of emotional intelligence among the group and a group understanding of where people are coming from. The goal is not to delve into why a person is feeling a certain way but to hold the understanding of feelings in the group as an acknowledgement and validation that folks are all coming from different places. Goal sharing allows for others in the group to support one another to achieve their goals. Finally, by asking each person to identify someone present who they can ask for help, a norm of social responsibility is set (Community Meeting, 2018).

One program manager reflected on the use of “community meetings” to allow staff to spend time talking about how they feel. The first time this participant facilitated the “community meeting” with staff, two staff members ended up crying just because they were going through “stuff” and somebody was asking them how they felt, which was a kind of “big wakeup” for this participant. The same program incorporates elements of TIC into their “house reports” that summarize what happened on the shift by having the staff indicate whether there were safety issues that arose and what feelings came up for them. This practice allows staff to tap into the feelings that the work draws out in them.

Another tool of the Sanctuary® Model that participants discussed was the “self-care plan”, a self-designed, tailored compilation of wellness strategies for both clients and staff that help to protect against re-traumatization and vicarious trauma (Yanosy et al., 2011, p. 94-95). The “self-care plan” strategies are longer term in comparison to the “safety plan” strategies, which are designed to be used in-the-moment. The “self-care

plan” strategies are more preventative in nature whereas the “safety plan” strategies are used to deal with stress as it arises. Part of “self-care planning” is for the organization to work to ensure that the organizational context supports self-care and wellness (Yanosy et al., 2011). One case manager noted how important “self-care plans” are for clients although being poor is a barrier to self-care because of the lack of time and money to practice self-care strategies. Nevertheless, the participant reminds clients that they are worthy of rest and self-care and that it is ok to take care of themselves. A few participants talked about focusing on self-care with staff members. One manager worries about their staff and therefore focuses on vicarious trauma and staff self-care every day by instituting activities such as movement and exercise classes for the staff. Another manager tries to find projects for staff that match staff strengths so that they feel motivated and interested as well as helps to prevent staff burnout. Another strategy used by one program to help with burnout is giving staff gift cards and taking them out to lunch periodically.

A few participants talked about the importance of providing support to staff so that they do not feel burnt out and so that they are well equipped to best support the clients in addressing their needs. Another participant, a senior manager, explained that staff are coming in with all kinds of issues from home and clients have their own issues and concerns and all of that trauma is brought to the program. Staff and client trauma combined can create a cauldron of trauma reactions that requires using a trauma-informed approach to make sure people feel safe. Furthermore, the participant has an open-door policy for clients and staff to meet with her if they have issues and concerns about talking to their direct supervisor or case manager. Subsequently, the manager brings everyone

together to discuss the issues. Even the case management supervisor comes to this manager to ask for support when they are not reacting well to a client. There is a recognition that everyone has a different approach and that if one staff person is not able to work effectively with the family, they need to find someone that will so that no client walks away feeling as if there is no one they can talk to in the program. The case manager from the same program described a similar sense of team,

Whenever somebody feels uncomfortable or they don't like speaking to somebody, there is always somebody else here. So, we work as a huge team to try to resolve the issue.

Another program has a standing agenda item for staff meetings about any struggles that staff are having with clients as a way to work through the issues and support the staff.

In addition to the “self-care planning” tool, the Sanctuary® Model “safety plan” tool was also mentioned by a few participants. A “safety plan” is a self-designed list of simple, self-soothing activities that a client, staff, or another community member can do in the moment when they are feeling overwhelmed as a way to promote the four types of safety connoted in the Sanctuary® Model: physical, psychological, social, and moral (Yanosy et al., 2011). “Safety plans” are meant to be used by all community members and displayed in some way to serve as a visual reminder of the need to manage emotions in the community as a universal precaution (Yanosy et al., 2011). One participant noted that staff wears their “safety plan” visibly on their person (e.g. on a lanyard or clip), in part to encourage clients to create and use a safety plan. These participants understood how to frame issues in terms of trauma in order to deescalate potential incidents. For example, one overnight support staff person advises clients that their behavior may

trigger others or even themselves as a way of positively framing the potentially negative impacts of their behavior. Another participant talked about the importance of modeling healthy behavior including self-care especially when clients have interest in working as a social service helper themselves,

One of the questions that I ask is, what are some ways that you can model the healing work that you want your clients to do in their own life? So, you [clients] shouldn't say, I want to be a therapist, or I want to work with kids who have disabilities or who have traumatic background, a lot of them actually articulate that they want to serve people who also have trauma in their lives. But then at the same time you [clients] shy away from therapy or think it's not worth it or that it is something that you just wouldn't do. So how can you [clients] walk the walk that you want to assist other people in doing? I talk to them about how working in this field can be triggering and how you're really going to be working on yourself so that you have the tools to deal with some of those triggers that you're going to face in your work.

Many of the manualized practices used with clients are also used with staff, as the goal of TIC is to create a socially, morally, physically and psychologically safe environment to prevent more serious consequences of traumatic stress (SAMHSA, 2014).

Resistance to Re-Traumatization

One of the four assumptions of TIC (SAMHSA, 2014) is active resistance to re-traumatization of clients as well as staff. "Staff who work within a trauma-informed environment are taught to recognize how organizational practices may trigger painful memories and re-traumatize clients with trauma histories" (SAMHSA, 2014, p. 10).

Many participants understood that it was important to work to mitigate re-traumatization of clients, “realizing that certain things trigger people back to things that happened to them in childhood”, including the words and actions of staff. Participants described applying their historical knowledge about clients’ past trauma to avoid re-traumatization including an awareness of what each client’s triggers are. Participants understood that something as innocuous as a look or a comment can trigger a trauma response in clients and described being sensitive to this dynamic. One participant alternatively described this as having a self-awareness and using self-talk to avoid re-traumatization. Another participant provided an example of a triggering situation for a client,

I was sitting across the kitchen table, one of my favorite places is to sit at the kitchen table and talk to our moms and I slid a glass out of the way so that we had a direct line of vision and she flinched, and I kind of said, are you OK? And she said that's a trigger for me because when the glass moved, then it usually got thrown at me.

Another participant, an executive, described attending to re-traumatization by being mindful and respectful of all the baggage that people bring with them when they are coming into the program especially when setting up rules and program requirements. A few participants discussed specific examples of working to mitigate re-traumatization of clients. One executive explained the importance of supporting a client if they are facing eviction in the transitional housing (TH) program, reflecting on the need for sensitive communication skills and support with appropriate referrals to avoid re-traumatization. Another participant, a program manager, asks incoming clients not to be involved in any new relationships for the first 90 days so that they can be focused on their own wellness.

The participant explained that this is done based on research that has shown that more women relapse into addiction around relationship issues whereas men tend to relapse around celebrations. The program is asking this of clients in order to prevent the re-traumatization of relapse. Another participant described being “trauma-responsive”,

We didn't always as a staff, recognize how our own stuff would get in the way and how to be trauma responsive to someone, not take it personally, and allow people time to process. To just be much more conscious of our role and our part in it.

SAMHSA’s Six Principles of Trauma-Informed Care and Associated Practices

TIC practices described by participants were linked to SAMHSA’s six principles of TIC (see Table 11), a framework that I used for my analysis. TIC practices described by participants were often able to be attributed to more than one of the principles.

Therefore, I identified the most salient category based on the definitions of TIC principles when deciding how to code the data and organize the findings in this section. For example, certain practices may engender trustworthiness and transparency but also lead to collaboration and mutuality; and other practices may engender safety but also lead to empowerment, voice, and choice. There were a couple of specific instances that a rationale for the code was indicated such as the use of the “community meeting” tool from the Sanctuary® Model of TIC. This specific tool can engender various TIC principles, but I chose to code it as practices that bring about peer support because the format is designed to share feelings and goals with peers and to identify who they can ask for support. In this way, the most prominent feature of the “community meeting” is arguably to build peer support.

Table 11

SAMHSA's Six Principles of TIC

Practices that bring about safety	“Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.”
Practices that bring about trustworthiness and transparency	“Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.”
Practices that bring about peer support	“Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing.”
Practices that bring about collaboration and mutuality	“Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making.”
Practices that bring about empowerment, voice, and choice	“Throughout the organization and among the clients served, individuals’ strengths and experiences are recognized and built upon. Operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice, and choice and are often recipients of coercive treatment.”
Practices that bring about cultural, historical and gender inclusivity	“The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender- identity, geography, etc.); offers access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.”

Of the six principles that TIC practices are based on, the least noted practices fell into the categories of 1) peer support and 2) cultural, historical and gender inclusivity. Practices that engender empowerment, voice, and choice; and safety were the two most frequently noted categories of practices used in the programs.

Practices that Engender Collaboration and Mutuality; and Peer Support

The SAMHSA (2014) principle of collaboration and mutuality is described as placing, “importance on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making” (p. 11). A frequent theme was the importance of the manner in which staff communicates with clients, whether that is characterized by having a discussion verses talking at someone or engaging in a conversation verses making demands. In addition to the style of conversation, one case manager talked about collaborating with clients to support them in achieving their immediate goals while at the same time building a long-term vision for success. This participant summed up her work by describing the high level of collaboration they achieve with their clients,

A lot of my work is having motivational conversations with people and listening to them, listening to what their goals are and then helping them articulate how they can move to the next level and pointing out things that they might want to pay attention to or re-synthesizing information so that they hear it in a different light.

The same participant stressed the importance of letting clients know that no matter what they are going through, that the staff is there for them and believes in their ability to succeed.

Another participant, a senior manager, described a mutuality between clients and staff in that they all have the same core needs, and only differ in terms of how they try to get those needs met. This participant was talking about the commonality of the human experience and breaking down the divisiveness of an “us and them” framework.

One participant reflected on the tension clients experience in living in a residential program because it is not their own home and the clients have to keep a close watch on their children. They pointed out that this can sometimes cause struggles for the clients, but the participant prioritizes having a conversation to determine if the rules clients are struggling with should be changed. The participant considers that perhaps the program is asking for something that is unacceptable or could be adjusted. The participant strives to enter into those conversations to validate client feelings and discuss how they can partner to work out the issue. These conversations provide both an opportunity to learn different ways of doing things and allow for transparency with clients about external funder requirements that necessitate specific rules. Clients are then equipped with the information to understand the context of the rules and can work together with staff to identify a solution that satisfies all parties. Another executive regularly got feedback from clients through a satisfaction survey although felt that they could improve in engaging clients in decision making around prioritizing the recommended changes and helping with implementation. As it stands, these functions are carried out by the leadership team.

Another participant, an executive, explained how they partner with clients and the property management organization to create transparency and collaboration. This is necessary because the property management organization is not attuned to the manifestation of trauma, instead, they are primarily dealing with physical safety issues by ensuring that the housing unit and program space is safe and comfortable. Likewise, another participant, a case manager, expressed the importance of drawing the property management team into a partnership with the program and client. For example, if the clients are not keeping their unit clean or struggling to pay rent, having a joint conversation with the client, the property management representative, and the program representative, to help them understand what the client is going through and to ensure the client is not punished. The program also helps to coach the property management staff about different approaches to take with the clients to get a more positive response.

Another type of collaboration is between and among clients, “peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing (SAMHSA, 2014, p. 11).” Only a few participants talked about practices that engender peer support. One organization instituted “community meetings” in the mornings using the Sanctuary® Model’s “community meeting” tool to build peer support and connection among the clients. The participant also talked about the use of the “community meeting” tool as bringing about empowerment, voice, and choice. When the program had staff vacancies, they discontinued the morning “community meetings” and there were clients who came to staff almost every day asking what had happened with the meetings and whether they would be reinstated. One of the clients offered to

run the meeting. Another participant explained that they hire people in recovery because they understand what some of the clients have gone through and have a trauma-informed outlook. This is another example of how peers can make a difference to the culture.

Practices that Engender Cultural, Historical and Gender Inclusivity

Few participants spoke of cultural, historical or gender inclusivity, defined as

actively moving past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender- identity, geography, etc.); offering access to gender responsive services; leveraging the healing value of traditional cultural connections; incorporating policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizing and addressing historical trauma. (SAMHSA, 2014, p. 11)

One executive discussed the importance of acknowledging all clients in the same warm and friendly way when they come into the program regardless of their background.

While another participant, a program manager noted that not having a Spanish speaking case manager was problematic in creating the culture that they are striving for. One case manager spoke from a perspective of a person of color,

I'm an African-American woman and I'm well aware of how we struggle culturally with accepting mental health as a valid health issue and then also stigmatizing folks who seek help from therapists or caregivers or healers for their mental health issues. So, I like to talk with my clients about the benefits of addressing their emotional health. Acknowledging our cultural background and where we come from and maybe discussing some of those contradictions or some

of the limitations of that way of thinking that tells you that it's not OK to see a therapist.

The same participants' program is located in a predominantly black community and the participant noted the need for more social workers from different ethnic, cultural, and socio-economic backgrounds to better serve clients. The participant went on to say that even if the staff person was from a different background than the clients, they could be effective with a certain level of cultural competency and sensitivity to what black women go through as well as a humbleness to want to learn. Without this level of competency and sensitivity, clients may not be well served and even re-traumatized by micro-aggressions or misunderstandings when some of the ways that clients behave do not represent the behaviors that the social worker is familiar with. The participant summarized how this is problematic for the practice of TIC,

If you can't layer your understanding and your practice of trauma-informed care with cultural competency then the trauma-informed care hits a wall. Part of it is understanding that trauma is not independent of some the systems that folks are experiencing living under in the United States and across the world. Whether that's capitalism, racism, sexism or patriarchy, all of those things are in some ways contributing to their trauma...and not even having visible safety within the nation in which you live...call your home, in a very public sense, you don't have safety there.

Practices that Engender Empowerment, Voice, and Choice

The principle of empowerment, voice, and choice means that

Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. Operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice, and choice and are often recipients of coercive treatment. (SAMHSA, 2014, p. 11)

Several participants described working with clients to create individualized, client-driven and flexible goal plans presenting options and resources to assist in decision making and address past trauma, building on client strengths as a platform for future progress, and supporting clients to achieve their goals and to build healthy relationships. For example, one case manager described approaching services holistically with a focus on empowering clients not only to maintain stable housing but also to move towards their life goals while addressing other aspects of their life that may pose barriers to their empowerment such as mental health.

Participants consistently identified person-centered practices as part of TIC. A person-centered approach, defined as "a process that allows clients to use their own understanding of their experiences as a platform for healing" (Person-Centered Therapy, 2018), is aligned with practices that promote empowerment, voice, and choice. The three tenants of a person-centered approach include unconditional positive regard, empathetic understanding, and authenticity (Person-Centered Therapy, 2018). A person-centered approach allows for the client to be the expert in their own healing. One executive described this as "following the lead of the client." Another participant, a program manager, felt that being client-centered was a way of recognizing what people have gone

through and trying to provide services in a manner that is geared towards helping them and not just pushing them through a system. Another executive described TIC as care that starts with the clients' point of view, what they are feeling and experiencing. One of these executives explained that they try to hear the clients and consider their unique experiences and needs and bend the rules or be creative to offer flexibility. The participant provided a client story that highlights this practice,

There was a client recently that was in single shelter and her daughter was somewhere else with family. Typically, that's not the constellation of family that comes into our program because we only take families. But I tried to really hear what this mom was going through and what her daughter was going through, where she was. So kind of bending the rules or making a place that we were able to take this mother and her daughter into the program even though the mother and daughter were not together at that point. The daughter actually had, someone else had custody of her. But really trying to hear what this mother was telling me and listen to the case manager to sort of be flexible.

The idea of "bending the rules" to offer flexibility and consider the unique experiences and needs of the client fits into the TIC category of practices that bring about empowerment, voice, and choice because it allows for the clients' agency and desired direction to be recognized and honored. However, it is also aligned with the social work practice of being person-centered.

Participants described a wide range of other practices that bring about empowerment, voice, and choice, such as getting client input about the types of group sessions and activities offered in the program and inviting in other organizations and

individuals to facilitate these sessions. A few participants noted that they do not mandate services but instead give clients options and help to build a sense of community so that clients want to participate in the services. Since making this shift, one program has had to cap certain groups and activities because so many clients voluntarily participate. The manager noted that, “once you can build a level of trust and transparency, then they will come. Then your program, your community, will be fully functional and robust. And I think that's the point that we're at now.” However, another program reported that after they cut out mandatory workshops and groups, they had to use incentives, such as weekend passes, to get the clients to attend because they knew that the clients needed the service.

A few programs partner with an external counseling organization to provide weekly, on-site counseling groups where clients can confidentially voice any concerns or issues. And for those that want individual assistance or some privacy with their issues, they can meet with the counselors separately. The counselors from the partner organizations do not share information with the program staff so that the clients can freely share without concerns about conflicts with any of the program rules or regulations or fear of retaliation by the program that also provides an essential service for them:

housing.

One participant described provision of financial empowerment services that help clients to recognize that they actually can have a stake in their financial future. Another participant described a specialized training for clients about developing optimism to recover from challenges so that the clients are not feeling defeated by setbacks. One program manager described facilitating a vision boarding activity to help empower

clients to imagine the future they desire. Poster board was used to put together a physical depiction of where clients wanted to see themselves in the future.

Practices that Engender Safety

SAMHSA (2014) defines safety as, "...staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety (p. 11)". Furthermore, SAMHSA (2014) underscores the importance of understanding how clients define safety. Participants described safety broadly, encompassing physical, social, emotional, and moral elements akin to the Sanctuary® Model's multiple forms of safety. One participant described the importance of creating social safety in order to avoid the "scuttlebutt" that ensues when people are traumatized. For example, one executive described promoting social and emotional safety through avoiding stigmatization of clients by refraining from calling them out on behavior that might be odd and instead helping them work through the behavior. A few participants identified safety as their number one priority and the foundation of TIC. One executive described a variety of practices that contribute to safety in some way such as consistency, taking a non-judgmental approach and being open. Another participant, a program manager, supported clients through crises by offering to watch their children while they took a few minutes to de-escalate. In this way, the staff person was promoting social and psychological safety. Another program manager told a story of how the community comes together after incidents that threaten safety,

Today in response to a fight upstairs on the second floor, where a knife was pulled, the residential department has put together a community meeting and the

agenda is focused on, not only physical safety but social safety. And they are doing a "wordle" to have folks do some vision boarding of what safety looks like and how it would feel to them after a knife was pulled and one of the clients felt bullied. So, I'm really happy that they get it.

One program had an outdoor garden on an upper floor of the facility, accessible without leaving the building. The garden was created to be a respite for clients and staff and was also certified as a "nature explore" classroom for children to reconnect with nature as a way to mitigate the trauma that they've experienced. Another program described weekly nonviolent communication sessions for staff that included didactic learning as well as practicing with consultants. In these sessions, the staff are learning things like how to change their word choices and listen in depth. One of the Sanctuary® Model's seven commitments is non-violence and although the model that the program is using was developed by Marshall Rosenberg, it is very much aligned with TIC components. Another program provided conflict resolution workshops so that when clients are in a disagreement it does not become violent. Another participant told a story that illustrates practices that support safety,

We're very, very good at providing you a safe place. And that was very important for this woman to know that the doors lock at 7:30 at night and all that type of thing, we have a professional staff that's on 24/7, you can come down in the middle of the night if things are getting out of control, we have myself and somebody else is on call all the time. So that was all comforting to her.

One program exemplified safety by welcoming and assisting people in crisis that are not their clients or part of the program. The participant explained,

Where I think we really employ trauma-informed care is at our front desk, helping anyone who is coming in the door looking for housing. One woman that came in when it was so cold, she had a baby, she looked beat up, she had so many issues and I was like, here, let's call together, charge your phone, stay in here as long as you need to. We don't have anything right now but here are some resources. I gave her tokens. She ended up going to a domestic violence organization.

One case manager told a client story that highlights how staff create safety through allowing space, time, and flexibility for clients that are struggling,

I have a client who has...a lot of anxiety being around other people as well as general inability to regulate her impulses. When it comes to dealing with people, counseling her on why people are saying what they say and teaching her how to handle the situation. Making sure she understands what's wrong and when she should come back and apologize as well as offering her respite...when she feels unable to attend certain groups. So she doesn't feel like she's being penalized because she can't do certain things at that time and place and just giving her the leeway. A lot of time she uses inappropriate language and I can see that it's not me, it's just a lack of impulse control skills and allowing her to vent without forcing her to hold back because that inhibits our relationship and it inhibits her progress through the program.

Practices that Engender Trustworthiness and Transparency

Trustworthiness and transparency are other principles of TIC (SAMHSA, 2014), defined as, “organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among

staff, and others involved in the organization” (p. 11). One executive described their transparency with clients. For example, upon entry into the program, staff advise clients about the rationale for the responsibilities of the program and they are asked to sign off on them. This helps to establish a clear understanding from the beginning, in part to diffuse emotions when staff have to hold clients accountable. On the other hand, another participant, a case manager, felt that doing unit inspections, in some cases, caused resentment and mistrust with clients when they got upset about their space being entered. The participant felt that this mistrust can impact the quality of the helping relationship.

Another program is transparent with clients about funder compliance provisions that require the program to demonstrate an in-kind match of services equal to the amount that the funder provides in financial support. Failure to demonstrate this match could result in a loss of funding which could lead to closure of the program. The participant explained that they “go with the truthfulness method, helping clients understand what's happening with the systems” so that they are fully informed to make decisions about their participation especially because affordable housing is so scarce. In this way, the staff are also collaborating with the clients as partners in working to make the programs successful, which benefits current and future clients to continue to have access to scarce TH resources. The program encourages clients to speak up about any problems they are having and assures them that they will not be penalized or judged for raising issues. The overarching priority is to make sure that the clients are supported through their struggles and are able to access needed resources. Further, the participant described eliciting feedback from clients on how the program can change practices to be more effective.

The participant went on to describe a client story involving the TIC practice of trustworthiness and transparency,

I had one client who, and the reason why I'm even mentioning it is because I wound up not having to do anything about it, it's why I know everything is working the way it's supposed to. She came to me and informed me that she had kept her daughter out of child care for a couple of days because she ran into a previous abuser. She told me she contacted the state child care agency because we have told them not to mess with their child care. She told me she didn't need anything else from me. But the reason why I credit TIC is because based on everything that we've done in the program thus far, she was able to come to me, whereas in the past, a lot of people wouldn't say what's going on and then everything else gets messed up.

One participant's story summarized the use of a few TIC practices including trustworthiness and transparency as well as empowerment,

We had a client who had been with us for close to 18 months and she was 24 years old. She had a 9-year-old, 6-year-old, and a 4-year-old and she had a lot of challenges with parenting and was very explosive when she felt depressed or overwhelmed with caring for her kids. She would get very angry at me [and the other staff] on a regular basis. But we were always transparent with her about what we needed from her to make the situation better and what our concerns were. There were times when she wouldn't leave her room for days at a time and she wasn't coming down for meals. And we had to make child welfare calls because her kids were not being bathed or having meals and she wasn't getting

them to school. And so we had to let her know that we needed to do this and we want to know what we can do to help. I can't imagine that this feels good to be in your room, it's one large room so it was just her and her kids in there for days on end. When she wasn't responsive in the first few days, we ended up having family members take her kids and she needed to do an inpatient stay but she was very, very angry at us for doing that. But the relationship that we formed with her...we had been very candid, allowed her to still know that we were doing this out of concern for her and her family...she's not with us anymore [but] she will still occasionally just check in and talk. It was a hard situation but we treated her with the care and concern and transparency and also empowerment to make decisions about what she needs to do outside of what happened with her kids.

Trauma-Specific Services

In addition to TIC, a few programs also utilized trauma-specific services (TSS). Although only three participating organizations offered on-site TSS, many talked about making referrals to and linkages with, external providers of TSS. One program manager thought that these services were an important component of TIC for which they worked hard to provide within their parent-child education and behavioral health services. Another program manager discussed her organization's experience with implementing TREM-Trauma Recovery and Empowerment Model- groups, a TSS,

Back in 2006, we started sending folks to get certified in TREM. And I knew we were onto something. I said this is wonderful, gosh, but, the problem with TREM and I think the transient nature of our folks, they weren't able to commit to the 25, 26 sessions.

Programs serving the subpopulation of survivors of domestic violence provide a specialized TSS of safety planning to address clients' physical and emotional safety. One participating organization uses a special assessment to evaluate whether clients have traumatic brain injury as a result of domestic violence. Another participant from an organization that did not provide TSS, noted that clients who have experienced trauma participate in groups specific for women in early treatment.

Overlap of Trauma Informed Care Practices with General Social Work Practices

In describing their use of TIC, several participants described specific practices that, while fitting into the TIC practice category of "empowerment, voice, and choice", are also widely used general social work practices and/ or counseling skills. For example, practices such as allowing the client to talk freely and direct the topic of conversation while using active listening, being open to client feedback, providing clients with tools to utilize to continue their healing; being able to "suspend the ego, be there for the client, let them heal the way they need to heal, and accept what they say as the truth"; offering non-judgmental, patient, and respectful care and support even when participants consistently make what seems to be poor decisions.

The importance of listening was mentioned several times with one program manager explaining that listening is at the root of understanding what is going on with the client and how best to assist them. One director described their intake process,

So he [the staff person] immediately starts with, OK, I'm here to listen, not tell you. And that is markedly different than just about every other experience this person has probably had. OK, we're going to switch from talking to listening so I don't want somebody typing. They can write a couple notes down but I don't

really want that happening in the initial interview because that's what happens at welfare, children and youth and all the places that are usually stigmatizing or negative experiences for the families that we're working with.

Similarly, another program manager explained that their program intake process begins with the question, “what happened to you that caused you to become homeless” rather than, “what did you do to become homeless.” It is cathartic for their clients when they go through the intake and focus on the person’s story, asking how they became homeless and treating them like they understand that the client survived a lot of adversity.

Another element of TIC’s “empowerment, voice, and choice” category that is prominent in general social work practice is a strengths-based approach to care. A few participants noted the importance of tapping into a client’s strengths to mobilize them for healing “as a platform to move on.” A few other participants discussed using motivational interviewing as part of TIC. Part of the process of motivational interviewing is to elicit the client’s verbalization of their rationale for change (Hettema, Steele, & Miller, 2005, p. 92), thereby mobilizing the client’s “voice and choice”.

Another component of social work practice that was identified as part of TIC by one participant was the use of person-first language and thinking,

We refer to our families as families; we refer to very humanizing language rather than homeless women. We see people experiencing homelessness because that’s what they are [experiencing]. It's not a part of their identity, it's a part of what they're going through right now. It's momentary.

Programs that had implemented TIC described various social work direct services that they used with clients such as individual and group counseling, case management, and

provision of wraparound services either in-house or via referral, based on the clients' needs. Other programs had their own on-site therapists and one even had a therapy dog. Another participant believed that the use of evidence-based practice in all programs and services is part of practicing TIC.

The Impact of Trauma-Informed Care

A few participants shared information about the impact of TIC. For example, one participant noted that most clients would say that they feel safe in the program. One executive noted change in the language that clients use, how they interact with staff, and how they talk about themselves, as positive outcomes related to TIC. Another participant felt that an indicator of TIC would be if staff could describe what TIC was and what it means to the organization. A manager's story highlights the overall impact of use of TIC,

Two moms came before me, they were dismissed, there was a bad fight outside. One mom didn't like the way the other mom was treating her four-year old daughter. And I don't know what happened, but it came to blows outside. And so, then that was an automatic dismissal and they came before me. I met with each one separately. And what we did, we typically asked, now we do things differently, but we asked them to leave for the night until they write a letter and ask for an appeal hearing. And it was just horror stories, one went into a hotel and went back with her abuser. And when she came to see me, she was bruised and battered. It was one of the most disturbing things, having to... anyway, they both felt terrible and they were sincere, and they were remorseful and when they understood that the one was just concerned about the safety of the 4-year old

because mom was starting to get agitated, they understood. When I brought them together and they talked to each other and they heard each other's story, that their backgrounds were so similar, they started to cry, and they hugged each other and they themselves then became agents of change. They modeled the behavior and would share their stories with others that they were both dismissed. But here they were, now best of friends and mentors, they've both graduated, they come back and mentor other people, other residents and so I think they got it.

Summary

Although some participants described a systematic approach to TIC in policies, procedures and practices for the benefit of both clients and staff, a limited number had implemented a systematic assessment. Part of this analysis involves assessing program rules to determine if they present challenges for clients with a primary goal of promoting flexibility. In addition to being identified as a practice used to promote TIC, flexibility was also understood as an element of defining TIC. When participants described practices associated with TIC, they often spoke about what they were thinking rather than what they were doing. For example, one participant described “non-violent communication” as a way of delivering TIC although the description of using this approach was related to the philosophy that “everyone in every situation is trying to meet a need and that our core set of needs are the same.” I asked the participant if that was how they were thinking when working with clients or if it was associated with an action and they said it was a thought process.

Participants described staff level practices that they used with clients and staff to deliver TIC, most of which are tools of the Sanctuary® Model, the primary model of TIC

used by participants. Participants also talked about the importance of providing support to staff so that they do not feel burnt out and are well equipped to best support the clients. Many of the manualized practices used with clients are also used with staff as the goal of TIC is to create a socially, morally, physically, and psychologically safe environment to prevent more serious consequences of traumatic stress (SAMHSA, 2014). Participants understood that it was important to work to mitigate re-traumatization of clients, describing this as being mindful and respectful of all the baggage that people bring with them.

TIC practices described by participants were linked to SAMHSA's six principles of TIC. Of the six principles that TIC practices are based on, the least noted practices fell into the categories of 1) peer support and 2) cultural, historical, and gender inclusivity. One program shared feedback about cultural inclusivity, explaining that even if a staff person was from a different background than their client, they could be effective with a certain level of cultural competency and sensitivity as well as a humbleness to want to learn. Without this level of competency and sensitivity, clients may be re-traumatized by micro-aggressions or misunderstandings.

Practices that engender empowerment, voice, and choice and safety were the two most frequently noted categories of practices used in the programs. Participants described a range of practices that engender empowerment, voice, and choice such as client-driven and flexible goal plans, presenting options and resources to assist in decision making and address past trauma, building on client strengths as a platform for future progress, and supporting clients to build healthy relationships. While Bloom (2013) delineates four types of safety within the Sanctuary® Model of TIC: physical,

psychological, social and moral; much of the discussion about safety practices was focused on the physical safety of clients and staff within the facilities. Another component of safety raised by participants was psychological safety. One example of this are the efforts made by staff to pace the psychosocial work with clients in order to be sensitive to how the client was feeling and what the client needed. Only a few participants utilized trauma-specific services directly, preferring instead to refer clients to specialized providers for these services.

Many participants described an overlap between TIC practices and general social work practices. In describing their use of TIC, participants described specific practices that, while fitting into the TIC practice category of “empowerment, voice, and choice”, are also widely used general social work practices and/ or counseling skills. Participants consistently identified person-centered practices as part of TIC. Another element of TIC that is prominent in social work practice is a strengths-based approach to care. In the following chapter, I present information and findings on the internal implementation factors of TIC.

CHAPTER 6: INTERNAL IMPLEMENTATION FACTORS: BARRIERS AND FACILITATORS

I used the Consolidated Framework for Implementation Research (CFIR) as my primary theoretical frame for analyzing barriers and facilitative factors in the implementation of trauma-informed care (TIC). The CFIR has five major domains, each with several constructs for a total of 39 constructs and sub-constructs. The domains are: intervention characteristics, outer setting, inner setting, characteristics of individuals, and implementation processes (Damschroder et al., 2009). These domains can be broken out into two categories: internal factors and external factors, with the outer setting domain being the only external factors category. For information on the CFIR constructs under each domain, see Appendix I. I also include definitions of the applicable constructs in my findings in this chapter and the next chapter on external implementation factors. There were several constructs in the CFIR that did not apply to this data set. During data analysis, I added a code for “lack of an intervention source” although I later merged this code with the existing CFIR code of “process: planning”, a category that speaks to the need for clear implementation plans including intervention manuals.

Facilitative factors and barriers were addressed in an integrated manner under each of the CFIR categories since at times, participants discussed the factors interchangeably. For example, when participants identified a factor that would help with the implementation of TIC, there was often something that got in the way of implementing that factor. For example, one participant felt that more training would help but the lack of accessible training served as a barrier. Whether or not participants

identified using TIC, they all had things to share about factors that were either barriers to or facilitators of the implementation of TIC.

Intervention Characteristics

The CFIR framework defines a range of intervention characteristics that influence implementation of an intervention including the intervention source, evidence strength and quality, relative advantage, adaptability, trialability, complexity, design quality and packaging; and cost (Damschroder, 2009). Participants did not discuss factors related to relative advantage, trialability, or design quality and packaging. Participants primarily discussed barriers to implementation related to the intervention characteristics, having little to say about how the characteristics of the intervention helped to facilitate TIC, with the exception of “evidence strength and quality.” The CFIR defines “evidence strength and quality” as involving “stakeholders’ perceptions of the quality and validity of evidence supporting the belief that the intervention will have desired outcomes” (Damschroder et al., 2009, p. 6). One executive explained that the fact that TIC was evidence based was an important factor in their decision to implement it (9:5).

On the other hand, there were several barriers to TIC related to the intervention characteristics, including complexity, staff capacity, and adaptability. Complexity refers to the, “perceived difficulty of implementation, reflected by duration, scope, radicalness, disruptiveness, centrality, and intricacy and number of steps required to implement” (Damschroder et al., 2009, p. 6). One case manager felt that TIC may be inaccessible because of the academic language and framework surrounding it. One executive explained that they were hesitant to invest in a certain TIC model because of the significant time commitment necessary. The same participant talked about their

uncertainty as to whether staff could learn and practice the model and felt that they would need more “user friendly tools” that are accessible to program staff.

Adaptability of the intervention model was another concern for one program. The CFIR defines adaptability as, “the degree to which an intervention can be adapted, tailored, refined, or reinvented to meet local needs” (Damschroder et al., 2009, p. 6). One case manager felt that TIC needed to be adapted to be inclusive and relevant to people with different backgrounds.

A few programs that utilized the Sanctuary® Model, one of the few evidence-based models of TIC, felt that the cost was prohibitive for them. The CFIR outlines costs as an implementation factor both for “the intervention and costs associated with implementing that intervention including investment, supply, and opportunity costs” (Damschroder et al., 2009, p. 7). Because of this financial barrier, one senior manager tries to piece things together by bringing trainings to the agency, attending external trainings, and hosting internal discussions. Another program became a peer reviewer for the Sanctuary® Model as a way of bartering for the technical assistance that they needed.

A few programs discussed barriers related to the strength and quality of the intervention. One program manager from a program that has implemented TIC does not feel that they know if what they are doing works or if there is something more or different that they should be doing, despite using client surveys to get feedback. While another case manager in a program that relied on government funding discussed the struggle to implement TIC when it doesn’t result in some type of measurable outcome that the government values.

Several people shared barriers that were linked to the actual intervention source. The intervention source category involves the, “perception of key stakeholders about whether the intervention is externally or internally developed” (Damschroder et al., 2009, p. 6). One program manager indicated that actually having a curriculum to use to guide the intervention would be helpful. One executive commented that there needs to be a greater range of available TIC intervention sources to guide implementation because “one size does not fit all” and there were programs that did not feel that the Sanctuary® Model would work for them although that was the only model presented by one of their funding agencies. The Sanctuary® Model was almost the only intervention source discussed by the participants as a whole with the exception of one program that had a general TIC consultant come in to assess for TIC and assist with implementation. Therefore, TIC implementation seemed to be limited by the few available models to assist organizations with ensuring that staff had the tools needed to understand what it means to implement TIC.

Inner Setting

The CFIR model authors view inner setting elements as active components of implementation and not simply a backdrop for implementation (Damschroder et al., 2009a, p. 8). The inner setting includes “structural, political, and cultural contexts through which the implementation process will proceed” (Damschroder et al., 2009b, p. 4).

Inner Setting: Structural Characteristics

Structural characteristics as a factor in the CFIR framework is defined as, “the social architecture (i.e. organizational structure), age, maturity, and size of an

organization” (Damschroder, 2009, p. 7). Participants summarized a few structural elements that helped to facilitate TIC. For example, one program manager thought that the small size of their staff team helped in TIC implementation because folks did not have to go through a lot of layers to make changes. Another program’s move into a new building was helpful in implementing TIC since it allowed for the staff to be together in one space along with the residential program. This transition led to consideration of how to improve services, which ultimately led to TIC implementation. Alternatively, in some cases, the physical structure of the program made TIC implementation more difficult. One program’s offices were very small and felt cramped and cluttered when more than one person was in the office. Another program thought that the flexible structure of private rooms and private bathrooms allowed them to be accommodating to diverse families and individuals. One participant thought that transitional housing (TH) was a suitable setting for TIC implementation because of the longer length-of-stay and the resultant time available to work with clients.

Several participants shared barriers to TIC implementation related to structural characteristics of the program or organization. One program manager felt that TIC implementation was too dependent on one staff person, the only paid staff person in the organization, since their program model relies primarily on volunteers. Another organization had to halt some of the TIC activities for clients due to staff shortages and their inability to recruit staff. In addition, the remaining staff were left to do multiple jobs, and this had an impact on their capacity to carry out TIC implementation. The staff shortages seemed to be attributable to the structural characteristics of the organization although at the time, the organization was investigating the factors causing the difficulty

in retaining staff. Another program concurred that the structure of nonprofits led to staff turnover that was a barrier to TIC implementation. Another organization with a relatively small staff, struggled with staff turnover and the resultant loss of institutional knowledge about TIC. On the other hand, an organization with a large staff struggled as well although in their case it was to get a consistent message out to all of the staff.

One program has a unique structure that makes it more challenging to infuse TIC throughout the program. The organization serving as the client services partner in the program is a large organization with many programs that was contracted to provide the supportive services component for the TH program while a partner organization provides the property management function. Therefore, the senior manager feels that there are actually three entities involved, the service provider (the program), the larger organization that the program is embedded in (the organization), and the partner organization that provides the property management for the housing component of the program (the partner organization). The participant feels that the program only has control over the supportive services component in terms of practicing TIC. This configuration introduces a level of complexity in trying to implement TIC especially because the partner organization is not a TIC organization and the staff are doing things that are detrimental to TIC. For example, if someone had a mental health issue, the partner organization staff would take it personally, which often led to re-traumatization for the clients. Additionally, the frequent transitions in staff at the partner organization have a negative impact on maintaining a trauma-informed environment.

Another organization also felt that trying to work with a partner organization to deliver the property management component was a barrier to TIC implementation. In

this case, the participant describes the partner's model as operating within a legal framework, which is a barrier to the program's full implementation of TIC since the clients do not feel a full sense of safety, empowerment, and choice. This participant, a program manager, noted that,

We could see someone who's making lots of progress but ultimately, they're not compliant with the program if they're not paying their rent. And that could lead to eviction from the property as well as from the program.

Inner Setting: Culture and Implementation Climate

Building a culture of support and teamwork was a facilitative factor in TIC implementation. The CFIR framework defines culture as "the norms, values, and basic assumptions of a given organization" (Damschroder et al., 2009, p. 8). One executive who was responsible for leading TIC implementation in the organization explained that TIC has become a workplace culture and part of the everyday expectation among staff. Another participant, a program manager, described their supportive executive management and board of directors and explained that they treat staff the way they want staff to treat clients. In one organization, the program manager described a small staff and team culture as contributing to a trauma-informed environment,

Because there is a lot of support available and it's also a team effort. So, a participant isn't assigned just one case manager, but a team. For the families that need more support, they're able to really pull on a team and have a little bit of a group think of the best way to work with a family and to help them through a crisis. Having a small staff is very good because they all work very closely with

each other and are supportive of each other and are able to have an avenue if their feeling frustrated, to vent their frustrations.

In contrast, one program manager discussed a group of long-tenured residential staff that are entrenched in some of the older and more punitive styles of intervention and how challenging it has been to help them shift to the TIC paradigm.

The implementation climate as a factor in the CFIR framework is “the absorptive capacity for change, shared receptivity of involved individuals to an intervention and the extent to which use of that intervention will be rewarded, supported, and expected within their organization” (Damschroder et al., 2009, p. 8). The implementation climate construct has six sub-constructs including tension for change, compatibility, relative priority, organizational incentives and rewards, goals and feedback and learning climate. There were no data about two of the sub-constructs: 1) organizational incentives and rewards and 2) learning climate. One executive thought that having cohorts of clients interested in learning how to continue to be empowered and facilitate change in their own life helped to facilitate TIC overall. Whereas, a few programs’ managerial staff said that staff have difficulty with change and that change in general is hard for the staff. One executive described the challenge of trying to infuse TIC throughout the entire organization so that it goes beyond just the staff that work directly with clients. While another executive felt that they had “just scratched the surface” when they were thinking through TIC implementation with other like agencies in their county. One program manager described the implementation stages of TIC as very difficult because staff feel a sense of loss of control,

And it feels very disjointed, the organization becomes very turbulent and very chaotic and people need to be mindful of that. Changes will lead to that. And that's what happens and its really still resistance sometimes. Folks will resort back to that feeling, like a loss of control when consequences aren't punitive.

That's just one of the challenges of implementation.

Another sub-construct of the implementation climate construct is compatibility, defined as “the degree of tangible fit between meaning and values attached to the intervention by involved individuals, how those align with individuals’ own norms, values, and perceived risks and needs, and how the intervention fits with existing workflows and systems” (Damschroder et al., 2009, p. 8). The way that TIC fits within existing workflows and systems was a facilitative factor in TIC implementation for one program manager whose program became aware of TIC because the organization had a clinical services division who were leaders in TIC implementation including providing TIC training for the entire organization. Conversely, another program’s executive director felt that the nature of their program was not always a fit with TIC since their services are not mandatory and clients were sometimes resistant.

Another sub-construct of the implementation climate, goals and feedback, is defined as “the degree to which goals are clearly communicated, acted upon, and fed back to staff and alignment of that feedback with goals” (Damschroder et al., 2009, p. 9). Goals and feedback were important components of TIC implementation for one program manager who discussed clinical supervision as key to TIC implementation. This manager described elements of supervision that were relevant to TIC implementation including talking in detail about each client, what is happening with them, and how staff responds

to the clients. One case manager discussed the need to raise the consistency of TIC implementation as a standard of care.

Relative priority, another sub-construct of the implementation climate construct, is defined as, “individuals’ shared perception of the importance of the implementation within the organization” (Damschroder et al., 2009, p. 8). Placing TIC as a priority and not compromising on it was cited as something that facilitates TIC implementation. One senior manager noted that it helped that the staff “really wanted this to happen” because they knew that it was important. In contrast, another senior manager noted that it has been a challenge for them to prioritize TIC implementation and that it would send a powerful message if they could prioritize it by investing in the Sanctuary® Model. Even though the organization had allocated funds for this work, due to their staff turnover, they did not feel that they had the staff capacity to prioritize it while recruiting new staff. The participant went on to say that “it's never exactly the right time.” Likewise, a few other programs mentioned that competing priorities and limited time are barriers to TIC implementation. These programs are addressing housing crises and related case management issues such as securing employment and arranging childcare. Furthermore, due to the number of clients that are facing homelessness, they are focused on trying to get clients out into stable housing as quickly as possible. Therefore, the programs do not feel that they have enough time to carry out TIC implementation due to time and staffing constraints and the relative priority of securing stable housing with limited resources. Likewise, another participant, a case manager, noted that they are too busy addressing crisis to focus on TIC implementation. One executive who felt that TIC should be prioritized said, “Everyone (program and local government oversight agency) knows that

it is important, when will we make it top priority?” The same participant discussed the struggle between balancing crisis response in the moment with practicing TIC.

Tension for change, another sub-construct of the implementation climate construct, is defined as “the degree to which stakeholders perceive the current situation as intolerable or needing change” (Damschroder et al., 2009, p. 8). A few participants described factors related to tension for change that help to facilitate TIC. First, one program’s peer support staff person took on a leadership role in TIC training of the staff and this helped to encourage TIC. While another program noticed that clients were coming into the program more traumatized with increasingly complex and perplexing behaviors, which led them to want to address trauma in their program.

Inner Setting: Readiness for Implementation

Readiness for Implementation in the CFIR model is comprised of the “more immediate and tangible factors of available resources, leadership engagement (commitment), and infrastructure for information and knowledge to support intervention adoption and use” (Damschroder et al., 2009a, p. 14). There are three sub-constructs of the domain of “readiness for implementation” including 1) access to knowledge and information, 2) available resources and 3) leadership engagement (Damschroder et al., 2009).

Inner setting: readiness for implementation- access to knowledge and information. Readiness for implementation- access to knowledge and information, as a construct in the CFIR framework is defined as “ease of access to digestible information and knowledge about the intervention and how to incorporate it into work tasks” (Damschroder et al., 2009, p. 9). Several participants cited training as a facilitative factor

for TIC implementation, both having access to training, either externally or internally, and/ or having financial resources to pay for training. A few organizations raised funds to pay for expert trainers to provide intensive on-site training for the staff, while one program paid for their staff to attend an external training, and another had staff that were experts and able to do the training in-house. One program that implemented TIC requires every staff person to receive at least three trainings in TIC. A few other programs noted the importance of training all staff who come into contact with clients, even those that may be peripheral to direct social service provision such as property management staff. One program manager said that they were permitted to go to any trauma-informed training necessary in order to take care of the clients better. While another participant, an executive, felt that over the past several years, the number of available training opportunities in TIC and the Sanctuary® Model has grown.

One program sends all staff for TIC training that includes techniques for responding to clients that may be reacting out of their trauma, and how and why a strengths-based model is so effective. Another program noted that it would be helpful to have a detailed training as they would like to understand TIC more in depth as a case manager. While another participant, an executive, thought that developing TIC trainings that could be delivered through video conferencing, would allow for more staff participation. The same participant advocated for flexible training including local trainings, low cost trainings, refresher courses, and training that is appropriate to the level of knowledge of the staff. In summary, the participant does not believe that a one-size-fits-all training approach is effective.

In addition to utilizing consultants to provide training, one program engaged consultants to help facilitate the implementation of TIC through ongoing staff practice groups and check-in meetings as well as working with clients simultaneously. Although not formally a model of TIC, another organization was being trained in non-violent communication as part of their ongoing TIC implementation strategy. This organization was also engaged in practice groups on a regular basis to support the team in responding to other staff and clients in a non-violent and trauma-informed way.

Participants also saw access to knowledge and information, specifically access to training for staff, as one of the biggest barriers to implementing TIC. One case manager noted that the available TIC trainings all tend to be TIC 101, which is not that helpful. One executive was challenged to find time for staff to attend trainings especially when they are not local, or they involve a full day and there are multiple staff that need to attend. The same participant, as well as another executive, talked about the importance of access to refresher training as well as keeping the training “fresh and alive.” One case manager described the need for summary information from the research literature on TIC including a summary of TIC models practiced in similar settings. Another case manager thought that it was important to make TIC terminology more accessible to all staff.

In talking about barriers to TIC, one program manager who had been working with the organization for over 20 years, noted that staff are afraid to hear the real issues of clients and afraid to get too close. This comment points to the need for more training about TIC and more support for the staff in addressing vicarious trauma and working with traumatized clients. The same participant had never been to a TIC training even though their organization had partially implemented TIC.

Inner setting: readiness for implementation- available resources. Readiness for implementation- available resources, as a construct in the CFIR framework is defined as, “the level of resources dedicated for implementation and on-going operations including money, training, education, physical space, and time” (Damschroder, 2009, p. 9). There were many ways that resources assisted the participating programs in TIC implementation including hiring more staff, renovating the facility, hiring consultants to support TIC implementation, and utilizing volunteers as a resource to create a trauma-informed environment. One program was applying for grants to hire more staff so that they would be better situated to implement TIC. Another program, challenged to listen to clients talk extensively about their issues due to inadequate staffing resources, found a creative way to support clients through volunteer mentors whose job was to listen and let clients vent and then report back to the program staff. Another participant noted that their organization received a grant to have their administrative wing renovated so that they could transform it into a more user-friendly atmosphere and thus create a trauma-informed physical environment since everything was old and worn. Another program hired consultants to assess the organization’s implementation of TIC and provide feedback and a ranking.

More than half of all participants cited available resources as a key barrier to TIC implementation. This was the category most frequently commented on when participants talked about barriers to TIC implementation. Several programs cited financial resources for training or additional staff/ staff time as a barrier. At least one program, who had not implemented TIC, had also never been trained in TIC. One program manager talked about the difficulty in trying to identify the financial resources to send people to

conferences or to do trainings because of the overall budget cuts that they have experienced over the years. Overall, these programs want to do more to learn about and implement TIC, but budget cuts are a hindrance.

When participants discussed education and training factors, there were three relevant CFIR categories: 1) characteristics of individuals-knowledge and belief about the intervention, 2) inner setting, readiness for implementation- available resources, and 3) inner setting, readiness for implementation- access to knowledge and information. When participants discussed their own higher education as a facilitative factor for TIC implementation, I coded the data as “characteristics of individuals-knowledge and belief about the intervention.” When participants discussed resource barriers to access training about TIC, I coded the data as “inner setting, readiness for implementation-available resources” and when participants discussed a lack of useable information and training materials, I coded the data as “inner setting, readiness for implementation- access to knowledge and information.”

In addition to the cost for training and implementation support, several programs noted scarce staff time as another barrier to full implementation of TIC including the time to train volunteers and other stakeholders in TIC. One case manager described TIC as “expensive” in terms of the personnel needed to provide the care and all of the different levels of service that people might need for healing. Another program felt that the high caseloads, one case manager per 30 families, was an internal barrier to TIC implementation because it impedes case management’s ability to be trauma-informed in every interaction. One senior manager explained that when staff are stretched and become overwhelmed, they can no longer be as receptive to the families as they need to

be, and TIC suffers. Another case manager whose program had not yet implemented TIC felt that they needed a therapist on site in order to implement TIC. While another participant, a senior manager whose program had implemented TIC, suggested that the high level of support that clients need warrants adding an aide to help families with activities of daily living like accompaniment to appointments since clients often have difficulty with these tasks. In describing the nature of this difficulty, the participant makes an assumption that the clients need support rather than assuming negative attributions such as laziness or disregard. The participant stated,

I'm thinking that maybe they're afraid, but they won't say. Or they just don't know what to do. You tell them and they're not doing it. Well why aren't they getting their identification and all that. I said, maybe they don't know how to get them, even though you're telling them.

This assumption is aligned with the TIC philosophy of “what happened to you” instead of “what is wrong with you.”

One executive felt that it was particularly difficult to implement TIC with a relatively small staff that always feels overwhelmed. Another participant, a case manager, summarized the impact of insufficient staff and funding on TIC,

There's only so much you can do for folks within the limitations of your staff and your funding. And I think sometimes folks who come in with really high barriers and a severe traumatic situation, we don't have the capacity to support those folks. And I think that they end up really being re-traumatized.

One senior manager felt that it was important to have volunteers so that the staff would not get worn out trying to be available in the evenings to offer workshops to

accommodate schedules of the families. However, it has been harder for the program to get volunteers in recent years. The participant also talked about the importance of having childcare services to give the mothers a break although the funding landscape is getting tighter and this is one of the services that has been cut.

A few programs identified the time-limited client length-of-stay imposed by either the scarcity of TH resources or government funding regulations as a barrier to TIC implementation as this results in a lack of time to deliver TIC. One of these programs has a limited number of units reserved for families experiencing domestic violence and if clients stay too long, then others that are in need of safety cannot access the scarce resource. One program manager felt that programs need to invest more in TIC and understand how that investment will ultimately save money in the long run. Overall, these programs felt they needed more opportunities and resources for TIC implementation.

Inner setting: readiness for implementation- leadership engagement and networks and communication. Readiness for implementation- leadership engagement, as a construct in the CFIR framework is defined as, “commitment, involvement, and accountability of leaders and managers with the implementation” (Damschroder, 2009, p. 9). Leadership engagement was instrumental in facilitating TIC implementation for many programs. One program manager thought that leadership engagement was the first thing that you need in order to be successful in implementing TIC. A few program managers said that it was the CEO and Board of Directors that made the decision to start using TIC and it was top leadership that was the driving force in making progress in implementing TIC. Another program manager spoke about leadership’s encouragement

of staff to take advantage of available training. One case manager credited management in helping with client “buy in.” In speaking about practices that embody TIC, one executive discussed the challenges that social service staff face and the need for leadership to be sensitive to that and refrain from drawing conclusions, but instead to be open in discussions with staff. One senior manager explained that their program’s clinical director, also a professor specializing in TIC, served as the internal expert on trauma-informed care, provided leadership for the effort and pushed for implementation. The clinical director from the same program was also a participant in this research and corroborated the information shared by the other participant.

In contrast, lack of leadership engagement was a barrier to TIC implementation. One program manager noted that the leadership did not understand trauma because they did not allow wellness time off for staff. This participant went onto say that TIC implementation requires a total commitment from the top down in an agency. Likewise, another participant, a senior manager, noted that TIC must be supported and prioritized from the top so that it permeates throughout the entire agency. On the other hand, another senior manager said that the administrators do not know what TIC is and the participant did not believe that this negatively impacts TIC implementation.

Another element of leadership is forging networks and internal communication. As a construct in the CFIR framework, this is defined as “the nature and quality of webs of social networks and the nature and quality of formal and informal communications within an organization” (Damschroder, 2009, p. 8). There were a few ways that networks and communication within the organization assisted programs in implementing TIC. A few participants noted that they have been engaged in more conversations about TIC

through meetings and focus groups with staff with a goal of helping to facilitate TIC implementation. One case manager noted that some clients have come from shelters where they also used the Sanctuary® Model and therefore, they are familiar with parts of the model when they arrive.

Characteristics of Individuals

Since organizations are made up of individuals, the constructs related to inner and outer setting as well as the intervention are all influenced by behaviors of individuals (Damschroder et al., 2009, p. 16). Ultimately, individual behavior is the mechanism of all organizational change (Damschroder et al., 2009, p.9). There are five constructs under the domain of characteristics of individuals: knowledge and belief about the intervention, individual stage of change, self-efficacy, individual identification with the organization, and other personal attributes (Damschroder et al., 2009).

Characteristics of Individuals: Knowledge and Belief about the Intervention

Knowledge and belief about the intervention, as a construct of CFIR is defined as an, “individuals’ attitudes toward and value placed on the intervention as well as familiarity with facts, truths, and principles related to the intervention” (Damschroder, 2009, p. 9). One executive noted that TIC is defined differently by each staff person depending on their skills, knowledge and education. The participant explained that they have been fortunate to recruit employees who have different skill sets and educational backgrounds, two of whom have clinical trauma-informed care degrees. Similarly, another executive said that they brought TIC along when they started working with the organization. Other participants in the same program corroborated this. Being able to

implement approaches that they had recently learned about in school was a priority because they did not want to use “other people's outdated approaches.”

There were a range of attitudes about TIC, both affirming and skeptical. One senior manager shared that many of the staff were very excited about integrating TIC practices and approaches into their work. Another management level participant said that they have always been a champion of TIC and have both education and experience teaching TIC. A few participants noted that their own higher education in social work is what leads to their TIC practices. One participant summed up this connection by noting that “the entire education of social work focuses on the strengths perspective.” Another participant, a program manager, felt that it was advantageous to fill vacant staff positions with MSW’s to promote TIC implementation. One case manager reported having a formal education in TIC and continues to brush up on it independently including seeking out psychological articles and research on TIC.

A few participants were either fearful or skeptical of TIC implementation. One senior manager explained that staff feel overwhelmed by TIC because it needs to be comprehensive. The same participant noted that some staff don’t think that TIC applies to them because they are not therapists or counselors. For example, attorneys may not believe that they are part of TIC. In another organization, according to a program manager, TIC was a “hard sell” to the middle management team because they felt that they were already “doing it” but they were not because they only understood part of it. One program manager expressed a desire to lead the team in TIC but wasn’t sure that her education and skills were at the level that would allow her to be successful. This points

to the need for education and training for supervisory staff so that they are able to lead, coach, and support their teams as they implement TIC.

Characteristics of Individuals: Individual Stage of Change and Other Personal

Attributes

Individual stage of change, as a construct in the CFIR framework is defined as, “characterization of the phase an individual is in, as he or she progresses toward skilled, enthusiastic, and sustained use of the intervention” (Damschroder, 2009, p. 10).

Participants described individual stage of change as both a facilitative factor and a barrier to TIC implementation. In one agency that had not implemented TIC, a senior manager expressed a personal desire to see the agency implement TIC. Another participant, a program manager, talked about the staffs’ commitment to do the best job they can because they care and want to do things that will help them be better at their job such as being more self-aware of their own values that might get in the way of how they respond to a client.

A few participants noted that staff can be a barrier to implementation of TIC when they do not embrace TIC practices. One program manager explained that if staff are not cooperative with TIC implementation, there is a danger of “internal terrorism or negative contagion” and that is hard to address. Staff that get stuck in these patterns tend to “either self-select out after three to five years or they’ll be asked to leave.” Staff at another program grew resistant to TIC because they thought that TIC meant that clients could “get away with everything.”

Other personal attributes, as a construct of CFIR is, “a broad construct to include other personal traits such as tolerance of ambiguity, intellectual ability, motivation,

values, competence, capacity, and learning style” (Damschroder, 2009, p. 10). Some participants related TIC utilization to their own personal attributes. One program manager felt that staff’s willingness to be transparent and comfortable taking risks was important to implementation of TIC. Another participant, a senior manager, noted that TIC has become a natural part of their approach now as they have grown in practicing the model. Whereas other participants noted several personal attributes that are barriers to TIC implementation. One case manager felt that not having a diverse staff was a barrier to the implementation of TIC. The participants’ program serves primarily black women and in order to serve this community well, staff needs to have a certain level of cultural competency. The participant went on to say that they do not necessarily need to be African-American themselves but they need a level of sensitivity and a humbleness to want to learn. In this case, the participant seemed to be pointing to the personal attributes of staff as one of the keys to effective implementation of TIC (i.e. ethnicity, cultural sensitivity, and humility).

Another organization felt that the staff had some communication skill deficits related to educational level that got in the way of TIC implementation. Even though the program had done a lot of mental health first aid and de-escalation trainings with staff and had all of their social service staff trained in TIC, the participant attributes the lack of communication skills to low levels of education. For example, a lot of the staff only have a GED or high school diploma and some of the information that is covered in the trainings would be hard to digest for these staff members. The same program has case managers who are not social workers who need improvement in being trauma informed. They were acting punitively and need to learn more about why clients sometimes behave

in maladaptive ways so they can depersonalize client issues. One case manager also mentioned the lack of qualified staff as a barrier to TIC implementation. Another participant, a manager, sees another type of barrier to implementing TIC related to some of the “non-professional” staff who feel that because they may have had similar issues as the clients have and were able to overcome, that clients just need to do what they themselves did. In addition, these staff express sentiments about wishing they would have had someone to help them like the clients have.

Process

Process is one of the five implementation domains identified in the CFIR framework and has “four essential activities... that are common across organizational change models: planning, engaging, executing, and reflecting and evaluating” (Damschroder et al., 2009, p. 10). These processes are not meant to be linear and can be carried out using a variety of approaches such as incrementally or via a stop-and-start method. In addition, each process can be “revisited, expanded, refined, and re-evaluated throughout the course of implementation” (Damschroder et al., 2009, p. 10).

Process: Engaging

Engaging as a construct of the CFIR is defined as, “attracting and involving appropriate individuals in the implementation and use of the intervention through a combined strategy of social marketing, education, role modeling, training, and other similar activities” (Damschroder et al., 2009, p. 11). There were several activities that facilitated engagement in TIC implementation. Several participants felt that having frequent and ongoing training and refresher courses helped to facilitate TIC implementation. In addition to TIC education, one case manager thought that it was also

important to get broad education on behavioral health. Two participants described the importance of activities that complement and reinforce the ongoing training such as following up in staff meetings, documentation in program manuals, artifacts hanging on the wall, and incorporating TIC into the day-to-day operations. These participants provided a rationale for reinforcing activities including,

the more that you hear, the more you're going to think about it, the more aware you're going to be, it's going to have a better impact on our work and incorporating little things that would reconnect to the whole of TIC.

Another participant, a program manager, described a “trauma-informed response group” made up of staff that meets monthly to discuss ways to collaborate within the organization to promote TIC. For example, they developed a newsletter to bring people together around TIC. Another participant, a case manager, also felt that it was important to have conversations within the organization about how to address different situations with concrete practices. One program manager was concerned that TIC could become something that they “did” as opposed to something that they continue to do especially since the trauma is constant and the need is so great. This participant felt that they needed to keep reinforcing the value of TIC through increased training opportunities.

On the other hand, participants discussed ways that the lack of an ongoing process to engage staff around TIC was a barrier to full implementation. One case manager noted that training alone does not help with determining what to do when faced with real life situations, specifically, knowing the right words to say, the right tone of voice to use, and how to handle the situation in a trauma-informed manner. Overall, the participant feels that there needs to be much more engagement of staff in the application of TIC

principles, “just like you reiterate information while you're growing up through school.”

One case manager felt that TIC utilization was inconsistent between staff on different shifts, underscoring the need for reinforcement of staff training and complimentary activities for all staff. In addition to inconsistencies in engaging all staff in TIC continuously, one program manager thought that it would be helpful to incorporate it more in individual and group work with clients.

A few participants felt that the lack of continuous activities to reinforce the culture and importance of TIC among all staff was a barrier to full TIC implementation. One program went through an initial intensive training in TIC but did not keep up with ongoing training and at the same time had a key partner organization that was not TIC trained, both of which hindered TIC implementation.

Process: Engaging Internal Champions and External Change Agents

Engaging internal champions as a construct of the CFIR is defined as, “individuals who dedicate themselves to supporting, marketing, and ‘driving through’ an [implementation]” (p. 182), overcoming indifference or resistance that the intervention may provoke in an organization” (Damschroder et al., 2009, p. 11). One program manager discussed their initial encounter with the program’s internal TIC champion on their first day on the job. The “champion” met with them to explain the Adverse Childhood Experiences Study and TIC and advised them to attend all of the TIC related trainings and activities available. This had a positive impact on the participant’s desire to learn more about TIC and practice it. One case manager felt that having someone internally who was motivated to pursue TIC would be helpful to implementation.

Engaging external change agents as a construct of the CFIR is defined as, “individuals who dedicate themselves to supporting, marketing, and ‘driving through’ an [implementation]” (p. 182), overcoming indifference or resistance that the intervention may provoke in an organization” (Damschroder et al., 2009, p. 11). In addition to setting policy and providing incentives for change, another element of governmental influence on organizational practice raised by one program manager, was engagement of county officials in TIC implementation through active participation in the TIC training. The participant thought that this demonstrated the counties’ investment in the change and considered the government agency a consistent champion of TIC.

Process: Planning

Planning as a construct of the CFIR is defined as, “the degree to which a scheme or method of behavior and tasks for implementing an intervention are developed in advance and the quality of those schemes or methods” (Damschroder et al., 2009, p. 10). One executive believed that they were providing TIC, but they subsequently realized that they were not providing it based on a specific model and therefore their utilization of TIC was inconsistent. Subsequently, the program began to engage in discussion about ensuring that staff were equipped to implement TIC through identifying a specific TIC model to utilize. Similarly, another executive used TIC in components of their work such as case management but they had not done a comprehensive assessment of their services to develop plans to more fully implement TIC. While another program manager described an uneven TIC implementation across the various programs in the organization. In this case, the organizations children’s services department had implemented TIC

including use of a curriculum although the TH program had not and was just working to develop a curriculum.

A few other participants mentioned that the lack of a specific model or curriculum was a barrier to implementing TIC as was ongoing training of staff. One case manager in a program that had not implemented TIC felt that they first needed to agree on a definition of trauma-informed care. While another program was unsure if a model curriculum would be helpful because they rely heavily on volunteers. Therefore, much depends on the background of the volunteer mentor who is working with the specific family. Those volunteers that have a background in social work or something similar may benefit from a specific model curriculum. The lack of a written standard operating procedure or curriculum for new staff to use to consistently implement all of the different strategies involved in TIC was another barrier to implementation. Even when staff went through TIC training and received manuals, the knowledge transfer of TIC to new staff was hindered because they had not incorporated the manualized strategies into their own policies and procedures, nor did they have a train-the-trainer plan. Similarly, an executive from another program felt that it would be helpful to have a summary of all available TIC models so that organizations can select the model that fits best for them. Further, the participant thought that the local government agency closest to the work would be best positioned to take a leadership role in identifying specific models. In all, there were nine instances where the lack of a specific intervention model was a barrier to TIC implementation.

Summary

In this chapter, I explored the internal barriers and facilitative factors in implementing TIC using four of the five CFIR domains that are internally focused as a theoretical frame and tool for data analysis. The internal implementation factors reported on in this chapter were related to the implementation process whereas in the prior chapter on TIC practices, there were barriers and facilitative factors noted that pertain to the actual intervention of TIC itself and not its implementation process. Many of the barriers to TIC implementation identified by participants are related to available resources and the accessibility of the intervention models. On the other hand, leadership engagement was instrumental in facilitating TIC implementation. In the next chapter, I explore the external barriers and facilitative factors in TIC implementation.

CHAPTER 7: EXTERNAL IMPLEMENTATION FACTORS: BARRIERS AND FACILITATORS

I used the Consolidated Framework for Implementation Research (CFIR) as my primary theoretical frame for analyzing barriers and facilitative factors in the implementation of trauma-informed care (TIC). The CFIR has five major domains, each with several constructs for a total of 39 constructs and sub-constructs. The domains are: intervention characteristics, outer setting, inner setting, characteristics of individuals, and implementation processes (Damschroder et al., 2009). These domains can be broken out into two categories: internal factors and external factors, with the outer setting domain being the only external factors category. For information on the CFIR constructs under each domain, see Appendix I. I also include definitions of the applicable constructs in my findings in this chapter.

Outer Setting: Cosmopolitanism and Peer Pressure

The outer setting was integral to a programs' ability to implement TIC. Programs that were more networked with external organizations benefited with respect to TIC implementation. The CFIR refers to this state of networking as cosmopolitanism, "the degree to which an organization is networked with other external organizations" (Damschroder et al., 2009, p. 7). For example, one program noted that their two state coalitions hosted training on TIC that was helpful in facilitating TIC implementation. Another participant, a program manager, described their organization as multi-faceted with departments that provide an array of services, resulting in connections with several government agencies. The participant felt that this type of networking helps them to approach programing holistically, which in turn supports TIC implementation. The idea

of having a county agency convene local providers to collaborate around TIC implementation was suggested by more than one participant as something that could help to facilitate TIC especially in a small agency with little opportunity for this type of sharing. Another participant, a case manager, summed up the power of networks to facilitate TIC,

I think people know on some level that trauma-informed care is necessary but when we start articulating it and acknowledging it in public spaces, I always hear that people are really grateful to be able to talk about it. So it is exciting and I hope that we can grow it in society.

One senior manager explained that their county had a network of providers who were getting together to reinforce TIC practice and education. Although this effort was connected with the county government, the gathering and collaboration of the providers is what reinforced utilization of TIC.

Peer pressure is one of the constructs under the domain of outer setting in the CFIR and is defined as, “mimetic or competitive pressure to implement an intervention; typically, because most or other key peer or competing organizations have already implemented or in a bid for a competitive edge” (Damschroder et al., 2009, p. 7). Two programs reported instances where peer pressure was a facilitative force in the implementation of TIC. One senior manager described friendly peer pressure from a partner whose organization was learning to use TIC. The partner organization provided on-site services for the program and recommended that the program adopt TIC.

Outer Setting: External Policy and Incentives

The CFIR describes external policy and incentives as “a broad construct that includes external strategies to spread interventions including policy and regulations (governmental or other central entity), external mandates, recommendations and guidelines, pay-for-performance, collaboratives, and public or benchmark reporting” (Damschroder et al., 2009, p. 7). Participants discussed components of external policy and incentives that helped to facilitate TIC implementation. However, there were almost as many participants that identified barriers related to external policy and incentives and some programs identified both facilitators and barriers related to this construct.

Power of Government Funders to Change Organizational Practice

Several programs spoke about local government supporting, expecting, and in some cases mandating the use of TIC. One relatively frequently mentioned facilitative factor was local government sponsorship of agencies to attend intensive TIC training. A few participants expressed appreciation for this support with one describing it as transformational for the organization. Another participant, a program manager, summarized the impact of this support,

If the people who are paying you to do this thing say that it's important to them and put their money where their mouth is through training, workshops, and support, I think that makes a very big difference in the implementation.

The same participant felt that all the governmental agencies that they interface with were moving in the right direction toward TIC. Another program manager believed that part of their progress towards being strengths based and providing more choice and empowerment was due to changes that have happened with county regulations. Another

program manager expressed similar sentiments about the power of funders to change organizational practice. At least one participant, a program manager, believed that the county government actually had an understanding of the needs of families and how trauma plays a role in their current issues.

One executive explained that in their search for best practices and under the umbrella of their governmental contracts, they felt compelled to provide TIC. The same participant explained that governmental funders are more interested in funding programs that are evidence based and TIC fits that bill. Likewise, another managerial level participant noted that they get funding from a lot of different places and TIC is one of the things that everybody is interested in at this time in history. One executive explained funders' desire for grantees to be conversant in TIC although did not think they understood what TIC was. Another managerial level participant described TIC as a "buzzword" among funders, albeit a positive movement. However, "the funders have absolutely no idea what TIC means, what it looks like and what it entails." Because of the recent popularity of TIC, the same participant was familiar with it when they started working at the program since it was utilized at other organizations where the participant worked.

Coalition Work Advances Trauma-Informed Care

In addition to government actions incentivizing the utilization of TIC, coalition work also helped to advance TIC. One program manager explained that there are a lot of different local coalitions that are evaluating TIC that include county administrators participating as coalition members. Another program manager explained that their state coalition began mandating TIC and this solidified their own movement in that direction

including shifting the executive director's role from supporter of TIC to a leader in TIC.

The same program was participating in a local government TIC systems initiative that funded service providers to come together regularly to discuss TIC implementation.

Although the participant notes that there are "so many good things happening", they added that "it feels sometimes like a drop in the bucket but at least we're moving in the right direction." One executive explained that a recent change in federal regulations requiring coordinated assessment of the homeless system, although not directly related to TIC, prompted the local county agency to provide TIC training. The training then prompted the program to seek out other TIC trainings with provider organizations.

Federal Government as a Barrier to TIC

On the other hand, there were several negative critiques of the federal government as a barrier to TIC implementation for TH providers. One executive felt that the United States Interagency Council on Homelessness failed to ensure that governmental regulations did not conflict with the implementation of TIC across different types of supportive housing programs for families experiencing homelessness. For example, policies such as the "housing first" approach, that are now being applied more universally, clash with TIC because client choice is taken away with respect to the range of supportive housing options available. The same participant noted that the United States Department of Housing and Urban Development (HUD) is not talking about or prioritizing TIC. Another program manager agreed, explaining that the federal government has not been incentivizing TIC through funding priorities. While another program manager felt that the federal government wants to fund easy fixes that demonstrate tangible impacts in the short-term. However, short-term impacts are hard to

demonstrate when you are working to address more “amorphous” things like healing from trauma and the use of TIC. Another program manager felt that discussions at the federal level in the current political climate are about who is deserving of program resources and which interventions have the best financial return on investment without any understanding of the deeper impact that trauma has on families and their success.

A few others thought that HUD’s trend away from funding for supportive services had a negative impact on building trauma-informed programs due to the lack of financial support for services and supports needed to provide a trauma-informed program environment. One of these participants felt that HUD focused on general goals such as increasing income but that other types of progress related to trauma are not measured or valued,

Instead of working with folks to have them start to work on feeling safe and to negotiate through their losses, It’s, get down to the child care office, get this, do this, do that.

One case manager criticized HUD’s target subpopulation preferences because it reduces flexibility in who you can serve, which in turn reduces the programs ability to be inclusive. For example, the program might be willing to take any family configuration, but HUD restricts the resource for a certain target subpopulation such as youth. Another barrier was the onerous level of data collection imposed upon programs by government funders. One program manager was concerned about the impact of arduous data collection on the time staff has to provide client services.

Another participant, a program manager, shared a client success story related to the trauma-informed philosophy that the program is based on but noted that the positive

outcome that the client experienced would be considered negative by HUD, one of the main federal funding sources for their program. In this case, HUD's benchmark of 90 days' maximum stay would have resulted in institutionalization for the client due to all that she had to negotiate as a result of a series of traumas including mental health issues. The participant explained that HUD does not understand that "one size does not fit all".

Transitional Housing is a "Horrible" Word

A few programs discussed the federal and state funding cuts to transitional housing (TH) programs as a barrier to TIC. One program's federal funding for TH was cut while other programs in surrounding counties had to close their TH because of the impact of state funding cuts. The participant explained that they have had to advocate strongly for TH especially for domestic violence victims in the wake of HUD's shift from TH to the "housing first quick fix kind of thing" such as "rapid rehousing." This participant believes that the shift will cost much more in the long term as they have seen clients experiencing domestic violence move into "rapid rehousing" only to have the abusers move right in. Likewise, another participant explained that they don't know exactly what works for families experiencing homelessness, but they think it is a combination of several factors including space and time. However, this participant, a program manager, does not believe that TIC and a housing first philosophy work together because housing first is about, "blast them out of there as soon as you can" even if you don't have the appropriate supports in place. In which case, the program will just end up seeing the client again somewhere in the system. The same participant explained that TH is now a "horrible" word to the government, resulting in the defunding of TH programs. The participant recommended that the folks writing policy spend two weeks at the

programs and learn about the reality of dealing with a human and not a fictitious client.

The participant expounded on this idea,

And I think that would be, oh well wait a second, it took you this long for one family. Well yeah, there were kids involved, there was this, there was that, she's running, she's fleeing domestic violence. We have to deal with it, so I just think there's a giant disconnect between the ground level and HUD. It's just the disconnect between writing the rules and the people.

Another program manager worried that there are dwindling options where families experiencing homelessness can go to be safe and to heal in a trauma-informed environment.

Local Government as Barrier to TIC

In addition to the many ways that local government helped to incentivize and support TIC, participants also raised several ways that they caused barriers to the implementation of TIC. One senior manager did not think that the local government understood the implementation of TIC in the real world especially in residential settings. They provided an example of when a client was terminated from the program as a natural consequence of their behavior and the local government agency felt that the client should not be terminated because TIC meant that programs should withhold natural consequences (i.e. if a client poses a safety risk to the community, they would be terminated from the program). Another program's executive remarked that a local government agency (the agency) doesn't seem to have an understanding of the vulnerable populations that they are working with. This participant felt that the way in which the agency interacts with the providers is not trauma-informed, specifically, decisions are

made, and policies are rolled out without including providers' voices. The participant feels that the program staff are traumatized by trying to respond to the changing nature of policies and procedures that the agency wants to implement. For example, how they report data, how they work with people, and what services they're able to provide to families. The participant felt that the agency could do better at coordination and understanding through the use of TIC themselves. For example, although the agency instituted a TIC tool in collaboration with providers, the Sanctuary® Model "community meeting", it was a short-lived effort and felt superficial at best especially when the conversation became passive aggressive as the meeting went on.

Another organization's program manager expressed similar sentiments about the lack of trauma-informed local government systems,

There's so much disarray about the way that changes are being implemented or what the new regulations are, that it doesn't allow us to be fully informed and transparent in conveying information to the clients about what they can expect and what they can do. There have been multiple occasions where we thought that something was going in a certain way and then we found out that it wasn't, and we have to tell the clients that the information we had was not accurate.

The same participant felt that the significant changes underway in a local government agency had created a lot of work for their programs' leadership team, which in turn resulted in less time to focus on growing their efforts in TIC. The participant added that the system is moving towards a myopic focus on housing without prioritizing the needed supportive services for clients to sustain housing. The participant feels that clients are

being set up to fail especially with the “rapid rehousing” program offering clients time limited rental subsidy and expecting that they'll be able to pay market rate rent,

It doesn't seem fair and in a lot of ways it kind of almost perpetuates this idea that if people don't succeed, that it's their own fault. And I don't think that that's particularly trauma-informed.

Another program's executive had a similar experience with the local government agency they collaborate with. The participant felt that the local government and providers needed to practice TIC together and although both groups agree that it is important, they are so focused on compliance, funding and day-to-day crises that it has not been prioritized. The participant feels that at one point, they were moving in that direction, but they lost momentum because of other priorities.

Outer Setting: Patient Needs & Resources

Another CFIR construct that is part of the domain of the outer setting is patient needs and resources, defined as, “ the extent to which patient needs, as well as barriers and facilitators to meet those needs are accurately known and prioritized by the organization” (Damschroder et al., 2009, p. 7). Client needs were an incentive for staff to implement TIC. A few participants spoke about the great need for TIC in all of the work that they do because of the level of trauma that they see in clients experiencing homelessness. One program manager noted that they did not think they would stop using TIC anytime soon due to the great need. Another participant, a senior manager, discussed her realization that the way they were responding to and working with clients might not have been as effective as it could have been which led to the team's reflection on what they might be missing. At the same time, the concept of TIC started to surface.

On the other hand, programs also discussed client needs and resources as a barrier to engagement in TIC. One executive talked about competing client needs and their finite energy to focus on the myriad of things vying for their attention. The participant felt that TIC requires much more concentrated time while many of the clients do not have time because they are actively working towards not being homeless anymore and they simply don't have the space in their brain to hear it, absorb it, or to implement it in their own lives. Likewise, another participant, a program manager, noted that dealing with life in general, such as finding a job and paying bills, is a barrier to TIC because the clients are focused on many other things.

One executive described barriers to TIC posed by federal policies that negate the voice of the participant. Specifically, the way that quantitative data is being used to drive policy and practice without consideration of the voice of the clients, even when the data is admittedly flawed. Additionally, the participant had not seen any qualitative research that draws in the voice of those experiencing homelessness to evaluate whether the policy was helpful. Therefore, the participant does not believe that the federal government understands the impact of their policies on the programs ability to infuse TIC. Overall, it feels like a disconnect between the funder and the provider and client.

Bioecological Systems Factors

Two of the constructs under the domain of outer setting, cosmopolitanism and external policy and incentives, relate to ecological factors. However, these two constructs do not fully capture the ecological factors that have an impact on the implementation of TIC. Therefore, I utilized Bronfenbrenner's Bioecological Systems Theory to expand the CFIR outer setting framework to highlight the ways that external

factors related to the microsystem, mesosystem, exosystem, macrosystem, and chronosystem, impact TIC implementation.

Microsystem and Mesosystem Factors

One program manager described a barrier to TIC implementation related to the clients' *microsystem*, an ecological setting in which one experiences life. For example, people and places that a person comes into contact with on a regular basis such as the home and immediate family, workplace, church, or a homeless shelter. The participant felt that the systems that clients interface with continue to take power away from clients because they are not trauma-informed and therefore inevitably result in re-traumatization. For example, the State Department of Public Welfare's lack of a trauma-informed approach to services has a negative impact on their clients. The participant acknowledges that there may be people in that system that are trauma-informed but trying to change the system feels like pushing a boulder uphill. While another senior manager talked about the rules and regulations of subsidized child care as a system that seems to work against clients. For example, when clients get jobs, they lose their childcare subsidy. The participant describes working with clients to fight the system so that they can move forward in their lives.

One program discussed the immediate community itself, the *mesosystem*, as a support to healing for the clients because of the safety that clients experience in the community. The participant described the community as very nice with a library, places to take children where they are safe, and a main street where clients can go to get pizza. Overall, they are located in a safe neighborhood, which the participant feels will also help

the clients to feel a sense of safety. The school district is also in a safe area and there is available employment in the vicinity.

Exosystem Factors

One executive described facilitative factors to TIC implementation related to the *exosystem*, a layer in one's ecological context that is comprised of places/ groups that the individual has no direct contact with but that affect them nonetheless (Bronfenbrenner, 1979). In contrast, the external policy and incentive construct refers to external strategies to spread the target intervention. The factors discussed in this section are not directly related to the intervention of TIC. Specifically, because this program does not receive federal funding, they are able to do more with the families since they do not have to "jump through the fiery hoops" of the federal government's regulations. This assists them in streamlining their program and administrative burden and allows the program to have a little more flexibility that their peers don't have. The participant sees the frustration of their peers because they want to be effective, but they are constrained by the funding requirements.

Several participants described barriers to TIC implementation related to the *exosystem*. One case manager described the negative impact of any source of funding cuts on their ability to implement TIC since cuts result in staff reductions. Staff that are left behind or whose hours are reduced still have to ensure that all of the work gets done. The participant summarized this phenomenon well,

Funding cuts are always going to affect the level of service that you can provide.

We're not a manufacturing company, you can't have a machine come in and produce twice as much of what one person does.

In addition to funding cuts, one program manager commented on all of the uncertainty around government funding, “since the Trump Administration, you have no idea what you're going to get.” The participant noted that even the state budget is tenuous. Another program manager discussed the lack of affordable housing as a barrier to TIC when clients end up having to live in shelter or transitional housing for a much longer period of time than they should be according to government standards. The same participant discussed the negative impact of exclusionary government policies related to criminal history and drug use on accessing affordable housing. According to the participant, these policies leave people experiencing homelessness with nowhere to go and “that's not trauma-informed.”

One program manager thought that the many restrictions on government funding result in making the support not helpful at all. Similarly, another participant, an executive, noted that funding streams dictate what gets done and what doesn't. And unfortunately, the things that are being funded are not the cutting edge of what is effective and what is not. A case manager provided an example of how external regulations get in the way of practicing TIC,

For example, I have a client who is very guarded, she is extremely guarded, and I know that there's a past history but unfortunately because of program requirements, which I understand the need for them and it's not that I would necessarily do everything different. I would just try to do it a little bit differently but because of the program requirements, I'm required to do certain things. Whereas on the outside, I would be a little more lenient and hopefully gain that person's trust so that I can actually help them, versus being the enforcer.

While another participant, a case manager, spoke about the philosophical mismatch between funding regulations and TIC,

We try and interact with humans as if they are processes or stocks and bonds, so we invest something into them and get something out. And I think when you're trying to work with someone in a way that's sensitive to who they are and to their trauma and to their journey, you can't always get those results.

The participant went on to explain that if TIC means 'meeting you where you are' and acknowledging the limitations of where your experiences have left you, then we will need to invest time, energy and money into people who might not give us back the responses that we want. The participant believes that the system, via the funding structure, rewards programs that can connect with people who have the ability to get those outcomes verses folks who need more support or do not fit within the program model, these folks pull on the outcomes and they will be left behind. The participant feels that funding incentives for outcomes can put us in a difficult position because "everybody deserves to be invested in, everyone deserves opportunities to improve themselves and their situation." Similarly, another participant, a program manager, felt that the biggest barrier to TIC implementation was the government's notion of who is worthy of support.

Macrosystem Factors

One case manager described *macrosystem* barriers to TIC implementation rooted in the cultural background of individuals. This participant described the importance of cultural competency to TIC practice,

If you can't layer your understanding and your practice of trauma-informed care with cultural competency, that's where the trauma-informed care hits a wall. Part of that is understanding that trauma is not independent of some of the systems that folks are experiencing living under in the United States and around the world. Whether that's capitalism, racism, sexism or patriarchy; all of those things are usually in some ways contributing to their trauma and related to the trauma, so you have to be able to hold both and know both in order to implement trauma-informed care well.

The participant also described the constraints of their program given the *macrosystem* that structures the program,

Structurally, our program is about housing and anti-homelessness, anti-poverty and we are working within the constraints of capitalism and running a business model ourselves. So, there's not really much that we can do if someone comes into the program and they're not employed and are having struggles getting employed or they lose their job and they fall behind three, four months in rent or they're just like really struggling with money management, then they'll eventually face a court process up to eviction. It's frustrating for me to want to work in a space where I'm empowering people to make better decisions with their lives and you want to be able to give them space to make mistakes...trying to help people

to make radical changes in their lives when you don't have radically different systems for them to make those changes in.

The participant points out that this is a contradiction in the program because if clients are not making clear gains, they will find themselves facing homelessness again and experiencing yet another traumatizing situation. On one hand, they want to support people and give them space to not be perfect as they are learning how to take care of themselves. On the other hand, they have to run the organization and deal with the external systems and societal expectations. This creates a contradiction inherent in the work and the business model.

Chronosystem Factors and Bi-Directionality

One senior manager with a long-tenure at the organization reflected on a factor connected to the *chronosystem*, a layer in the ecology that is indicative in each other layer and related to the passage of time. Over the decades, there has been a change in their client population. The clients are a lot needier than they were when the program started in the 1990s and the incoming clients don't seem to have basic information about how to go about activities of daily living. The program is concerned about moving them into permanent housing before they understand how to budget and pay their rent. The participant explained that everything has to be taught to the clients and this is a significant shift over the decades.

Bronfenbrenner (1992) described bidirectionality, variations in developmental processes and outcomes as a joint function of the characteristics of the environment and of the person (p. 115). One participant described using TIC in a bidirectional manner in that it is not only about attending to staff responding appropriately to clients but also

educating clients on what kind of responses they might receive when they behave in certain ways even if it is due to their own trauma histories. The participant feels that it is important to educate clients about how their behavior may shape the response they get from others.

Summary

In this chapter, I explored the external barriers and facilitative factors in implementing TIC using one of the five CFIR domains that is externally focused, “outer setting”, as a theoretical frame and tool for data analysis. The outer setting was integral to a programs’ ability to implement TIC. Programs that were more networked with external organizations or working with a coalition benefited with respect to TIC implementation. Government funders had significant power to change organizational practice by incentivizing and supporting TIC. On the other hand, there were several critiques of the federal government as a barrier to TIC implementation for TH providers including the widespread defunding of TH programs. Furthermore, any source of funding cuts had a negative impact on a program’s ability to implement TIC since a loss of funding resulted in staff reductions and less time to carry out TIC practices. Similarly, there were many ways that local government both helped to incentivize and support TIC as well as posed barriers to the implementation of TIC. Examples of barriers included the lack of trauma-informed local government systems and their myopic focus on housing without consideration of the necessary supportive services needed by families experiencing homelessness.

Client needs motivated staff to want to utilize TIC especially due to the level of trauma that clients experiencing homelessness have gone through. On the other hand,

programs also discussed client needs and resources as a barrier to engagement in TIC due to competing client needs and their finite energy to focus on the myriad of things vying for their attention. Furthermore, the systems that clients interface with continue to take power away from them because they are not trauma-informed and therefore inevitably result in re-traumatization.

Another prominent barrier to TIC implementation was the sociopolitical ethos that views human transactions as market transactions. The idea that, “if TIC means ‘meeting you where you are’ and acknowledging the limitations of where your experiences have left you, then we will need to invest time, energy and money into people who might not give us back the responses that we want”, makes it clear that there is a dichotomy between TIC as a human system of care and the U.S. market driven system. This mismatch between TIC and government systems plays out through funding streams that often support TH programs. One participant summed this up poignantly when they said,

We are working within the constraints of capitalism and running a business model ourselves...trying to help people to make radical changes in their lives when you don't have radically different systems for them to make those changes in.

The internal implementation factor of “process: engaging external change agents” was linked to the external implementation factor of “outer setting: external policy and incentives” in that government agencies that were requiring TIC, also had leaders that were active in participating in joint trainings on TIC with program staff. Overall, external factors related to networking with external groups seemed to positively reinforce the practice of TIC in programs. The following chapter is the final summary, recommendations, and conclusion of the study.

CHAPTER 8: SUMMARY, RECOMMENDATIONS, AND CONCLUSIONS

First, I will highlight conclusions about participants' understanding of trauma within the families they serve. I will then focus on how my participants understanding of TIC reflected on or departed from the existing literature and in the ways TIC was valued by participants. Following this, I will reflect on how participant practices contributed to the six principles of TIC, how they overlapped with social work practice, and highlight emerging findings on practices that may relate to TIC. I will then discuss how the Bioecological Systems Theory added to the Consolidated Framework for Implementation Science (CFIR) to create a helpful heuristic framework for understanding the broad range of external factors that impinge on a program's ability to implement TIC. I will review the ways that barriers and facilitative factors to TIC implementation present themselves in TH programs for families experiencing homelessness along with strategies to overcome the barriers. I will then review several limitations of this study and end with recommendations for policy and practice.

Participants Understanding of Trauma

Participants recognized trauma as a universal experience for their clients that require a universal approach to service delivery. One study participant explained the universal need for TIC, "Because we are all living in a world where we are watching people be traumatized by various systems, whether that's capitalism or racism or something else". Another participant concurred, "I would say all of us have had some kind of trauma in our life, whether or not it's physical or emotional or psychological." Although research on the effectiveness of TIC is in its infancy (DeCandia, Guarino, & Clervil, 2014), many researchers have called for the universal application of TIC in the

human service system due to the high levels of trauma experienced by clients (Elliott et al., 2005; Bloom, 2013).

Research suggests that among poor, homeless mothers, more than nine out of ten have a history of some sort of interpersonal trauma in their lifetime ranging from childhood sexual abuse and/ or severe physical abuse, to adult intimate partner violence as well as physical or sexual assault by a non-partner (Bassuk et al., 1996; DeCandia & Guarino, 2015). In addition to this trauma, both the experience itself of homelessness as well as factors that lead to homelessness, involve events that are experienced as traumatic for both adults and children (Goodman, Saxe, & Harvey, 1991; Guarino & Bassuk, 2010; USICH, 2015). In the same way, from the experiences of homelessness and poverty to interpersonal violence and other forms of trauma, participants in my study were acutely aware of the high levels of trauma in the lives of the families they serve and the impact that it has. For example, one participant shared a story about a highly-traumatized client explaining, “If you push... too hard, she would’ve just been back at our local hospital on the...mental health unit.”

Participants understanding of the impact of trauma was not limited to the trauma personally experienced by clients but also the ways that social systems and policies re-traumatize clients who are seeking assistance. This finding aligns with literature suggesting that the first step to TIC is to train all staff on the pervasiveness and impact of violence in client’s lives (Elliott et al., 2005). However, even when TH programs understood the need for TIC and practiced TIC, my respondents noted how the negative system interactions seemed to counterbalance the positive impact. With regards to the impacts of systems on the actual manifestations of TIC, Bowen and Murshid (2016)

developed a conceptual framework for trauma-informed social policy analysis and advocacy using the TIC principles of safety, trustworthiness and transparency, collaboration and peer support, empowerment, choice, and intersectionality of identity characteristics. The authors propose that bringing policies more into alignment with TIC principles would result in a greater focus of attention and resources on the prevention of negative social determinants of health. This could prevent human suffering and possibly result in financial savings. They conclude that "even service providers delivering the highest quality of trauma-informed care must draw their clients from and release them to a society and a social order that are largely not trauma-informed" (Bowen & Murshid, 2016, p. 228). This literature is among the few pieces of scholarship on the topic that highlight the need for a systems view on TIC. As my findings indicate, providers are keenly aware of the limitations of their practices when clients are sent out into systems that are re-traumatizing.

Traumatic stress can produce serious and chronic changes in physiological arousal, emotion, cognition, character, and memory as well as interfere with the connection between these functions (Herman, 1997; van der Kolk et al., 2007). Aligned with these findings, participants in this study confirmed the complexity of the effects of trauma on the clients they serve, for example, clients are "...coming through the front door...more and more traumatized. Their behaviors were more complex and perplexing." This finding underscores the need for TIC within programs serving highly traumatized families experiencing homelessness.

What is Trauma-Informed Care?

In my study, participants understood TIC as a broad philosophical framework that shifts the emphasis from “what is wrong with you?” to “what happened to you?” and from rigid to flexible programs. This aligns with the literature on the topic asserting that TIC shifts the focus from “how can I fix you” to “what do you need to support your development and recovery?” (DeCandia & Guarino, 2015). Thus, TIC inspired questions of “what happened to you?” and “what do you need to support your development and recovery?”, lend themselves to a flexible service approach based on a client’s needs and desires and are a form of person-centered care. Reflecting on this approach, the participants described TIC as a set of practices such as compassion, care, empathy, and a strengths-based approach in which providers meet a client where they are, concepts which are also related to a person-centered approach to care. The values of the dignity and worth of the individual, self-determination, and the importance of social responsibility and reciprocity underlie the person-centered approach (Turner, 2017) and are closely aligned with the TIC principles of collaboration and mutuality and empowerment, voice, and choice. A thread running through participants understanding of TIC was the social work concept of a person-centered approach to care.

Participants underscored how their understanding of TIC is largely a question of how they understand it, not just as a set of practices, but as a philosophy. When responding to the question about practices, some participants described their philosophical understanding of TIC rather than identifying concrete practices. I often had to provide prompts after the question about practices, and participants still had some difficulty naming practices, often referred back to what they were thinking about as they

delivered TIC; their understanding of TIC seemed to be synonymous with practicing TIC which supports the idea that TIC is a philosophy or framework to enact a culture or create an environment where healing can occur (Wilson et al., 2015). Although having an understanding of TIC is primarily a philosophical enterprise that may or may not lead to action, in my study, participants used their understanding of TIC as a lens with which they approached their interaction with clients, looking through the lens of Sanctuary. Participants that had an understanding of TIC also seemed to take action to enact TIC. For example, one participant described “looking through the Sanctuary® lens” to apply the principles and tools to a situation before reacting. In each interaction with clients, “looking through the lens of Sanctuary®” or some type of trauma-informed frame, seems to be the first step in taking action to engender TIC practices. In this way, the current study supports the idea that practices leading to TIC emerged from the participants’ philosophical understanding of TIC.

Participants understanding of TIC was aligned with what researchers have found in programs serving people experiencing homelessness. For example, Hopper et al. (2010) describe TIC as “an overarching framework that emphasizes the impact of trauma and that guides the general organization and behavior of an entire system” (p. 81). Hopper et al. (2010) performed a comprehensive literature synthesis to survey the ways that TIC was defined as well as to determine what was known about the effectiveness of using TIC with people experiencing homelessness. From this analysis, the authors developed a consensus definition of TIC, “Trauma-informed care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers

and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment” (Hopper et al., 2010, p. 82). Subsequently, SAMHSA (2014) published guidance on the concept of trauma and a trauma-informed approach to care which also defined TIC and identified six key principles that undergird TIC and ten implementation domains to help guide TIC implementation. Although many participants understanding of TIC was aligned with this literature, they were not systematically utilizing it. Other participants that were less familiar with what TIC is, were eager for greater clarity and direction around TIC.

The current research study underscores the point that due to "the lack of definitions and behaviorally-defined changes signifying trauma-informed services, there is no consistent basis for identifying whether or not and to what degree a program is trauma-informed" (Hopper et al., 2010, p. 87). Practitioners in the current research study were striving to implement TIC without having a clear understanding of what TIC means for programs serving homeless families or how to implement it. Even participants that answered yes to the question about whether they had implemented TIC, had not always implemented it fully as evidenced by their interview responses taken as a whole.

How is Trauma-Informed Care Unique from Social Work Practice?

Social work practice is broken down into numerous sub-specialties encompassing many different approaches. Social workers support clients in working through specific traumatic events and cumulative historical trauma when clients present in a therapeutic setting or are in crisis. Within the homeless service system, clients are presenting with the primary issue of homelessness, therefore, resolving trauma is not often the main focus of the work. In my study, there were some participating programs that did not see TIC as

a priority in their work, believing that they were best suited to focus their efforts on stable housing and jobs for clients while leaving issues of trauma to therapists and other specialists. Nevertheless, clients that present in the homeless system have been exposed to high levels of trauma (DeCandia, Guarino, & Clervil, 2014). The United States Interagency Council on Homelessness (USICH) released the report, *Family Connections: Building Systems to End Family Homelessness*, summarizing strategies for addressing family homelessness, which included the recommendation of using trauma-informed services in all interventions (USICH, 2014). TIC helps practitioners to recognize that presenting problems are often related to past trauma and are an attempt at coping (Levenson, 2017). Participants in my study understood TIC as an approach that helps to avoid re-traumatization in clients and establish a culture that creates safety to support clients in making progress towards specific goals including resolution of homelessness. Many of the ways of thinking about TIC overlap with social work values and ethical principles (NASW, 2017a). The most salient of these values articulated by participants in my study were the importance of human relationships, the dignity, and worth of the person and the importance of service. Participants expressed a tension between their values of providing high-quality TIC services and the pressures from funders to produce measurable impacts in the short-term.

Participants working in TH settings reserved for domestic violence survivors understood TIC as a repackaging of the empowerment counseling model, a concept that is marginally touched upon in the literature on TH for survivors of domestic violence (Berman, 2016; Phillips, Lyon, Fabri, & Warshaw, 2015). Phillips, Lyon, Fabri, and Warshaw (2015) interviewed practitioners from 45 programs from across the United

States who serve survivors of domestic and sexual violence. Of these programs, 30 were domestic violence programs and 18 of these programs had a residential component. Most of these programs felt that using TIC was complementary to working within the rubric of the empowerment model (Phillips et al., 2015), a model which has been practiced in domestic violence shelter programs for decades (Cattaneo & Goodman, 2010). When discussing the empowerment model, one domestic violence TH program participant in the current study described TIC as “sort of a return [to] and with a higher level of understanding [of] the way the services were supposed to be delivered in the first place.” Likewise, the participants in the Phillips et al. (2015) study felt that TIC enhanced the empowerment model by highlighting the range of trauma experienced by clients and the impact of trauma on clients, staff, the organization, and the community. Indeed, one of the principles of TIC is empowerment, voice, and choice (SAMHSA, 2014) and the empowerment model is based on the idea that in order to improve one’s life, one must have control over their environment (Busch & Valentine, 2000). According to Gutiérrez, DeLois, and GlenMaye (1995), empowerment practice requires a helping relationship based on collaboration, trust and power-sharing, building on the clients’ strengths, increasing client consciousness, involving the client in change, teaching skills, modeling personal power within a helping relationship, and garnering resources on behalf of the client. The attributes of empowerment practice (Gutiérrez et al, 1995) are highly aligned with many of the TIC principles and assumptions outlined by participants in the current study such as trustworthiness and transparency and collaboration and mutuality.

The sense of puzzlement as to how TIC is unique from social work practice is an ongoing discussion, though the existing literature is limited in its usefulness in

understanding these differences, TIC seems to be a conglomeration of social work practices combined with a deeper understanding of trauma theory, described by social workers as the missing piece in their knowledge base (Smyth, 2013). As I reported in the external implementation factors chapter, one participant summarized this “missing piece” when explaining what helped their organization to implement TIC,

Just realizing that at some point the way we're responding and working with our survivors might not have been working on the level it could be...we're missing something, something's not right, not necessarily wrong, but it's not as right as it could be....those kind of internal thoughts started happening at the same time that this concept began to surface. I don't know that there was one point-in-time. It's sort of been this metamorphosis if you will.

Social workers have been working with trauma survivors from the beginning of the profession and with the growing knowledge base about the prevalence and impact of trauma, this knowledge is being used to inform changes in policy and practice to support recovery and resist re-traumatization (Smyth, 2013). As noted in the findings chapter on understandings of TIC, one participant summarized the importance of understanding and using TIC in practice,

We need to create space for working through trauma both in communal settings and individually and respecting how our experiences shape our lives and understanding, that's not intangible things that don't need to be paid attention to. These are the way we experience trauma and then the way we recover from it, the way we move on and navigate for the rest of our lives.

Trauma-informed social workers emphasize strengths versus pathology, and they focus on supporting clients in building healthy skills (Levenson, 2017). TIC social workers attend to the helping relationship to avoid reenacting dynamics of past abusive relationships by establishing healthy relationships with clients as a way of modeling how relationships can be different from what clients have experienced in past abusive or disempowering relationships (Levenson, 2017). Participants described building trustworthy helping relationships as part of TIC which resulted in clients reaching out for support at critical junctures in their process of recovery. These helping relationships were achieved through the worker's non-judgmental stance, generous listening, and overall encouragement. TIC stresses collaboration and mutuality, safety, and trustworthiness and transparency, all of which are components of the helping relationship and are paramount to good social work practice.

Trauma-informed care for the TH programs in my study seems to be a constellation of ways of thinking and practicing rooted in trauma theory with a goal of creating an environment in which clients feel safe and empowered to work on rebuilding their lives. Likewise, the literature describes TIC as a framework for creating this type of safe environment in which other interventions may be more likely to be effective (Morrissey, 2005; Levenson, 2017). Similar to the work of Carl Rogers' client-centered therapy, in which a set of core conditions are responsible for change rather than a specific intervention, as well as the work of several other psychologists that conclude that certain "common factors" in the therapeutic relationship are paramount to client change rather than any specific intervention (Kirschenbaum & Jourdan, 2005, p. 44), TIC is a set of conditions which helps practitioners to create a healing milieu which may be key to the

success of TH's primary goal of transitioning families who have experienced significant levels of trauma to permanent housing as well as sustaining that housing (HUD, 2012d). Participants in my study reinforced the importance of the creation of a trauma-informed milieu as paramount to their clients' success in terms of retaining TH housing and/ or securing stable housing upon exit from the TH program. Similarly, the existing literature suggests that individual interventions paired with the organization-wide approach to creating a culture that is sensitive to trauma are complimentary (DeCandia, Guarino, & Clervil, 2014). Based on my findings, TIC seems to act as the contextual fabric into which social work practices can be woven so that they are effective.

The co-founder of the Sanctuary® Model, Dr. Sandra Bloom, acknowledged the complexities of TIC, noting that "There is no how-to-cookbook for Sanctuary. Life is far more complex and changeable than that." (Bloom, 2018c). In a study on the use of TIC in TH programs for domestic violence and sexual assault survivors (Phillips et al., 2015), practitioners felt that the process of implementing TIC was "an ongoing, reflective process involving a shift in understanding of how trauma affects staff, survivors, organizations, and communities rather than a checklist of improvements or service components to be implemented" (Phillips et al., 2015, p. 5). The participants echoed this sentiment in that even the organizations that were using a TIC model and dedicating resources to training and support for ongoing implementation, noted that they were still working to build upon their achievements to bolster the culture of TIC in their programs. I did not encounter a program that felt that they had arrived at a final destination of TIC. These findings are aligned with SAMHSA's literature on creating trauma-informed organizations declaring that, "creating a trauma-informed organization is a fluid, ongoing

process; it has no completion date” (SAMHSA, 2014, p. 160). If we are to spread TIC as a philosophy and a practice, there is much room for growth in refining and clarifying our understanding of TIC. We are far from having a cookbook that would clearly guide us in the use of TIC within TH programs for families experiencing homelessness.

The Need for and Value of Trauma-Informed Care

Although approximately a third of the participants did not utilize TIC and approximately 40% only partially used it (with the remainder fully implementing it), most participants desired to use TIC and learn more about it. Given that the majority of clients in the human service system are trauma survivors (Elliott et al., 2005) and support in the literature for the use of TIC with populations that experience high levels of trauma (Elliott et al., 2005; Menschner & Maul, 2016; Guarino & Bassuk, 2010; Hopper et al., 2010; Bloom, 2013) paired with participants positive appraisal of the use of TIC for their own clients, the government and other funders would benefit from prioritizing TIC practices within programs for families experiencing homelessness.

The Adverse Childhood Experience study replication in Philadelphia found that a whopping 40.5% of adults witnessed serious violence while growing up (Public Health Management Corporation, 2013). Furthermore, over one-third reported experiencing discrimination based on their race or ethnicity. In the current study, participants described the trauma that discrimination and oppression have on program participants who are already negatively impacted by various traumatic experiences. Use of TIC could serve to begin to address some of the impacts of cultural, gender and historical trauma related to oppression and structural racism, within a population that has experienced many forms of trauma.

Aligned with findings from the Service and Housing Interventions for Families in Transition (SHIFT) Longitudinal Study that concluded that the mothers' trauma symptoms predict housing stability (Hayes et al., 2013). Brush et al. (2017) concluded that it is not enough that services to families be "trauma-informed" but that addressing trauma and violence is integral to housing stability. However, my findings indicate that practitioners hold diverging views about the value of TIC. Specifically, a few participants did not think that TIC was pertinent in homeless service programs but that it should be left to clinical programs to address trauma issues. These participants either did not understand the distinction between TIC and trauma-specific services or felt that homeless service providers were inundated with pressing client issues related to meeting the basic need for housing. In line with these findings, recent research substantiates that there is far greater emphasis on securing housing and addressing financial needs than on a trauma-informed approach in programs that serve families experiencing homelessness (Brush et al., 2017). The authors argue that in order to effectively address homelessness, trauma must also be addressed as one of the roots of housing instability (Brush et al., 2017).

Range of Trauma-Informed Care Practices Used in Transitional Housing Programs

Of the six principles that TIC practices are based on, 1) safety, 2) trustworthiness and transparency, 3) peer support, 4) collaboration and mutuality, 5) empowerment, voice, and choice, and 6) cultural, historical and gender inclusivity (SAMHSA, 2014), the least noted practices by participants in my study were in the categories of peer support and cultural, historical and gender inclusivity. The most frequently used model of TIC noted by my participants was the Sanctuary® Model, which does not have a specific

focus on cultural, historical, and gender inclusivity or peer support. There are other manuals for building cultures of TIC that better emphasize cultural, historical and gender inclusivity such as Warshaw, Sullivan, and Rivera's (2018) organizational reflection toolkit that provides guidance on becoming an accessible, culturally responsive, and trauma-informed organization. Using this tri-pronged framework, the model provides guidance in several focus areas including 1) organizational commitment and infrastructure, 2) staff support and supervision, 3) physical, sensory and relational environment, 4) intake process, 5) programs and services, 6) community partnerships, and 7) feedback and evaluation. However, the authors note that the guidance is not meant to be a blueprint but a starting point for organizational discussion since each organization's process will be unique. Indeed, the manual is a broad overview and not a manualized intervention.

In Phillips et al.'s (2015) research with practitioners from 45 programs from across the United States, 18 of whom had shelters or transitional housing for domestic violence survivors, participants reported ongoing program initiatives to ensure cultural competency as a central part of being a trauma-informed agency. Likewise, in the current study the importance of cultural competence and inclusivity in upholding TIC, with an eye to the intersectionality of trauma, racism, and sexism was identified, "if you can't layer your understanding and your practice of TIC with cultural competency, then the TIC hits a wall." However, there were few that had put this idea into practice. According to SAMHSA's (2014) guidance on implementing a trauma-informed approach, an organization must address cultural, gender and historical issues that would entail, "actively moving past cultural stereotypes and biases (e.g. based on race, ethnicity,

sexual orientation, age, religion, gender- identity, geography, etc.); offers, access to gender-responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma” (p. 11). The need to address cultural and historical issues as part of TIC remains unmet in the study programs largely due to the shortcoming of existing TIC models. These models would benefit from enhancements to address this critical need.

Practices that bring about empowerment, voice, and choice, as well as safety, were the two most frequently noted categories of practices used in the programs. The principle of empowerment, voice, and choice is aligned with a person-centered approach, a prominent feature of social work practice. This person-centered approach, analogous with voice and choice within TIC, is also foundational to offering flexibility in service delivery based on a person’s unique needs and preferences. Flexibility was a common thread in participants’ discussion of practices that contribute to TIC.

The themes of bending the rules and balancing boundaries were examples of the gray areas that participants had to navigate as they sought to promote empowerment, voice, and choice. Participants worked to change or discontinue rules that were not tied to safety based upon input from clients. In terms of negotiating boundaries, one example provided by a study participant was the decision of a staff person to watch a client’s children in order to provide an opportunity for the client to deescalate when they were struggling. This is also an example of how the range of potential practices that would support TIC are as varied as the individual client needs are. Practicing TIC can be complex as staff struggle to establish and negotiate boundaries while working to keep

everyone safe and attending to client choice and empowerment. There was a tension between TIC, program structure and client accountability. Programs struggled to identify and teach staff this balance. For example, the balance between understanding that client behaviors may come as a result of trauma yet there are still natural consequences of these behaviors. Flexibility as described by participants within the rubric of TIC also applied among staff and between staff and the management team.

Historically, TH offered more flexibility in the length of stay and in program elements and according to participants in this study, this was beneficial to TIC implementation. It is more challenging for programs to offer flexibility when they are forced to comply with more restrictive funder requirements, some of which conflict with the flexibility that seems to be core to offering a TIC environment. For example, funder restrictions in the specific subpopulation or configuration of family permitted were one barrier to the flexibility needed for TIC. Furthermore, programs shared information about funder requirements with clients so that clients understood why programs imposed certain requirements on clients. It was important to provide clear expectations of the roles and responsibilities of the program and the client at the outset of the relationship in order to preserve trust and create transparency and collaboration in the working relationship.

As my findings indicate, practices that bring about safety may be more readily accessible in TH programs than in non-residential social work settings since a core element of TH programs is housing. Therefore, TH may offer unique opportunities to create physically safe spaces in addition to upholding psychological, social and moral safety. Participants gave some examples of ways they create physical safety for clients

such as installing peepholes in client unit doors, having on-site security, and making the space less institutional. Psychological safety and safe interpersonal interactions were, in part, promoted through active listening, being non-judgmental and a range of general counseling techniques that are also widely used in various social work settings.

Participants mentioned the use of tools unique to TIC to create psychological safety such as the Sanctuary® Model's safety plan.

Study participants took care to resist re-traumatization by identifying client triggers and being mindful of these issues in interactions with clients. Many of the common practices in service settings are triggering such as invasive or insensitive procedures, aggressive and confrontational group techniques, and not allowing survivors to discuss past victimization in the name of avoiding self-pity (Elliott et al., 2005).

Providers must first understand how violence impacts the lives of clients, then ensure that all interactions are trauma-informed so that clients are not re-traumatized (Elliott et al., 2005). Participants emphasized the importance of supporting staff in dealing with their own direct trauma history as well as the vicarious trauma staff experiences. In order to do this, participants utilized some of the tools offered in the Sanctuary® Model of TIC such as the community meeting and self-care plan.

Separate from the practices that I expected to find that were directly linked to the six principles of TIC, various non-TIC specific practice approaches were identified by participants as being related to TIC. These emergent findings include the link between mindfulness, non-violent communication, motivational interviewing, *Bridges out of Poverty*, housing first, and TIC. Of these approaches, mindfulness and non-violent communication were both methods used by participant practitioners to avoid re-

traumatization of clients and to be more empathetic in understanding the trauma that clients have experienced. The scientific definition of mindfulness delineated by a group of researchers is, “the self-regulation of attention with an attitude of curiosity, openness, and acceptance” (Niemic, 2017). Social workers have used mindfulness practice as a way to enhance their own listening skills, kindness, and levels of presence and connectedness with clients (Bindseil & Kitchen, 2017). Whereas, participants in my study described using mindfulness as a way to respect the baggage that clients are bringing with them and to remain aware of their own words, actions and thoughts in order to mitigate any re-traumatization of clients.

Another emerging approach identified by a study participant was *nonviolent communication* (NVC), an approach that helped to build on the psychological safety of clients and staff. The late Marshall B. Rosenberg, a Ph.D. psychologist, developed NVC as a tool for supporting partnerships and resolving conflict (Rosenberg & Chopra, 2015). NVC is based on the principles of nonviolence as used by Gandhi, defined as “the natural state of compassion when no violence is present in the heart” (Rosenberg & Chopra, 2015, p. 2). In these sessions on NVC, one study program was learning how to change their word choices and cultivate compassion to promote nonviolence. Rosenberg reflected on two questions for most of his career, “What happens to disconnect us from our compassionate nature, leading us to behave violently and exploitatively? And, conversely, what allows some people to stay connected to their compassionate nature under even the most trying circumstance?” (Rosenberg & Chopra, 2015, p. 1). One of the key principles of the Sanctuary® Model is non-violence in all of its forms: social, physical, moral, and psychological (Bloom, 2013). In this way, NVC overlaps with TIC.

SAMHSA (2014, p. 201) identified motivational interviewing as a client-centered, non-pathologizing counseling technique to improve engagement in treatment and commitment to change. Motivational interviewing is a combination of supportive counseling (i.e. client-centered therapy) with a directive method for resolving ambivalence for change through eliciting the client's verbalization of their rationale for change (Hettema, Steele, & Miller, 2005, p. 92). By talking about motivation for change, the plan for change becomes more concrete and is more likely to be acted upon (Hettema, Steele & Miller, 2005, p. 92). Likewise, as noted in my findings chapter on practices, one study participant explained that a primary part of their work is having motivational conversations and listening to client goals and then helping clients to articulate how they can move forward and what they might want to pay attention to. This finding is aligned with Menschner and Maul (2016) reference to motivational interviewing as part of a trauma-specific approach to care in their issue brief on key ingredients for successful TIC implementation. However, the use of motivational interviewing is only perfunctorily addressed as a strategy to foster engagement with clients in support of TIC in SAMHSA's (2014) two publications on trauma-informed care.

Another model identified by one participant as having some overlap with TIC was the use of mental models from Ruby Payne's book, *Bridges out of Poverty* (2001). This model focuses on addressing poverty by involving entire communities in the effort to reduce poverty by building on emotional, mental, spiritual, physical, financial and relational resources (Payne, 2001). Mental models are analogies or stories that help folks to understand their lot in life and get them thinking about how to change the model to achieve what they desire. This model does not seem to have a clear direct connection

with TIC. However, it would certainly support the TIC principle of empowerment and has elements of motivational interviewing.

Another approach identified by some participants as linked to TIC was the housing first approach. Housing first is an approach to homelessness in which housing is the first priority, above addressing other issues such as behavioral health issues or a lack of education or life skills (National Alliance to End Homelessness, 2014). Housing first was identified by participants as clashing with TIC because client choice is taken away with respect to the range of supportive housing options available to clients. With the housing first approach, there are no pre-requisites to eligibility for housing nor are there mandates for service participation to retain housing. This approach locates stable housing as a foundation for health and wellbeing. There are elements of the housing first approach that overlap with TIC such as endorsing client choice as to which services they participate in and not having eligibility requirements to access the housing. In this way, it also falls into the category of a person-centered approach. Participants felt that the main housing first program available to families, rapid rehousing, was not long-term enough to meet the needs of families for ongoing support and longer-term rental subsidy. These issues were pronounced for the study participants given the recent deprioritization of TH for families over less expensive models of supportive housing such as rapid rehousing, a model that uses a housing first approach. As highlighted in the findings chapter on external implementation factors, one participant explained that although they don't know exactly what works for families experiencing homelessness, they think it is a combination of several factors including space and time. However, a housing first

approach is about, “blast them out of there as soon as you can” even if you don’t have the appropriate supports in place.

Consolidated Framework for Implementation Research and Bioecological Systems

Theory

In addition to trauma theory, the Consolidated Framework for Implementation Research (CFIR), was the primary framework that I used to design this study and analyze the data. The CFIR (Damschroder et al., 2009) delineated a wide range of internal and external factors that can serve as barriers or facilitators for the implementation of a specific intervention. The CFIR was a helpful framework for evaluating the factors that were impacting a programs decision and ability to fully implement TIC. In addition, I utilized Bronfenbrenner’s Bioecological Systems Theory to expand the CFIR framework by accentuating the ways that various external factors impact TIC implementation.

The outer setting CFIR codes offered two options for factors related to ecological systems including cosmopolitanism and external policies and incentives.

Cosmopolitanism refers to “the degree to which an organization is externally networked with other external organizations” (Damschroder et al., 2009, p. 7) and external policies and incentives is “a broad construct that includes external strategies to spread interventions including policy and regulations (governmental or other central entity), external mandates, recommendations and guidelines, pay-for-performance, collaboratives, and public or benchmark reporting” (Damschroder et al., 2009, p. 7). By including the non-CFIR codes related to bioecological systems theory, a deeper understanding of the outer setting factors impacting TIC implementation was able to be drawn out of the data. For example, the exosystem code delineates a layer in one’s

ecological context that is comprised of places/ groups that the individual has no direct contact with but that affect them nonetheless (Bronfenbrenner, 1979), whereas the external policy and incentive code refers to external strategies to spread the target intervention and therefore did not cover all of the external forces that can impinge upon full implementation of TIC. One example of an exosystem factor raised by a participant that would not have fit into the CFIR codes was the impact of the Trump Administration on federal policies that negatively impact the tenor of the social policy and funding landscape, factors which participants noted as directly impacting their ability to implement TIC. In this way, the bioecological systems theory codes are a helpful heuristic framework for understanding the broad range of external factors that impinge on the programs ability to implement TIC. The bioecological systems theory also helped to capture an idea that one of the participant's put forth about how a client's own responses and behaviors also contribute to a TIC environment in a bi-directional way,

I believe trauma-informed care is not just you responding appropriately to clients but you educating the clients on what kind of responses they will get when they behave [in] certain ways so that they can, at some point understand why somebody might be responding to them [in] different ways.

Barriers to Trauma-Informed Care Implementation

Implementation is complex (Fixsen et al., 2005). It is important to understand that there are processes and outcomes related to the intervention and then there are processes and outcomes related to the implementation of the intervention (Fixsen et al., 2005). Similarly, there are barriers and facilitative factors related to the intervention and separately to the implementation process. For example, one barrier related to TIC as an

intervention was summarized in the findings chapter on external implementation factors, “if you can’t layer your understanding and your practice of trauma-informed care with cultural competency, then the trauma-informed care hits a wall.” At the most basic level, in order for implementation of an intervention to be successful, one must have a delineated “set of activities of known dimensions” (Fixsen et al., 2005, p. 5). One major barrier to full implementation for many of the participating programs was their lack of a written model or set of guidelines on TIC, a finding echoed in the existing literature (DeCandia, Guarino, & Clervil, 2014). In a study about the implementation of mental health interventions, Aarons (2004) found that the presence of written policies regarding treatments were part of internal processes that appear to predispose providers to be more open to new practices.

The primary model of TIC used by participants was the Sanctuary® Model, which is also the only evidence-based model of TIC (California Evidence-Based Clearinghouse for Child Welfare, 2018). However, the Sanctuary® Model, along with other existing TIC models, were inaccessible to participating programs, mainly due to the costs for materials, training and ongoing technical assistance as well as translation into user-friendly materials. The unmet need for education and training was extensive in the participating programs including training to equip supervisory staff to be able to lead, coach and support their teams as they implement TIC. Participants felt that training and access to summary materials would be helpful to TIC implementation. In fact, it was ongoing training and integrative activities that made the difference in sustained TIC implementation for the participating programs. These findings align with the most comprehensive synthesis on the use of TIC in programs for people experiencing

homelessness to date (Hopper et al., 2010), which calls for ensuring that policies provide for the funding needed to implement TIC. Furthermore, when programs had access to TIC materials, they were often complex and staff capacity to translate the materials into accessible information and tools for implementation was limited. The necessary levels of staff engagement for TIC implementation are not possible without the use of a model and written guidelines to serve as a foundation of shared knowledge. However, the existing models of TIC vary widely in their thoroughness including whether they incorporate 1) assessment and implementation curriculum, 2) comprehensive training guides and train-the-trainer modules, 3) technical assistance and support, and 4) tool kits (Jennings, 2008). Furthermore, there are few models designed for residential programs serving families experiencing homelessness. In addition to a written model, program participants need free, accessible, brief and clear, supplementary written materials (e.g. tool kits), in order to utilize TIC. Some researchers have provided skeletal summaries of some of the TIC models (Jennings, 2008; Hopper, 2010). However, what would be most helpful to participants are detailed summaries of all the TIC models available so that they can make an informed decision about which model would be the best fit for their organization. In this way, TIC continues to be a construct with ongoing ambiguity around the models and implementation.

The difficulty in measuring the impact of TIC was another barrier to implementation for participating programs since they were unable to articulate the outcomes to funders, who in turn did not want to support service elements of supportive housing that were not evidence-based. Although research on the efficacy of TIC is in its infancy, there are some recommended outcome measures outlined as part of the

Sanctuary® Model as well as some preliminary findings on the impact of TIC, such as a decrease in clients' emotional reactions and crises, an enhanced sense of client safety and increased collaboration among providers (Cocozza et al., 2005; Community Connections, 2002; Morrissey, Ellis, & Gatz, 2005; Vogel, Noether, & Steadman, 2007). More recently, Sullivan & Goodman (2015) developed the Trauma-Informed Practice Scales (TIPS) in order to measure the impact of trauma-informed practice on clients residing in a shelter for survivors of domestic violence. Nevertheless, participants in my study were not aware of these measures nor were they measuring the impact of TIC implementation in any other systematic way.

Participants described a few structures that were at odds with their work to implement TIC. First, specific to residential programs, working with a property management partner organization to operate TH programs served as a barrier to TIC implementation. In this case, the participants described property management partners that did not understand or practice TIC, resulting in inadvertently re-traumatizing clients. In addition to this structural issue, programs also identified external social systems as a structural barrier to TIC implementation. Specifically, when programs refer clients to various social systems in order to get their needs met and these systems are not operating in a trauma-informed manner, clients end up being re-traumatized. Programs do not operate in a vacuum and must partner on many different levels to meet the needs of clients. Therefore, it is not enough for individual programs to practice TIC, TIC must be widely used in the social service sector and social policies must be designed to be trauma-informed.

The loss of funding from government sources for TH and its impact on a program's ability to implement TIC was striking. Various programs reported that the resources for TH have been reduced or flat-funded. It was alarming to hear the stories of staff doing multiple jobs within the program as well as being deployed to other programs or projects within the organization just to sustain their position when the TH funding stream no longer covered their salary. Programs often had supervisors doubling as case managers. One program's staffing ratio was one case manager per 30 families all with significant challenges such as a history of domestic violence or being young single parents. In addition to the loss of funding specifically for TH, the overall lack of resources for programs serving families experiencing homelessness was also a major barrier to TIC implementation. Any loss of staff resulted in a reduced ability to uphold TIC principles.

Although many programs were negatively impacted by reductions in government funding for TH, one program that was not federally funded felt that this allowed them the freedom to be more flexible. They do not have to "jump through the fiery hoops" of the federal government's regulations, which allows them to streamline their administrative burden and focus on client services. The participant that shared this sees the frustration of their peers because they want to be effective, but they are constrained by the funding requirements. Therefore, while government funding allowed for resources to provide TIC, it also created constraints on programs due to compliance requirements.

In addition to funding, external policy and system issues posed formidable barriers to TIC implementation for participants. The issue of government policies

shaping programs to interact with humans as if they are market transactions was raised by one participant,

If TIC means meeting a person where they are and acknowledging the limitations of where their experiences have left them, then we will need to invest time, energy and money into people who might not give us back the responses that government funders expect within the timeframe required.

Dr. Sandra Bloom (2018c) writes, about the need for TIC, “Not only do we human beings...treat ourselves, our systems, and other living things as machines...we act in the world as if we actually understand these machines. We do so by...oversimplifying what are extremely complex...ever-changing processes that are flowing within each...human system...Machines can be ordered...Life is...changeable, unpredictable...though far more complicated than any machine” (Bloom, 2018c). There is a vast divide to bridge between the governmental ethos of human transactions as market transactions and an understanding of TIC as a system to address the complex implications of the impact of trauma.

Some programs that perceived TIC as a priority, felt unable to implement it due to the competing priorities of dealing with the crisis of homelessness including working to secure housing and addressing more pressing client needs. Some programs that had implemented TIC felt that it was the responsibility of the social services staff to practice TIC, while other staff and administrators did not have a substantive role in it. However, the literature on creating trauma-informed organizations is clear that TIC must also extend to the administrative practices of the staff in addition to direct services staff (SAMHSA, 2014).

Facilitative Factors in Trauma-Informed Care Implementation

Leadership from top management was mentioned by several participants from programs that had implemented TIC to some degree, as a key factor in successful TIC implementation. Other researchers have identified leadership and commitment from top management as a necessary condition for developing trauma-informed organizations (Elliott et al., 2005; Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; Hopper et al., 2010; SAMHSA, 2014) as well as a necessary factor in the implementation of any intervention (Damschroder et al., 2009; Aarons & Sommerfeld, 2012). In a study on testing the leadership and organizational change for implementation (LOCI) intervention in a substance abuse treatment intervention, Aarons, Ehrhart, Moullin, Torres, and Green (2017) found that “effective leadership in health services is associated with more positive staff attitudes toward adopting an evidence-based practice, as well as improved staff work attitudes and performance” (p. 9).

Although peer support is one of the six SAMHSA (2014) principles of TIC, only one participant discussed the impact of peer employees as informal leaders in TIC implementation (i.e. employees with lived experience). This participant felt that peer leadership was a significant factor in the success of TIC implementation. One way to achieve an expansion of peer leadership could be to fill any current or future vacant positions with peer employees. In addition to formal and peer leadership, educational background in social work and/or TIC engendered a positive belief about TIC and a level of efficacy around practicing TIC that facilitated TIC implementation. Human service educational institutions would benefit students by instituting a TIC curriculum as part of all programs of study.

In addition to factors related to the inner setting and individual characteristics, the outer setting was integral to a programs' ability to implement TIC. Programs that were more networked with external organizations benefited with respect to TIC implementation. Participants described the power in external networks, both funder and peer networks. These networks can either act as barriers to TIC implementation or can be highly facilitative of positive growth in TIC. However, growth can be slowed or reversed when government funders change course and stop prioritizing TIC, either in the form of funding support or via changes to the standards they set for programs as well as the ways that they are engaged in TIC implementation themselves. Bowen & Murshid (2016) have called for crafting trauma-informed social policies that would better reflect the experience of providers and clients lived experience. Pursuit of trauma-informed social policy would help to build on existing efforts to create trauma-informed programs. However, a trauma-informed social policy would need to extend to the manner in which policies are implemented at the local government level to make a difference for the programs that participated in my study. These local government agencies have discretion in how they implement policies, and this had both a positive and negative impact on the programs ability to fully implement TIC. As summarized in the findings chapter on external implementation factors, one participant provided commentary on the importance of considering the various groups that affect the implementation of social policies,

Does this work on paper to how it gets implemented on the ground and understanding what that means so you could then evaluate where there are opportunities to infuse the trauma-informed care to make the policy or the intervention even more effective. It just feels like there's a disconnect from the

funder to the provider to the client and sometimes even the partners who help to make that process work.

There were connections between participants' understanding of TIC, the practices used and factors that helped or hindered implementation. Participants struggled to understand how TIC was different from good social work practice. Furthermore, some participants did not believe that funders understood TIC either: "the funders have absolutely no idea what TIC means, what it looks like and what it entails." Although participants have a desire to implement TIC, there are currently insurmountable barriers including the inaccessibility of the models available, detrimental government social policies and the lack of resources needed for this work. This research confirmed much of what Hopper et al. (2010) found in one of the most comprehensive reviews of existing evidence for the use of TIC in programs for people experiencing homelessness, namely, the need for trauma-informed homeless service policies supported by the broader systems that guide homeless services; the need for adequate funding to do the work of TIC implementation and program policies to support the prevention of re-traumatization. However, this research extended the research of Hopper et al. (2010) by identifying the importance of external funder and peer networks as well as the importance of leadership engagement to TIC implementation.

Overall, this research provides support for the three types of implementation and their effectiveness outlined by the National Implementation Research Network in a brief on effective implementation (NIRN, 2016): "letting it happen", "helping it happen", and "making it happen." The first level of implementation, "letting it happen", is simply sharing information about innovations. The second level of implementation, "helping it

happen”, includes providing tools and training to support implementation and the third level of implementation, “making it happen”, entails offering support to implement the intervention as intended. A combination of “letting it happen and helping it happen” result in only 5-15% use of the interventions as intended whereas “making it happen” or “active implementation” can result in upwards of 80% use of the interventions as intended (NIRN, 2016). The programs in my study that seemed to have implemented TIC most deeply are the programs that were “making it happen” by not only accessing information about TIC and providing tools and training to staff in support of TIC implementation, but also offering ongoing support via supervisors or consultants to fully implement TIC.

Limitations of Research

There were several limitations to this research related to both internal factors including the sampling method, research design, and data analysis, as well as external issues. First, there were several issues related to my sample. Participation was limited by federal and state policy changes, taking place at the same time of this research, which resulted in the closure and/or reduction in staffing for some TH programs. A handful of programs declined participation because they were closing their programs due to being defunded or because the funding cuts left them so leanly staffed that participation could not be prioritized. Retrospectively, widening the sampling frame to include other types of supportive housing for families experiencing homelessness may have resulted in a richer data set. In addition to the loss of TH beds due to funding cuts, there has been an increase in the diversity of supportive housing interventions for families experiencing homelessness over the past several years with the advent of rapid rehousing. I could have

expanded the types of supportive housing in the sampling frame such as rapid-rehousing and permanent supportive housing for families.

Because only about a third of the programs felt that they fully implemented TIC and another third had partially implemented it, there was a limited range of TIC expertise. However, regardless of whether or not and to what degree programs had implemented TIC, their perspectives on barriers to TIC implementation was informative. Perhaps if I would have included only programs that purported to use TIC, I may have gotten more depth of understanding about the use of TIC in these programs. Restricting inclusion criteria to the supportive housing type of TH and including programs that did not implement TIC likely resulted in a restricted range of understanding of the matters under investigation.

Another problem related to my sample was the inclusion of staff that had a short tenure with the program. Retrospectively, I could have excluded staff that had not worked at the organization for some minimum amount of time since a lack of tenure seemed to be a limiting factor in terms of the participants' ability to articulate the agencies understanding of TIC. In addition, there was a limited range of staff roles represented among participants, with almost all being management or case managers. There was no participation by facilities staff, which is a major component of TH programs, and little to no participation among other support staff and para-professionals. The low levels of participation among these staff roles may have been related to the use of email as the method for recruitment since they often do not entail sitting at a desk or frequently accessing email. Perhaps asking administrators to post flyers about the research with a contact phone number would have been more effective.

There were also several issues related to my research design. I did not gather any demographic information about the participants. Therefore, I do not know whether the sample was diverse with respect to age, race, ethnicity, gender, educational background, or other categories. However, demographic data at the county level could be used for further analysis. In addition, the survey question about the type of geographic classification was based on participant self-report and the options were urban, suburban, rural, mixed and other. Participants may have been responding based on the specific location of their program rather than the overall county. Alternatively, I could have used an existing classification system for PA state counties. However, allowing participants to self-define their geographic classification may provide more detail about their specific geographic experience. Although I collected several categories of survey data, I used it primarily for inclusion and exclusion criteria. Therefore, there are additional analyses that can be done using the program components and goals, the number of transitional housing units at a point-in-time, the average length of stay, the physical structure of the housing, and target population.

During the interview process, I initially gave the participants a written copy of the TIC definitions script. This may have prompted them to use the script as a guide to answer some of the questions. After 16 of the 35 interviews, I discontinued sharing the written script due to some participants' references to the script when answering the question about how they understood TIC, which was always asked before I read the script out loud to the participant. I subsequently only read the script out loud without sharing a hard copy of the script. I coded all incidents where participants referenced the script when answering a question, whether or not they had received a written script, in order to

track the impact of the script. The TIC script was referenced by seven participants overall, four of whom were in the group of 16 participants that were given the written script in advance and three from the group that did not receive the written script. Therefore, it does not appear that the written script had that much of an influence on whether or not participants referenced the content of the script in their response. However, participants who received the written script may have tried to align their feedback with the information in the script.

In addition to the potential impact of the written script, because of my experience in the field and associated ability to understand industry shorthand, I missed some opportunities to ensure that my understanding of participant responses was accurate by asking clarifying questions. I did not realize this pattern until I listened to the audio recordings of the interviews, which was not until most of the interviews were completed since I had to prioritize follow up, scheduling and carrying out the interviews in this particular phase of the research. In order to mitigate the potential impact of any misinterpretation, I hosted a post-research webinar and posed a range of questions, some of which served to clarify and expound on participant interview responses. Overall, I could have more frequently asked participants to clarify how each TIC-related practice that they discussed was connected to the elements of TIC.

The phone was an impediment during the interviews as I could not read body language, was not sure if participants were distracted, was not as able to build rapport as well as an in-person interview would have afforded and had some poor phone connections that resulted in lags that impacted the spontaneity and clarity of the conversations. For example, I sometimes asked another question when a participant

veered off topic to redirect them back to the question or to the next topic if they had already answered. However, this may have cut off valuable data. This was hard to gauge during the interview since I could not see the person. Consequently, the data may have been richer if I had allowed the participants more time to respond even if the response was tangential. However, the post-research webinar gave another opportunity for participants to clarify specific points and to provide additional feedback.

There also were a few limitations related to the data analysis process. First, although I coded each interview twice, I did not utilize an independent coder due to time limitations and financial constraints. Second, it was hard to separate my own knowledge of TIC utilization in programs for families experiencing homelessness from the participant data. In order to address this issue, I frequently went back to the source data when writing up the findings and drawing conclusions to ensure that I was not mixing in my own experience.

Nonetheless, despite these limitations, this study provides important insight into the state of TIC utilization in TH programs for families experiencing homelessness. The use of TIC within TH programs for families experiencing homelessness is a complicated and largely unexplored topic, albeit an important one. Before this study, there were few studies on this topic that investigated the lived experience of providers in TH programs.

Recommendations for Future Research

Participants noted the overlap between “practicing strengths-based, empowering social work and trauma-informed” care; “some of the things that you call trauma-informed are also essential social work values, strengths-based, inclusivity, empowerment, those are not, in my estimation exclusive to trauma-informed care, it’s

just sort of social work's best practice.” Future research could further delineate specific practice elements of TIC and compare them to elements of social work practice to clearly outline the unique elements of TIC.

Furthermore, the field would benefit from a careful comparison of all available models of TIC to make it easier for programs to select a model that fits their specific organization. One executive commented that there needs to be a greater range of available TIC intervention sources to guide implementation because “one size does not fit all” and there were programs that did not feel that the Sanctuary® Model would work for them although that was the only model presented and supported by one of their funding agencies. The Sanctuary® Model was the primary intervention source discussed by the participants as a whole with one exception. Therefore, TIC implementation seemed to be limited by the knowledge of available models. There is also a need for adaptation of the models to create tools to make it easier for programs to implement TIC. One participant discussed the uncertainty as to whether staff could learn and practice the model and felt that they would need more “user-friendly tools” accessible to all program staff.

Finally, there is a need for effectiveness studies of models of TIC in programs for families experiencing homelessness. This type of study could compare programs for families experiencing homelessness that practice TIC against programs that do not practice TIC, measuring for client outcomes related to housing stability and wellness. In a study such as this, it would be important to comprehensively document the types and intensity of services offered and the specific TIC model and practices utilized. One of the perennial problems with research on the effectiveness of transitional housing programs is the lack of standardized service models (Burt, 2010). Similarly, TIC has been

implemented without the use of comprehensive standardized models (Hopper et al., 2010), as was the case in this research where programs were using TIC tools or practices but not the full model due to time and resource constraints. Therefore, they were only partially practicing TIC. For example, when asked about whether they had implemented TIC, some participants described implementing bits and pieces of TIC but not the entire framework or not to the extent that they felt they needed to.

Implications for Policy and Practice

The majority of clients in the human service system are trauma survivors and specifically, families experiencing homelessness suffer high levels of trauma (Elliott et al., 2005). In the current study, participants described the trauma that discrimination and oppression have on program participants who are already negatively impacted by various traumatic experiences. These high levels of trauma paired with support in the literature and endorsement by participants in this study for the use of TIC in residential programs for families (Elliott et al., 2005; Menschner & Maul, 2016; Guarino & Bassuk, 2010; Hopper et al., 2010; Bloom, 2013) indicates a need for universal use of TIC in TH for families. The use of TIC could serve to begin to address some of the impacts of cultural, gender and historical trauma related to oppression and structural racism, within a population that has experienced many forms of trauma. However, TIC is not fully understood by practitioners and implementation supports are lacking.

The current research study underscores the lack of TIC definition, including how to put it into practice and how to measure whether a program is trauma-informed. Practitioners in the current research study were striving to implement TIC without having a clear understanding of what TIC means for programs serving homeless families or how

to implement it. Even participants that answered yes to the question about whether they had implemented TIC, had not always implemented it fully as evidenced by their interview responses taken as a whole. In order to address this issue, government funders would need to prioritize TIC so that practitioners can secure the resources needed to understand and implement TIC effectively. In addition, participants were not aware of outcome measures for TIC nor were they measuring the impact of TIC implementation in any systematic way. The use of outcome measures to assess the impact of TIC could help programs to understand how their efforts to practice TIC impacts clients. To that effect, there are a few measures freely available (Bloom, 2013; Sullivan & Goodman, 2015) that can be utilized by programs to start to measure the impact of their efforts to implement TIC.

In terms of practices that contribute to TIC, flexibility was a common thread in participants' description of practices. The themes of "bending the rules" and balancing boundaries were examples of the gray areas that participants had to navigate as they sought to promote empowerment, voice, and choice. Historically, TH offered more flexibility in the length of stay and program elements and according to participants in this study, this was beneficial to TIC implementation. It has been more challenging for programs to offer flexibility recently because they are forced to comply with more restrictive funder requirements, some of which conflict with the flexibility that seems to be core to creating a culture of TIC.

Of the six principles that TIC practices are based on (SAMHSA, 2014), the least noted practices in my study were in the categories of peer support and cultural, historical, and gender inclusivity. The need to address cultural and historical issues as part of TIC

remains unmet seemingly due to the shortcoming of existing TIC models. The most frequently used model of TIC noted by my participants was the Sanctuary® Model, which does not have a specific focus on cultural, historical and gender inclusivity or peer support. TIC models would benefit from enhancements to address these critical areas of focus. However, TIC models are not “cookbooks” proscribing a set of actions, but frameworks that programs can use to guide practices that engender TIC. Participants use of practices to enact TIC were varied and defied a rigid set of proscriptions.

Separate from the practices that I expected to find directly linked to the six principles underlying TIC, various non-TIC specific practice approaches were identified by participants as being related to TIC. These emergent findings include the link between TIC and mindfulness, non-violent communication, motivational interviewing, *Bridges out of Poverty*, and the housing first approach (DeVol & Smith, 2001). Additionally, the attributes of empowerment practice (Gutiérrez et al, 1995), a practice utilized by virtually all domestic violence service providers, are highly aligned with many of the TIC principles and assumptions outlined by participants such as trustworthiness and transparency and collaboration and mutuality. Therefore, the literature on residential programs for domestic violence survivors provides support to practitioners for understanding TIC and strategies for implementation. Additionally, the emergent practices noted above serve as additional tools for practitioners to enact TIC.

Participants described a few structures that were at odds with their work to implement TIC. One of these structures was specific to residential programs and occurs when there is a separate property management organization operating the housing portion of the TH while another organization operates the services. In this case, the participant

service providers described the property management partners as not understanding or practicing TIC, resulting in inadvertently re-traumatizing clients. TH programs that partner with an external property management partner need to develop a plan for training and support if TIC is to be effectively implemented.

Leadership from the top was a key factor in successful TIC implementation as well as peer leadership. Leaders must dedicate time and effort to practice TIC and model the culture if TIC is to be fully implemented. Additionally, in order to increase peer leadership, programs could fill current and future vacant staff positions with peer employees.

I utilized Bronfenbrenner's (1992) Bioecological Systems Theory to expand the CFIR framework by accentuating the ways that various external factors impact TIC implementation (Appendix J). In this way, the bioecological systems theory codes are a helpful heuristic framework for understanding the broad range of external factors that impinge on the programs ability to implement TIC.

Organizational growth in practicing TIC can be slowed or reversed when government funders change course and stop prioritizing TIC, either in the form of funding support or via changes to the standards they set for programs and/or the ways that they have engaged in TIC implementation themselves. The government and other funders would benefit from prioritizing TIC practices within programs for families experiencing homelessness including providing funding support. Furthermore, funders of residential programs for families should offer more flexibility in how their funding can be utilized so that programs are able to fully implement TIC.

More broadly, it is time to call for the use of a trauma-informed framework in the design of social policies. Providers are keenly aware of the limitations of their practices when clients are sent out into systems that are re-traumatizing. There is a vast divide to be bridged between the governments' ethos of human transactions as market transactions and an understanding of TIC as a system to address the complex implications of the impact of trauma.

This study investigated exploratory questions about providers' understanding and utilization of trauma-informed care (TIC) in transitional housing (TH) programs for families experiencing homelessness. Specifically, my research questions were, 1) How do providers understand TIC? 2) What staff behaviors and program attributes are linked to TIC practice? 3) What are the barriers to implementing TIC? and 4) What are the factors that help to facilitate TIC? There were very few studies focused on the use of TIC in TH programs for families. Therefore, this study helps to fill a considerable gap in the state of knowledge on the use of TIC within TH programs for families experiencing homelessness. Participants understood TIC both as a broad philosophical framework and a conglomeration of social work practices combined with a deeper understanding of trauma theory. In order to embody TIC, participants had to navigate "bending the rules" and balancing boundaries to achieve a high level of flexibility necessary to TIC implementation.

In addition to understanding and practicing TIC, programs had to overcome a myriad of barriers related to the TIC intervention characteristics, the program's inner setting, outer setting factors, characteristics of individual practitioners, and process elements of implementation. TIC implementation was limited by the few accessible TIC

models to equip organizations with the tools needed to understand and implement TIC.

Leadership from the top, including board and senior management level leaders, was a key inner setting factor in successful TIC implementation. The outer setting was integral to a programs' ability to implement TIC with government funding agencies having both positive and negative influences on TIC implementation. One of the most influential personal characteristics of practitioners that promoted TIC implementation was having a formal social work, trauma-specific or related higher education. In terms of process level factors that supported TIC implementation, frequent and ongoing staff training as well as activities that complement and reinforce the training were most helpful. The theme that cut across all of the barriers and facilitators of TIC implementation was the need for financial resources to support this important work.

This study underscored the critical importance of working across ecological levels using a trauma-informed lens. It is not enough for individual programs to practice TIC, TIC must be widely used in unison across agencies, systems, and structures within the social service sector and social policies must be designed to be trauma-informed.

REFERENCES

- Aarons, G. A. (2004). Mental health provider attitudes toward adoption of evidence-based practice: The evidence-based practice attitude scale (EBPAS). *Mental Health Services Research, 6*(2), 61-74.
- Aarons, G. A., & Sommerfeld, D. H. (2012). Leadership, innovation climate, and attitudes toward evidence-based practice during a statewide implementation. *Journal of the American Academy of Child & Adolescent Psychiatry, 51*(4), 423.
- Aarons, G. A., Ehrhart, M. G., Moullin, J. C., Torres, E. M., & Green, A. E. (2017). Testing the leadership and organizational change for implementation (LOCI) intervention in substance abuse treatment: A cluster randomized trial study protocol. *Implementation Science, 12* doi:<http://dx.doi.org/10.1186/s13012-017-0562-3>
- Atlas.ti8. (2018). *Atlas.ti8: Qualitative data analysis*. Retrieved from <https://atlasti.com/>
- Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist, 37*(2), 122.
- Bassuk, E. L. (2010). Ending child homelessness in America. *American Journal of Orthopsychiatry, 80* (4), 496-504.
- Bassuk, E. L., Weinreb, L.F., Buckner, J.C., Browne, A., Salomon, A., & Bassuk, S.S. (1996). The characteristics and needs of sheltered homeless and low-income housed mothers. *The Journal of the American Medical Association, 276* (8), 640-646.
- Bassuk, E. L., DeCandia, C. J., Tsertsvadze, A., & Richard, M. K. (2014). The effectiveness of housing interventions and housing and service interventions on

ending family homelessness: A systematic review. *American Journal of Orthopsychiatry*, 84 (5), 457-474.

Bassuk, E. L., Decandia, C. J., & Richard, M. S. (2015). Services matter: How housing and services can end family homelessness. The Bassuk Center on Homeless and Vulnerable Children and Youth.

Berman, F. (2016). Transitional housing for survivors of domestic and sexual violence: A 2014-15 snapshot. *American Institute for Research-National Center on Family Homelessness*.

Bindseil, K., & Kitchen, K. (2017). Mindfulness and Social Work. *Social Work Treatment: Interlocking Theoretical Approaches*, 325.

Birken, S. A., Powell, B. J., Presseau, J., Kirk, M. A., Lorencatto, F., Gold, N. J., ...Damschroder, L. J. (2017). Combined use of the consolidated framework for implementation research (CFIR) and the theoretical domains framework (TDF): A systematic review. *Implementation Science*. Advance online publication. doi: 10.1186/s13012-016-0534-z

Bloom, S. L. (2018a). Building bridges between trauma-informed & trauma specific: Trauma responsive programs. *The Sanctuary® Model*. Retrieved from <http://sanctuaryweb.com/PublicHealth/Trauma-ResponsivePrograms.aspx>

Bloom, S. L. (2018b). The seven sanctuary commitments. *The Sanctuary® Model*. Retrieved from <http://sanctuaryweb.com/TheSanctuaryModel/THESANCTUARYMODELFOURPILLARS/Pillar2SharedValues.aspx>

- Bloom, S. L. (2018c). *Sanctuary philosophy*. Retrieved from <http://sanctuaryweb.com/TheSanctuaryModel/WHOWEARE/SanctuaryPhilosophy.aspx>
- Bloom, S. L. (2018d). Trauma-informed, trauma responsive culture. *The Sanctuary® Model*. Retrieved from <http://sanctuaryweb.com/PublicHealth/Trauma-ResponsivePrograms/TheSanctuaryModelTrauma-Informed,Trauma-ResponsiveCulture.aspx>
- Bloom, S. L. (2013). *Creating sanctuary: Toward the evolution of sane societies*. Routledge.
- Bloom, S. L., & Farragher, B. (2011). *Destroying sanctuary: The crisis in human service delivery systems*. New York, NY: Oxford University Press.
- Bloom, S. L., Foderaro, J.F., Ryan, R. A. (2006) *S.E.L.F.: A trauma-informed psychoeducational group curriculum*.
- Bowen, E. A. & Murshid, N. S. (2016). Trauma-informed social policy: A conceptual framework for policy analysis and advocacy. *Perspectives from the Social Sciences*, 106 (2), 223-229.
- Brett, E. A. (2007). The classification of posttraumatic stress disorder. In van der Kolk, B.A., McFarlane, A.C., & Weisaeth, L. (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society* (pp. 117-128). New York, NY: The Guilford Press.
- Bronfenbrenner, U. (1992). Ecological systems theory. In Bronfenbrenner, U., (2005; Ed.), *Making Human Beings Human: Bioecological Perspectives on Human Development* (pp. 106-173). Thousand Oaks, CA: Sage Publications, Inc.

- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.
- Brush, B. L., Gultekin, L. E., Dowdell, E. B., Saint Arnault, D. M., & Satterfield, K. (2017). Understanding trauma normativeness, normalization, and help seeking in homeless mothers. *Violence against Women*, 1077801217738583.
- Buckner, J. C. (2014). The why and the who of family homelessness. In M.E. Haskett, S. Perlman, B.A. Cowan (Eds.), *Supporting Families Experiencing Homelessness: Current Practices and Future Directions* (pp. 3-21). New York, New York: Springer.
- Burt, M. (2001). What will it take to end homelessness?. *Urban Institute*. Retrieved from <https://www.urban.org/research/publication/what-will-it-take-end-homelessness>
- Burt, M. R. (2007). Understanding homeless youth: Numbers, characteristics, multisystem involvement, and intervention options. *Testimony delivered before the US House Committee on Ways and Means Subcommittee on Income Security and Family Support*.
- Burt, R. S. (2010). *Neighbor networks: Competitive advantage local and personal*. Oxford University Press.
- Busch, N. B., & Valentine, D. (2000). Empowerment practice: A focus on battered women. *Affilia*, 15(1), 82-95.
- California Evidence-Based Clearinghouse for Child Welfare. (2018). *Trauma treatment; System level programs*. Retrieved from <http://www.cebc4cw.org/topic/trauma-treatment-system-level-programs-child-adolescent/>

- Calton, J., & Cattaneo, L. B. (2014). The effects of procedural and distributive justice on intimate partner violence victims' mental health and likelihood of future help-seeking. *American journal of orthopsychiatry*, 84(4), 329.
- Cattaneo, L. B., & Chapman, A. R. (2010). The process of empowerment: a model for use in research and practice. *American Psychologist*, 65(7), 646.
- Cattaneo, L. B., & Goodman, L. A. (2010). Through the lens of therapeutic jurisprudence: The relationship between empowerment in the court system and well-being for intimate partner violence victims. *Journal of Interpersonal Violence*, 25(3), 481-502.
- Center for Health Care Strategies, Inc. (2016, April). Key ingredients for successful trauma-informed care implementation. Hamilton, NJ: Menschner, C. & Maul, A.
- Cho, J. Y., & Lee, E. H. (2014). Reducing confusion about grounded theory and qualitative content analysis: Similarities and differences. *The qualitative report*, 19(32), 1-20.
- Clark, H. W., & Power, A. K. (2005). Women, co-occurring disorders, and violence study: A case for trauma-informed care. *Journal of Substance Abuse Treatment*, 28(2), 145-146.
- Clervil, R., Guarino, K., DeCandia, C. J., & Beach, C. A. (2013). *Trauma-informed care for displaced populations: A guide for community-based service providers*. Waltham, MA: The National Center on Family Homelessness, a practice area of American Institutes for Research Health and Social Development Program.

Cocozza, J. J., Jackson, E. W., Hennigan, K., Morrissey, J. P., Reed, B. G., Fallot, R., &

Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma:

Program-level effects. *Journal of Substance Abuse Treatment*, 28(2), 109-119.

Community Connections. (2002). *Trauma and abuse in the lives of homeless men and*

women. Online PowerPoint presentation. Washington, D.C. Retrieved from

<http://www.pathprogram.samhsa.gov/ppt/Traumaand Homelessness>. Ppt

Community Meeting. (2018). *Community meeting: The Sanctuary® Model*. Retrieved

from

<http://sanctuaryweb.com/TheSanctuaryModel/THESANCTUARYMODELFOUR>

PILLARS/Pillar4SharedPractice/TheSanctuaryToolkit/CommunityMeeting.aspx

Consolidated Framework for Implementation Research. (2009). Retrieved from

<https://cfirguide.org/>

Creswell, J. W. (2013). Steps in conducting a scholarly mixed methods study.

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery,

J. C. (2009). Fostering implementation of health services research findings into

practice: A consolidated framework for advancing implementation science.

Implementation Science. Advance online publication. doi:10.1186/1748-5908-4-

50

DeCandia, C. J. & Guarino, K. (2015). Trauma-informed care: An ecological response.

Journal of Child and Youth Care Work, 7-32.

DeCandia, C. J., Guarino, K., & Clervil, R. (2014). Trauma-informed care and trauma-

specific services: A comprehensive approach to trauma intervention. *Waltham,*

MA: The National Center on Family Homelessness.

Department of Health and Human Services. (2018). *Trauma-informed organizational toolkit for homeless services*. Retrieved from

https://www.air.org/sites/default/files/downloads/report/Trauma-Informed_Organizational_Toolkit_0.pdf

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Glover Reed, B. (2005).

Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, 33 (4), 461-477.

Elwyn, L. J., Esaki, N., & Smith, C. A. (2015). Safety at a girls secure juvenile justice facility. *Therapeutic Communities: The International Journal of Therapeutic Communities*, 36(4), 209-218.

Family Options Study Webinar. (2016). Retrieved from

<https://www.youtube.com/watch?v=wZZPx06ayRw&app=desktop>

Family Provider Services Network. (2016). *People's emergency center*. Retrieved from

<https://www.pec-cares.org/leadership1.html>

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V.,

& Marks, J. S. (1998). Relationship of childhood abuse and household

dysfunction to many of the leading causes of death in adults: The Adverse

Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*,

14(4), 245-258.

Finkelstein, N., Rechberger, E., Russell, L. A., VanDeMark, N. R., & Noether, C. D.

(2005). Building resilience in children of mothers who have co-occurring

disorders and histories of violence. *The Journal of Behavioral Health Services and Research*, 32 (2), 141-154.

Fitzpatrick, K. M., LaGory, M. E., & Ritchey, F. J. (1999). Dangerous places: Exposure to violence and its mental health consequences for the homeless. *American Journal of Orthopsychiatry*, 69(4), 438-447.

Fixsen, D. L., Naoom, S. G., Blasé, K. A., Friedman, R. M. & Wallace, F. (2005). Implementation research: A synthesis of the literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Flatow, R. B., Blake, M., & Huang, L. N. (2015). SAMHSA's concept of trauma and guidance for a trauma-informed approach in youth settings. *Focal Point: Youth, Young Adults, & Mental Health*, 29, 32-35.

Goodman, L., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma: Broadening perspectives. *American Psychologist*, 46 (11), 1219-1225.

Grant, R., Gracy, D., Goldsmith, G., Shapiro, A., & Redlener, I. E. (2013). Twenty-five years of child and family homelessness: Where are we now? *American Journal of Public Health*, 103 (S2), e1-e10.

Greenhalgh, T., Robert, G., MacFarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *The Milbank Quarterly*, 82 (4), 581-629.

Guarino, K. M. (2014). Trauma-informed care for families experiencing homelessness.

In M.E. Haskett, S. Perlman, B.A. Cowan (Eds.), *Supporting Families*

Experiencing Homelessness: Current Practices and Future Directions (pp. 121-143). New York, New York: Springer.

Guarino, K., & Bassuk, E. (2010). Working with families experiencing homelessness.

Journal of Zero to Three: National Center for Infants, Toddlers, and Families, 30 (3), 11-20.

Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). Trauma-informed organizational toolkit. *Center for Mental Health Services, Substance Abuse and Mental Health Administration, and the Daniels Fund, the National Child Traumatic Stress Network and the WK Kellogg Foundation*, Rockville, MD,(www.familyhomelessness.org/media/90.pdf).

Guarino, K., Rubin, L., & Bassuk, E. (2007). Trauma in the lives of homeless families.

Trauma psychology: Issues in Violence, Disaster, Health, and Illness, Vol 2: Health and Illness. (pp. 231-258) Praeger Publishers/Greenwood Publishing Group, Westport, CT.

Gubits, D., Shinn, M., Wood, M., Bell, S., Dastrup, S., Solari, C. D., ...Kattel, U. (2016).

Family options study: 3-year impacts of housing and services interventions for homeless families. U.S. Department of Housing and Urban Development, Office of Policy Development and Research.

Gutiérrez, L. M., DeLois, K. A., & GlenMaye, L. (1995). Understanding empowerment

practice: Building on practitioner-based knowledge. *Families in Society*, 76(9), 534-542.

Harris, M. E., & Fallot, R. D. (2001). *Using trauma theory to design service systems*.

Jossey-Bass.

Hayes, M. A., Zonneville, M., & Bassuk, E. (2013). The SHIFT study: Final report.

Needham, MA: The National Center on Family Homelessness.

Health Care for the Homeless. (2010). *Healing hands*. National HCH Clinician's

Network. Retrieved from

<https://www.nhchc.org/resources/publications/newsletters/healing-hands/>

Herbers, J. E., & Cutuli, J. J. (2014). Programs for homeless children and youth: A

critical review of evidence. In M.E. Haskett, S. Perlman, B.A. Cowan (Eds.),

Supporting Families Experiencing Homelessness: Current Practices and Future

Directions (pp. 187-207). New York, New York: Springer.

Herman, J. (1997, 2015). *Trauma and recovery*. New York, NY: Basic Books.

Hettema, J., Steele, J., & Miller, W. R. (2005). Motivational interviewing. *Annual Review*

of Clinical Psychology, 1, 91-111.

Hopper, E. K., Bassuk, E. L., & Oliver, J. (2010). Shelter from the storm: Trauma-

informed care in homelessness services settings. *The Open Health Services and*

Policy Journal, 3, 80-100.

Hsieh, H. F. & Shannon, S. E. (2005). Three approaches to qualitative content analysis.

Qualitative Health Research, 15 (9), 1277-1288.

Institute for Children, Poverty, and Homelessness. (2010). *Boomerang homeless families:*

Aggressive rehousing policies in New York City. Retrieved from

<http://media.globenewswire.com/cache/12947/file/8434.pdf>

Institute for Children, Poverty, and Homelessness. (2009). *A home by any other name:*

Enhancing shelters addresses the gap in low-income housing report. Retrieved

from

http://www.icphusa.org/filelibrary/ICPH_PolicyBrief_AHomeByAnyOtherName.pdf

- Jennings, A. (2008). Models for developing trauma-informed behavioral health systems and trauma-specific services: 2008 update. *Alexandria, VA: National Center for Trauma-Informed Care.*
- Joseph, J. (2015). *Carl Roger's person-centered approach.* Psychology Today. Retrieved from <https://www.psychologytoday.com/us/blog/what-doesnt-kill-us/201503/carl-rogers-person-centered-approach>
- Joseph, S., & Murphy, D. (2014). Trauma: A unifying concept for social work. *The British Journal of Social Work, 44*(5), 1094-1109.
- Karnas, F. (2007). Comment on Dennis P. Culhane et al.'s "Testing a typology of family homelessness based on patterns of public shelter utilization in four US jurisdictions: Implications for policy and program planning".
- Katz, M. B. (2013). *The undeserving poor: America's enduring confrontation with poverty.* New York, NY: Oxford University Press.
- Kawam, E., & Martinez, M. J. (2016). What every social worker needs to know: Trauma-informed care in social work. *The New Social Worker.* Retrieved from <https://www.socialworker.com/feature-articles/practice/trauma-informed-care-in-social-work/>
- Kilmer, R. P., Cook, J. R., Crusto, C., Strater, K. P., & Haber, M. G. (2012). Understanding the ecology and development of children and families experiencing homelessness: Implications for practice, supportive services, and policy. *American Journal of Orthopsychiatry, 82* (3), 389-401.

- Kimberly, D., & Parsons, R. (2017). Trauma-informed social work treatment and complex trauma. *Social Work Treatment: Interlocking Theoretical Approaches*, 6, 553-585.
- Kirschenbaum, H., & Jourdan, A. (2005). The current status of Carl Rogers and the person-centered approach. *Psychotherapy: Theory, Research, Practice, Training*, 42(1), 37.
- Knight, C. (2015). Trauma-informed social work practice: Practice considerations and challenges. *Clinical Social Work Journal*, 43, 25-37.
- Levenson, J. (2017). Trauma-informed social work practice. *Social Work*, 62(2), 105-113.
- Lum, D. (1996). *Social work practice and people of color: A process-stage approach*. Pacific Grove, CA: Brooks.
- McKinney-Vento Homeless Assistance Act. (2009). As amended by S. 896, The Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009.
- Menschner, C., & Maul, A., (2016). "Key ingredients for successful trauma-informed care implementation," *Center for Health Care Strategies*. Retrieved from <http://www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation>
- Morrissey, J. P., Ellis, A. R., Gatz, M., Amaro, H., Reed, B. G., Savage, A., ... & Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program and person-level effects. *Journal of Substance Abuse Treatment*, 28(2), 121-133.

Morrissey, J. P., Jackson, E. W., Ellis, A. R., Amaro, H., Brown, V. B., & Najavits, L. M.

(2005). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services*, 56 (10), 1213-1222.

Moses, D. J., Huntington, N., & D'Ambrosio, B. (2004). Developing integrated services for women with co-occurring disorders and trauma histories. Retrieved February, 1, 2010.

National Alliance to End Homelessness. (2014). *RRH core elements brief*. Retrieved from <https://safehousingpartnerships.org/sites/default/files/2017-01/RRH%20Core%20Elements%20Brief.pdf>

National Association of Social Workers. (2017a). *Code of ethics*. NASW Delegate Assembly.

National Association of Social Workers. (2017b). History of social work. NASW Delegate Assembly. Retrieved from <https://www.socialworkers.org/News/Facts/Social-Work-History>

National Association of Social Workers. (2017c). *Preamble: Mission of the social work profession*. NASW Delegate Assembly.

National Association of Social Workers. (2017d). *Social work case management*. NASW Delegate Assembly.

National Association of Social Workers. (2017e). Social work practice sub-specialties. NASW Delegate Assembly. Retrieved from <https://www.socialworkers.org/Practice>

- National Center on Family Homelessness. (2011). *The characteristics and needs of families experiencing homelessness*. Newton, MA. Retrieved from <http://files.eric.ed.gov/fulltext/ED535499.pdf>
- National Center for Homeless Education. (2018). The McKinney-Vento definition of homeless. Retrieved from <https://nche.ed.gov/mckinney-vento-definition/>
- National Implementation Research Network. (2016, October). Active implementation practice and science (Issue Brief). Chapel Hill, NC.
- National Law Center on Homelessness and Poverty. (2017). Housing. Retrieved from <https://nlchp.wpengine.com/housing/>
- Niemiec, R. (2017). 3 definitions of mindfulness that might surprise you. *Psychology Today*, 2017, Retrieved from <https://www.psychologytoday.com/us/blog/what-matters-most/201711/3-definitions-mindfulness-might-surprise-you>
- Network for Public Health Law. (2016). *Domestic violence and homelessness: Issue brief*. Retrieved from https://www.networkforphl.org/_asset/71kcnk/Domestic-Violence-Housing-Issue-Brief.pdf
- Nunez, R. D. C. (2010). *A shelter is not a home...or is it? Family homelessness in New York City*. New York, NY: White Tiger Press.
- Nunez, R. D. C., & Adams, M. (2014). Primary stakeholders' perspectives on services for families without homes. In M.E. Haskett, S. Perlman, B.A. Cowan (Eds.), *Supporting Families Experiencing Homelessness: Current Practices and Future Directions* (pp. 209-232). New York, New York: Springer.
- Ohio Mental Health and Addiction Services. (2016). *Ohio trauma-informed care assessment tool*. Retrieved from

<https://mha.ohio.gov/Portals/0/assets/Initiatives/HumanTrafficking/2013-is-your-work-trauma-informed.pdf>

Oliva, A. M. (2013). *SNAPS weekly focus: What about transitional housing?*. HUD Exchange. Retrieved from <https://www.hudexchange.info/news/snaps-weekly-focus-what-about-transitional-housing/>

Padgett, D. K. (2008). *Qualitative methods in social work research, Second edition*. Thousand Oakes, CA: Sage Publications, Inc.

Payne, R. K., DeVol, P. E., & Smith, T. D. (2001). *Bridges out of poverty: Strategies for professionals and communities*. Aha Process Inc.

Person-Centered Therapy. (2018). *Psychology Today*. Retrieved from <https://www.psychologytoday.com/us/therapy-types/person-centered-therapy>

Phillips, H., Lyon, E., Fabri, M., & Warshaw, C. (2015). Promising practices and model programs: Trauma-informed approaches to working with survivors of domestic and sexual violence and other trauma. *National Center on Domestic Violence, Trauma & Mental Health, 39*.

Prescott, L., Soares, P., Konnath, K., & Bassuk, E. (2008). A Long Journey Home A Guide for Creating Trauma-Informed Services for Mothers and Children Experiencing Homelessness.

Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation research in mental health services: an emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health and Mental Health Services Research, 36*(1), 24-34.

Public Health Management Corporation. (2013). *Findings from the Philadelphia urban*

ACE study. Retrieved from

<https://www.instituteforsafefamilies.org/sites/default/files/isfFiles/Philadelphia%20Urban%20ACE%20Report%202013.pdf>

Richardson, S. A. (2014). Awareness of trauma-informed care. *Social Work Today*.

Retrieved from https://www.socialworktoday.com/archive/exc_012014.shtml

Roark, D. (1982). *Introduction to philosophy*. Retrieved from

<https://www.emporia.edu/socsci/research-and-teaching-links/philosophy-book/>

Rog, D. J., & Buckner, J. C. (2007, September). Homeless families and children. In

Toward understanding homelessness: The 2007 national symposium on

homelessness research. Washington, DC: US Department of Housing and Urban

Development.

Rog, D. J., McCombs-Thornton, K. L., Gilbert-Mongelli, A. M., Brito, M. C., &

Holupka, S. (1995). Implementation of the homeless families program: 2.

Characteristics, strengths, and needs of participant families. *American Journal of Orthopsychiatry*, 65 (4), 514-528.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality

change. *Journal of Consulting Psychology*, 21(2), 95.

Rosenberg, M., & Chopra, D. (2015). *Nonviolent communication: A language of life:*

Life-changing tools for healthy relationships. Puddle Dancer Press.

Schwartz, A. F. (2015). *Housing policy in the United States*. New York, NY: Routledge.

Shinn, M., Weitzman, B. C., Stojanovic, D., Knickman, J. R., Jimenez, L., Duchon, L., ...

& Krantz, D. H. (1998). Predictors of homelessness among families in New York

City: from shelter request to housing stability. *American Journal of Public Health*, 88(11), 1651-1657.

Shinn, M., Baumohl, J., & Hopper, K. (2001). The prevention of homelessness revisited. *Analyses of Social Issues and Public Policy*, 1(1), 95-127.

Smyth, N. (2013). Trauma-informed social work practice: What is it and why should we care?. *Virtual Connections*. Retrieved from <https://njsmyth.wordpress.com/2013/04/19/trauma-informed-social-work-practice/>

Substance Abuse and Mental Health Services Administration, Office of Policy, Planning and Innovation. (2014a). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. (HHS Publication No. (SMA) 14-4884). Retrieved from <http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf>

Substance Abuse and Mental Health Services Administration. (2014b). *Trauma-informed care in behavioral health services*. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sullivan, C. M., & Goodman, L. (2015). *A guide for using the trauma-informed practice (TIP) scales*. Retrieved from https://vaw.msu.edu/wp-content/uploads/2015/02/Tips_Using_TIPS_Sullivan_Goodman_2015.pdf

Sullivan, C. M., Lopez-Zeron, G., Bomsta, H., & Menard, A. (2018). There's just all these moving parts': Helping domestic violence survivors obtain housing, *Clinical Social Work Journal*, Published online.

Sullivan, C. M., Virden, T., Strom, J., Goodman, L. A., & Ramirez, R. (2018). Evaluation of the effects of receiving trauma-informed practices on domestic violence shelter residents, *American Journal of Orthopsychiatry* 88(5), 563-570.

Sussman, E. (2008). *State violence and the implications for survivors*. Center for Survivor Agency & Justice. Retrieved from <https://us5.campaign-archive.com/?u=58f89a02f55bf512cc8a5f88&id=6ceb6c212c&e=6a1c31c7e2>

Turner, F. J. (Ed.). (2017). *Social work treatment: Interlocking theoretical approaches*. Oxford University Press.

United States Department of Housing and Urban Development. (2017). Part 91—consolidated submissions for community planning and development programs. Retrieved from <https://www.govinfo.gov/content/pkg/CFR-2017-title24-vol1/xml/CFR-2017-title24-vol1-part91.xml>

United States Department of Housing and Urban Development. (2016a). *HUDs continuum of care: Annual performance report*. Retrieved from https://www.hudexchange.info/course-content/hud-s-coc-apr-revised-income-questions-q24a-and-q24b-webinar/FINAL%20CoC%20APR%20Income%20Question%20Revisions_Short_3%2012%2014.pdf

United States Department of Housing and Urban Development. (2016b). *Family options study outcome*. Retrieved from <https://www.youtube.com/watch?v=wZZPx06ayRw&t=6s>

- United States Department of Housing and Urban Development. (2012a). *CoC program interim rule*. Retrieved from <https://www.hudexchange.info/resource/2033/earth-coc-program-interim-rule/>
- United States Department of Housing and Urban Development. (2012b). *HEARTH act implementation updates*. Retrieved from <https://www.hudexchange.info/resource/2837/earth-act-implementation-updates/>
- United States Department of Housing and Urban Development. (2012c). *HUD homeless assistance program: COC 101 manual*. Retrieved from <https://www.hudexchange.info/resources/documents/coc101.pdf>
- United States Department of Housing and Urban Development. (2012d). *Introductory guide to the continuum of care presentation*. Retrieved from <https://www.hudexchange.info/resources/documents/CoCProgramIntroductoryGuide.pdf>
- United States Interagency Council on Homelessness. (2015). *Opening doors: Federal strategic plan to prevent and end homelessness*. Retrieved from https://www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf
- University of South Florida. (2016). *TIC organizational assessment*. Retrieved from http://traumatransformed.org/wp-content/uploads/tia_shift.pdf
- Van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (Eds.). (2007). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York, NY: The Guilford Press.

- Vogel, W. M., Noether, C. D., & Steadman, H. J. (2007). Preparing communities for re-entry of offenders with mental illness: The ACTION approach. *Journal of Offender Rehabilitation, 45*(1-2), 167-188.
- Warshaw, C., Sullivan, C. M., & Rivera, E. A. (2018). *A systematic review of trauma-focused interventions for domestic violence survivors*. Chicago: National Center on Domestic Violence, Trauma & Mental Health. 2013.
- Yanosy, S., Harrison, L. C., & Bloom, S. L. (2011). *Sanctuary® Model implementation guide* (3rd Ed.) New York, NY: The Sanctuary Institute at Andrus.
- Wilson, J. M., Fauci, J. E., & Goodman, L. A. (2015). Bringing trauma-informed practice to domestic violence programs: A qualitative analysis of current approaches. *American journal of orthopsychiatry, 85*(6), 586.
- Wilson, C., Pence, D. M., & Conradi, L. (2013). Trauma-informed care. *Encyclopedia of Social Work, 11*-04.

APPENDICES

Appendix A

Informed Consent for Participation in Research Study

Dissertation Project: Use of Trauma-Informed Care (TIC) in Homeless Programs for Families

Introduction and Purpose of Study

I am a doctoral student in the Ph.D. program at the Bryn Mawr College Graduate School of Social Work and Social Research. This project is part of fulfillment of the requirements of the program to complete a dissertation project. I am inviting programs for families experiencing homelessness to participate in a study to explore the understanding and utilization of trauma-informed care within residential settings.

What is involved?

This project involves a brief survey and a phone interview that will take approximately 30-60 minutes to complete. I will be inviting multiple staff from each program to participate in phone interviews. I will make an audio recording of the interview. I will ask questions about your experience with the utilization of TIC and the types of staff behaviors that contribute to TIC in the program.

Confidentiality:

The information you share will be kept confidential. I will not share information about who participates in this study with anyone, including the program administrator. I will not use your name or any other personal information including information about where you work in the summary of my findings.

Nothing with your name or other identifying information (names and places mentioned in the interview) will be submitted in any written or verbal work product. The only people who will listen to the audio recordings of the interviews are myself and/ or a hired contractor who signs a confidentiality agreement. I will store the audio recordings and transcripts in a password protected computer. Once I have analyzed the interview transcripts and written my final paper for this project, I will destroy the audio recording and any interview notes. The interview transcript will be retained although it will not have any participant identifying information or other names of persons or of institutions/ organizations that you mention in the interview. However, I will include aggregate information about the participating counties and will use the categories of rural, urban, and suburban to write about my findings.

Risks of participating:

The risks of participating are minimal. The ways that confidentiality will be protected have already been described. However, it might be possible for people that are briefed on the findings to determine which programs participated if they have special knowledge of the field and area.

Benefits of participating programs:

The dialogue about TIC may offer a space for reflection that may spark learning and enhancements to TIC practice. In addition, the results may help to garner support for TIC within homeless programs. You will have the opportunity to comment on a preliminary draft of the report as well as receive a copy of the final report. In addition, I will provide a free group consultation for your program on TIC implementation based on my knowledge and experience leading a successful implementation of the Sanctuary® Model of TIC.

If you have questions about the project after the interview is over, please feel free to contact me:

Jeannine L. Lisitski
jlisitski@brynmawr.edu
856-466-4985

If after talking with me you have other concerns, you can contact my Director of Work who is supervising this project:

Dr. Cindy Sousa, Assistant Professor
Bryn Mawr College
Graduate School of Social Work and Social Research
300 Airdale Road
Bryn Mawr, PA 19010
csousa@brynmawr.edu
[610-520-2623](tel:610-520-2623)

If you have any questions about your rights as a research participant, please be in touch with Dr. Leslie Alexander, Chair, Bryn Mawr College Institutional Review Board (IRB). She can be reached at (610) 520-2600 or lalexand@brynmawr.edu

Your participation is completely voluntary:

You do not have to participate in this study. There will be no negative consequences if you decide not to participate. The program that you work with will not know whether you participated or not unless you share it with them. If you don't participate, it will not affect your job.

If you do decide to be interviewed, you can stop the interview at any time. You can also refuse to answer any questions that you don't want to answer. Furthermore, you can change your mind at any time and withdraw from the study by telling me without penalty or loss of any benefit as outlined above.

By signing this consent form, I am indicating that I have had all of my questions about the interview answered to my satisfaction and that I have been given a copy of this consent form.

Program name: _____

Participant's signature: _____

Participant's printed name: _____

Date: _____

Interviewer's signature: _____

Interviewer's printed name: _____

Date: _____

Appendix B

Email Recruitment Script to Program Executive Directors

My name is Jeannine Lisitski and I am a doctoral student in the Ph.D. program at the Bryn Mawr College Graduate School of Social Work and Social Research. In addition, I am the Executive Director and President of Women Against Abuse, a Philadelphia based anti-domestic violence service provider and advocacy organization. In part, Women Against Abuse operates residential programs including transitional housing for families experiencing homelessness due to domestic violence. My experience in the field has me increasingly concerned that agencies are either not fully equipped to provide trauma-informed care (TIC) or are not communicating their impact to policymakers.

I am inviting Pennsylvania transitional housing programs for families experiencing homelessness to participate in a study to explore the understanding and utilization of trauma-informed care within residential settings. This research is part of the fulfillment of my dissertation project.

Participation in this project involves a brief (10 questions) survey about the program as well as a phone interview with the executive director or their designee. In addition, I will be asking you or your designee to invite all staff to participate in a phone interview to get the perspective of various staff members.

I am attaching the informed consent form that outlines the very limited risks and benefits to participating in this study. I will go over this with you in detail should you agree to participate in this study. One benefit of participation will be a free group consultation session with me about implementation of trauma-informed care within residential programs. I have significant experience in this area including leading the multi-year implementation and certification of Women Against Abuse in the Sanctuary® Model of trauma-informed care.

If you are interested or have questions, please contact me either via email (jlisitski@brynmawr.edu) or phone (856-466-4985) to discuss. If I don't hear from you in a week, I will give you a call to check-in with you on whether or not you are interested in participating. Thank you for your consideration.

Sincerely,

Jeannine L. Lisitski

Appendix C

Checklist for Recruitment and Data Collection Process

- Get correct email/ phone contact for the Executive Directors
- Send email script with informed consent form
- Follow up via phone to inquire about participation in research
 - Review informed consent and get signature
 - ask for the program description and eligibility criteria documents
 - ask about other TH / Supportive Housing Programs for families experiencing homelessness in the area (another way to ensure that sampling frame is complete)
 - Ask whether executive director is delegating the survey, follow up and initial interview to another administrator that has a thorough understanding of the operations
- Send link for program information survey to executive director/ designee
 - Ask for completion within a week
 - Review upon receipt and note all clarifying questions that need to be asked at first interview with Executive Director/ designee
 - Name of program- translate to unique identifier to protect confidentiality
- Send email for all staff to the Executive Director/ designee and ask them to forward it to all staff
 - Send a reminder email to the Executive Director/ designee a week after the initial email and ask them to forward to all staff
- Send reminders for interviews 2 days in advance along with the handout with definition of trauma-informed care with examples of models to interviewees prior to interview so that I can reference during interviews.
- Do phone interview with Executive Director/ designee- audio record
 - Create a unique identifier for program, participant name, job classification
- Complete phone interviews with staff and audio record
 - Create a unique identifier for program, participant name, job classification
- During this process, write memos and field notes to document what happened and what decisions I made and why
- Transcribe interviews
- Enter data into qualitative analysis software

When program agrees to participate:

- Review the attached informed consent, sign, date and return to me. Please let me know if you have questions.
- Please send a copy of any program description or eligibility criteria documents for your transitional housing that you already have.
- Do you know of other Transitional Housing Programs for families experiencing homelessness in your county/ area?

- Will you be the main contact during the research? If not, please send the main contact person's name, title and email. The main contact person would need to have a thorough understanding of the operations.
- Complete the brief survey by XXXXX (one week from request) - you will receive a separate email with that link from Survey Monkey.
- Once I get the completed survey and the other information noted above, I will contact you or your designee to set up a phone interview and forward an email for you to share with the rest of the program staff (including non-direct service staff such as maintenance and administrative support) inviting them to participate in a phone interview.

Appendix D

Staff Email

EMAIL FOR MAIN CONTACT TO FORWARD TO STAFF:

Here is the email that you can use to forward to the staff of your transitional housing program for families. Note: all types of staff can participate from maintenance to administrative to case management and/ or counselors regardless of their experience with trauma-informed care. Staff can contact me directly if they are interested and their participation would consist only of a brief phone interview. Thanks again, Jeannine L. Lisitski

Dear NAME OF PROGRAM Staff Members,

My name is Jeannine Lisitski and I am a doctoral student in the Ph.D. program at the Bryn Mawr College Graduate School of Social Work and Social Research. I am doing research as part of the fulfillment of my dissertation project about the utilization of trauma-informed care within residential settings for families experiencing homelessness. Your Executive Director, NAME, agreed to your program's participation in this project. However, you have no obligation to participate. My experience in the field has me increasingly concerned that agencies are either not fully equipped to provide trauma-informed care (TIC) or are not communicating their impact to policymakers.

You are invited to participate in a brief phone interview lasting approximately 30 minutes. I am attaching the informed consent form that outlines the very limited risks and benefits to participating in this study. I will go over this with you in detail should you agree to participate in this study.

If you are interested or have questions, please contact me either via email (jlisitski@brynmawr.edu) or phone (856-466-4985) to discuss within a week. Thank you for your consideration.

Sincerely,
Jeannine L. Lisitski

Appendix E
Interview Guide

Participant Name/ Number: _____
Date of Interview: _____ **Time of Interview:** _____
Name of Program: _____

Disclosure to read during interviews with people that I know from my work in the field:

I want to acknowledge our relationship as colleagues in this field and underscore the importance of preserving the integrity of this research by keeping our professional relationship separate from this research project. During this project, I will act solely in my role as researcher so that the data that I collect will be a good representation of your experience and insights. After this research, when we see each other in unrelated settings, I will not acknowledge that you or your program were part of this research project nor will I discuss the research with you in any public setting unless you ask me to. If you want to discuss the research, you can contact me and I will arrange a private discussion. To the greatest degree possible, it would be helpful to the integrity of this research, if you respond to my questions as openly as possible. I am not here to evaluate the quality of your program or job performance; I am here to learn more about whether TIC is used in residential programs for families experiencing homelessness, whether programs find it valuable, what types of practices make up TIC, and what could help to support programs in implementing TIC.

Do you foresee any problems arising in your ability to be open in this interview that are related to our relationship/ connection?

1. How would you describe TIC?
2. How does your agency define TIC?

SCRIPT OF TIC DEFINED READ OUT LOUD:

First, I want to clarify the difference between TIC and trauma-specific services. Trauma-specific services are clinical interventions that treat specific trauma symptoms that are part of PTSD or another trauma-based disorder (DeCandia & Guarino, 2015).

The questions that I will be asking you have to do with TIC.

There is not complete agreement on what TIC means. One consensus-based definition of TIC is: "Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper et al., 2010, p. 82).

Trauma-informed care (TIC) is a broad set of practices based on six key principles (SAMHSA, 2014) including 1) safety, 2) trustworthiness and transparency, 3) peer support, 4) collaboration and mutuality, 5) empowerment, voice, and choice; and 6) cultural, historical and gender inclusivity.

A few examples of formal models of TIC for application with families include: "A Long Journey Home" and the "Sanctuary® Model".

3. Has your agency implemented TIC?
4. How did your program arrive at the decision to implement TIC?
5. How is TIC practiced in your agency? (IF TIC IS NOT PRACTICED, SKIP TO QUESTION 7)
 - a) *Probe: Can you talk more about the specific behaviors that embody TIC in your role?*
 - b) *Probe: Do you have anything to add about how other staff roles practice TIC?*
6. Can you share a story of how clients have been part of TIC at your agency?
 - a) *Prompt: Do clients participate in groups or meetings that include education about trauma?*
 - b) *Prompt: Are there tools that are made available to clients or activities facilitated that contribute to TIC such as a Sanctuary "safety plan" or "community meeting"?*
7. What were OR are the barriers to implementing TIC?
 - a) *Prompts: Think of internal organizational issues, external factors, issues related to the TIC model you use, characteristics of individuals within the organization including yourself, and issues related to the process of TIC implementation.*
8. What types of things helped OR might help to facilitate TIC implementation?
 - a) *Prompts: Think of internal organizational issues, external factors, issues related to the TIC model you use, characteristics of individuals within the organization including yourself, and issues related to the process of TIC implementation.*

9. Do you have any thoughts about how governmental policies and / or funding streams have impacted TIC implementation?

10. Job title of respondent:

Circle One:

- a) Para-Professional direct care staff (FT, PT and relief
- b) Supervisor
- c) Case Manager or Clinician
- d) Administrator (program managers, directors, vice president, executive director, etc.)
- e) Support staff (e.g. office staff, maintenance, kitchen staff, security, etc.)

Circle One: FT, PT, on-call/ relief

11. How long have you worked for the program?

12. Do you know of other TH programs for families experiencing homelessness in your area?

13. Is there anything else that you would like to add?

14. Do you have any feedback about this interview experience?

Appendix F

Program Information Survey

This is a confidential survey. The data is being collected using a secure (encrypted) connection to the host survey service provider. Results are stored in a password protected account accessible by only the researchers and system administrators. While no absolute guarantees can be made regarding security, these measures provide safeguards against outside agents accessing the electronic data.

1. Name and Title of Person Completing this Form:

2. Name of Program:

3. Name of County:

4. Geographic Type (select one):

Rural

Urban

Suburban

Other (Please Identify)

5. What is the maximum number of families that the program can serve at a point-in-time?

6. What is the average length of stay for the families?

7. What type of physical structure does the program have (select one)?

stand-alone program- congregate

stand-alone program-multi-unit apartment

stand-alone program-single room occupancy

clustered apartments

scattered site apartments

Other (please specify)

8. Is the program reserved for a specialized target subpopulation of homeless

families (select all that apply)?

domestic violence

substance use disorder

serious mental illness

physical disabilities

LGBTQ+

Other (please specify)

9. Is your program specifically a drug and alcohol treatment program?

Yes

No

Other (please specify)

10. Do you offer “trauma-specific services” and if so, what are these services? Note: Trauma-specific services are clinical interventions that treat specific trauma symptoms that are part of PTSD or another trauma-based disorder (DeCandia & Guarino, 2015). Some examples of trauma-specific services are generic trauma-recovery groups; Addiction and Trauma Recovery Integration Model- ATRIUM; Essence of Being Real, Risking Connection, Seeking Safety; Trauma, Addiction, Mental Health, and Recovery- TAMAR; Trauma Affect Regulation: Guide for Education and Therapy- TARGET; and Trauma, Recovery and Empowerment Model-TREM.

No

Yes, please describe.

Appendix G
Interview Guide Script

SCRIPT OF TIC DEFINED READ DURING INTERVIEW:

There is not complete agreement on what TIC means to programs that serve families experiencing homelessness. I'm going to share one consensus-based definition of TIC to give you a sense of how others have defined it: "Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper et al., 2010, p. 82).

Furthermore, according to SAMHSA (2014), the concept of TIC is grounded in a set of four assumptions and six key principles. The four assumptions proscribe an understanding of trauma theory including the impact of trauma, a recognition of the symptoms of trauma, a systematic response to trauma based on principles of TIC, and an active resistance to re-traumatizing clients or staff.

Trauma-informed care (TIC) is a broad set of practices based on six key principles (SAMHSA, 2014) including 1) safety, 2) trustworthiness and transparency, 3) peer support, 4) collaboration and mutuality, 5) empowerment, voice, and choice; and 6) cultural, historical and gender inclusivity.

A few examples of formal models of TIC for application with families include: "A Long Journey Home" and the "Sanctuary® Model".

REVISED AFTER FIRST INTERVIEW:

First, I want to clarify the difference between TIC and trauma-specific services. Trauma-specific services are clinical interventions that treat specific trauma symptoms that are part of PTSD or another trauma-based disorder (DeCandia & Guarino, 2015).

The questions that I will be asking you have to do with TIC.

There is not complete agreement on what TIC means. One consensus-based definition of TIC is: "Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper et al., 2010, p. 82).

Trauma-informed care (TIC) is a broad set of practices based on six key principles (SAMHSA, 2014) including 1) safety, 2) trustworthiness and transparency, 3) peer support, 4) collaboration and mutuality, 5) empowerment, voice, and choice; and 6) cultural, historical and gender inclusivity.

A few examples of formal models of TIC for application with families include: "A Long Journey Home" and the "Sanctuary® Model".

Appendix H
Initial Coding Scheme

A-Priori Themes, Codes & Sub codes:

1. The programs' understanding of TIC¹
 - a. understanding of trauma theory and the impact of trauma
 - b. recognition of trauma symptoms
 - c. a systematic response to trauma based on TIC principles
 - d. resistance to re-traumatization
2. The specific staff practices and program attributes that are the basis for TIC²
 - a. Safety
 - b. trustworthiness and transparency
 - c. peer support
 - d. collaboration and mutuality
 - e. empowerment, voice, and choice
 - f. cultural, historical, and gender inclusivity
3. Facilitative factors of TIC implementation³
 - a. intervention characteristics
 - b. outer setting
 - i. microsystem⁴
 - ii. mesosystem
 - iii. exosystem
 - iv. macrosystem
 - v. chronosystem
 - c. inner setting
 - d. characteristics of individuals
 - e. process
4. Barriers to TIC implementation³
 - a. intervention characteristics
 - b. outer setting
 - i. microsystem
 - ii. mesosystem
 - iii. exosystem
 - iv. macrosystem
 - v. chronosystem
 - c. inner setting
 - d. characteristics of individuals
 - e. process

¹ based on the four assumptions underlying TIC (SAMHSA, 2014)

² based on the six principles of TIC (SAMHSA, 2014)

³ based on the five CFIR domains (Damschroder et al., 2009)

⁴ based on ecological systems theory (Bronfenbrenner, 1979)

Appendix I

Codebook-Use of Trauma-Informed Care in Transitional Housing for Families

Codes grouped by Code groups

Note: Codes with ** were added post data collection or inductively

Report created by Jeannine Lisitski on Nov 1, 2018

ⓓ **Barriers AND Facilitative Factors related to characteristics of individuals**

5 Codes:

- **Barrier/ Facilitative Factor: characteristics of individuals, Individual Identification with Organization**

Definition: A broad construct related to how individuals perceive the organization and their relationship and degree of commitment with that organization.

- **Barrier/ Facilitative Factor: characteristics of individuals, Individual Stage of Change**

Definition: Characterization of the phase an individual is in, as he or she progresses toward skilled, enthusiastic, and sustained use of the intervention.

- **Barrier/ Facilitative Factor: characteristics of individuals, Knowledge and Belief About the Intervention**

Definition: Individuals' attitudes toward and value placed on the intervention as well as familiarity with facts, truths, and principles related to the intervention.

Distinguishing Notes: When participants discussed education and training factors, there were three possible CFIR categories: 1) characteristics of individuals-knowledge and belief about the intervention, 2) inner setting, readiness for implementation- available resources, and 3) inner setting, readiness for implementation- access to knowledge and information. When participants discussed their own higher education as a facilitative factor for TIC implementation, I coded the data as "characteristics of individuals-knowledge and belief about the intervention". When participants discussed resource barriers to accessing training about TIC, I coded the data as "inner setting, readiness for implementation-available resources" and when participants discussed a lack of useable information and training materials, I coded the data as "inner setting, readiness for implementation- access to knowledge and information".

Exclude statements related to familiarity with evidence about the innovation and code to Evidence Strength & Quality.

- **Barrier/ Facilitative Factor: characteristics of individuals, Other Personal Attributes**

Definition: A broad construct to include other personal traits such as tolerance of ambiguity, intellectual ability, motivation, values, competence, capacity, and learning style.

- **Barrier/ Facilitative Factor: characteristics of individuals, Self-Efficacy**

Definition: Individual belief in their own capabilities to execute courses of action to achieve implementation goals.

ⓧ **Barriers AND Facilitative Factors related to inner setting**

14 Codes:

- **Barrier/ Facilitative Factor: inner setting, Culture**

Definition: Norms, values, and basic assumptions of a given organization.

Inclusion Criteria: Inclusion criteria, and potential sub-codes, will depend on the framework or definition used for “culture.” For example, if using the

Competing Values Framework (CVF), you may include four sub-codes related to the four dimensions of the CVF and code statements regarding one or more of the four dimension in an organization.

- **Barrier/ Facilitative Factor: inner setting, Implementation Climate**

Definition: The absorptive capacity for change, shared receptivity of involved individuals to an intervention and the extent to which use of that intervention will be rewarded, supported, and expected within their organization.

None of the CFIR model categories include the impact of clients readiness for change so I am coding it here.

Inclusion Criteria: Include statements regarding the general level of receptivity to implementing the innovation.

Exclusion Criteria: Exclude statements regarding the general level of receptivity that are captured in the sub-codes.

- **Barrier/ Facilitative Factor: inner setting, Implementation Climate-Compatibility**

Definition: The degree of tangible fit between meaning and values attached to the intervention by involved individuals, how those align with individuals’ own norms, values, and perceived risks and needs, and how the intervention fits with existing workflows and systems.

Inclusion Criteria: Include statements that demonstrate the level of compatibility the innovation has with organizational values and work processes. Include statements that the innovation did or did not need to be adapted as evidence of compatibility or lack of compatibility.

Exclusion Criteria: Exclude or double code statements regarding the priority of the innovation based on compatibility with organizational values to Relative Priority, e.g., if an innovation is not prioritized because it is not compatible with organizational values.

- **Barrier/ Facilitative Factor: inner setting, Implementation Climate- Goals and Feedback**

Definition: The degree to which goals are clearly communicated, acted upon, and fed back to staff and alignment of that feedback with goals.

Inclusion Criteria: Include statements related to the (lack of) alignment of implementation and innovation goals with larger organizational goals, as well as feedback to staff regarding those goals, e.g., regular audit and feedback showing any gaps between the current organizational status and the goal. Goals and Feedback include organizational processes and supporting structures independent of the implementation process. Evidence of the integration of evaluation components used as part of “Reflecting and Evaluating” into on-going or sustained organizational structures and processes may be (double) coded to Goals and Feedback.

Exclusion Criteria: Exclude statements that refer to the implementation team’s (lack of) assessment of the progress toward and impact of implementation, as well as the interpretation of outcomes related to implementation, and code to Reflecting & Evaluating. Reflecting and Evaluating is part of the implementation process; it likely ends when implementation activities end. It does not require goals be explicitly articulated; it can focus on descriptions of the current state with real-time judgment, though there may be an implied goal (e.g., we need to implement the innovation) when the implementation team discusses feedback in terms of adjustments needed to complete implementation.

- **Barrier/ Facilitative Factor: inner setting, Implementation Climate-Learning Climate**

Definition: A climate in which: a) leaders express their own fallibility and need for team members’ assistance and input; b) team members feel that they are essential, valued, and knowledgeable partners in the change process; c) individuals feel psychologically safe to try new methods; and d) there is sufficient time and space for reflective thinking and evaluation.

Include statements that support (or refute) the degree to which key components of an organization exhibit a “learning climate.”

- **Barrier/ Facilitative Factor: inner setting, Implementation Climate- Organizational Incentives and Rewards**

Definition: Extrinsic incentives such as goal-sharing awards, performance reviews, promotions, and raises in salary and less tangible incentives such as increased stature or respect.

Include statements related to whether organizational incentive systems are in place to foster (or hinder) implementation, e.g., rewards or disincentives for staff engaging in the innovation.

- **Barrier/ Facilitative Factor: inner setting, Implementation Climate- Relative Priority**

Definition: Individuals' shared perception of the importance of the implementation within the organization.

Inclusion Criteria: Include statements that reflect the relative priority of the innovation, e.g., statements related to change fatigue in the organization due to implementation of many other programs.

Exclusion Criteria: Exclude or double code statements regarding the priority of the innovation based on compatibility with organizational values to Compatibility, e.g., if an innovation is not prioritized because it is not compatible with organizational values.

- **Barrier/ Facilitative Factor: inner setting, Implementation Climate- Tension for Change**

Definition: The degree to which stakeholders perceive the current situation as intolerable or needing change.

Inclusion Criteria: Include statements that (do not) demonstrate a strong need for the innovation and/or that the current situation is untenable, e.g., statements that the innovation is absolutely necessary or that the innovation is redundant with other programs. Note: If a participant states that the innovation is redundant with a preferred existing program, (double) code lack of Relative Advantage, see exclusion criteria below.

JLL Added: include internal pressure or leadership by peers that want to prioritize the intervention. As distinguished from the outer setting: patient needs and resources.

Exclusion Criteria: Exclude statements regarding specific needs of individuals that demonstrate a need for the innovation, but do not necessarily represent a strong need or an untenable status quo, and code to Needs and Resources of Those Served by the Organization.

Exclude statements that demonstrate the innovation is better (or worse) than existing programs and code to Relative Advantage.

- **Barrier/ Facilitative Factor: inner setting, Networks and Communications**

Definition: The nature and quality of webs of social networks and the nature and quality of formal and informal communications within an organization.

Inclusion Criteria: Include statements about general networking, communication, and relationships in the organization, such as descriptions of meetings, email groups, or other methods of keeping people connected and informed, and statements related to team formation, quality, and functioning.

Exclusion Criteria: Exclude statements related to implementation leaders' and users' access to knowledge and information regarding using the program, i.e., training on the mechanics of the program and code to Access to Knowledge & Information.

Exclude statements related to engagement strategies and outcomes, e.g., how key stakeholders became engaged with the innovation and what their role is in implementation, and code to Engaging: Key Stakeholders.

Exclude descriptions of outside group memberships and networking done outside the organization and code to Cosmopolitanism.

- **Barrier/ Facilitative Factor: inner setting, Readiness for Implementation**

Definition: Tangible and immediate indicators of organizational commitment to its decision to implement an intervention.

Inclusion Criteria: Include statements regarding the general level of readiness for implementation.

Exclusion Criteria: Exclude statements regarding the general level of readiness for implementation that are captured in the sub-codes.

- **Barrier/ Facilitative Factor: inner setting, Readiness for Implementation- Access to Knowledge and Information**

Definition: Ease of access to digestible information and knowledge about the intervention and how to incorporate it into work tasks.

Distinguishing Notes: When participants discussed education and training factors, there were three possible CFIR categories: 1) characteristics of individuals- knowledge and belief about the intervention, 2) inner setting, readiness for implementation- available resources, and 3) inner setting, readiness for implementation- access to knowledge and information. When participants discussed their own higher education as a facilitative factor for TIC

implementation, I coded the data as “characteristics of individuals-knowledge and belief about the intervention”. When participants discussed resource barriers to accessing training about TIC, I coded the data as “inner setting, readiness for implementation-available resources” and when participants discussed a lack of useable information and training materials, I coded the data as “inner setting, readiness for implementation- access to knowledge and information”.

Inclusion Criteria: Include statements related to implementation leaders' and users' access to knowledge and information regarding use of the program, i.e., training on the mechanics of the program.

Exclusion Criteria: Exclude statements related to engagement strategies and outcomes, e.g., how key stakeholders became engaged with the innovation and what their role is in implementation, and code to Engaging: Key Stakeholders.

Exclude statements about general networking, communication, and relationships in the organization, such as descriptions of meetings, email groups, or other methods of keeping people connected and informed, and statements related to team formation, quality, and functioning, and code to Networks & Communications

- **Barrier/ Facilitative Factor: inner setting, Readiness for Implementation-Available Resources**

Definition: The level of resources dedicated for implementation and on-going operations including money, training, education, physical space, and time.

Distinguishing Notes: When participants discussed education and training factors, there were three possible CFIR categories: 1) characteristics of individuals-knowledge and belief about the intervention, 2) inner setting, readiness for implementation- available resources, and 3) inner setting, readiness for implementation- access to knowledge and information. When participants discussed their own higher education as a facilitative factor for TIC implementation, I coded the data as “characteristics of individuals-knowledge and belief about the intervention”. When participants discussed resource barriers to accessing training about TIC, I coded the data as “inner setting, readiness for implementation-available resources” and when participants discussed a lack of useable information and training materials, I coded the data as “inner setting, readiness for implementation- access to knowledge and information”.

Inclusion Criteria: Include statements related to the presence or absence of resources specific to the innovation that is being implemented.

Exclusion Criteria: Exclude statements related to training and education and code to Access to Knowledge & Information.

Exclude statements related to the quality of materials and code to Design Quality & Packaging.

In a research study, exclude statements related to resources needed for conducting the research components (e.g., time to complete research tasks, such as IRB applications, consenting patients).

- **Barrier/ Facilitative Factor: inner setting, Readiness for Implementation-Leadership Engagement**

Definition: Commitment, involvement, and accountability of leaders and managers with the implementation.

Inclusion Criteria: Include statements regarding the level of engagement of organizational leadership.

Exclusion Criteria: Exclude or double code statements regarding leadership engagement to Engaging: Formally Appointed Internal Implementation Leaders or Champions if an organizational leader is also an implementation leader, e.g., if a director of primary care takes the lead in implementing a new treatment guideline. Note that a key characteristic of this Implementation Leader/Champion is that s/he is also an Organizational Leader.

- **Barrier/ Facilitative Factor: inner setting, Structural Characteristics**

Definition: The social architecture (i.e. organizational structure), age, maturity, and size of an organization.

Social Architecture: the social architecture that describes how large numbers of people are clustered into smaller groups and differentiated and how the independent actions of these differentiated groups are coordinated to produce a holistic product or service [46, 47].

Inclusion: when participants are talking about having staff position vacancies, if it is related to ability to pay competitively due to lack of funding, then it would get coded to the available resources code but if the staff vacancies are due to the organizational culture or a poor performing HR department, then it would be a structural issue in the organization.

⊗ **Barriers AND Facilitative Factors related to intervention model**

9 Codes:

- **Barrier/ Facilitative Factor: intervention (model) characteristics, Adaptability**

Definition: The degree to which an intervention can be adapted, tailored, refined, or reinvented to meet local needs.

Inclusion Criteria: Include statements regarding the (in)ability to adapt the innovation to their context, e.g., complaints about the rigidity of the protocol.

Suggestions for improvement can be captured in this code but should not be included in the rating process, unless it is clear that the participant feels the change is needed but that the program cannot be adapted. However, it may be possible to infer that a large number of suggestions for improvement demonstrates lack of compatibility, see exclusion criteria below.

Exclusion Criteria: Exclude or double code statements that the innovation did or did not need to be adapted to Compatibility.

- **Barrier/ Facilitative Factor: intervention (model) characteristics, Complexity**

Definition: Perceived difficulty of implementation, reflected by duration, scope, radicalness, disruptiveness, centrality, and intricacy and number of steps required to implement.

Inclusion Criteria: Code statements regarding the complexity of the innovation itself.

Exclusion Criteria: Exclude statements regarding the complexity of implementation and code to the appropriate CFIR code, e.g., difficulties related to space are coded to Available Resources and difficulties related to engaging participants in a new program are coded to Engaging: Innovation Participants.

- **Barrier/ Facilitative Factor: intervention (model) characteristics, Cost**

Definition: Costs of the intervention and costs associated with implementing that intervention including investment, supply, and opportunity costs.

Inclusion Criteria: Include statements related to the cost of the innovation and its implementation.

Exclusion Criteria: Exclude statements related to physical space and time, and code to Available

Resources. In a research study, exclude statements related to costs of conducting the research components (e.g., funding for research staff, participant incentives).

- **Barrier/ Facilitative Factor: intervention (model) characteristics, Design Quality and Packaging**

Definition: Perceived excellence in how the intervention is bundled, presented, and assembled.

Inclusion Criteria: Include statements regarding the quality of the materials and packaging.

Exclusion Criteria: Exclude statements regarding the presence or absence of materials and code to Available Resources. Exclude statements regarding the receipt of materials as an engagement strategy and code to Engaging.

- **Barrier/ Facilitative Factor: intervention (model) characteristics, Evidence Strength and Quality**

Definition: Stakeholders' perceptions of the quality and validity of evidence supporting the belief that the intervention will have desired outcomes.

Inclusion Criteria: Include statements regarding awareness of evidence and the strength and quality of evidence, as well as the absence of evidence or a desire for different types of evidence, such as pilot results instead of evidence from the literature.

Exclusion Criteria: Exclude or double code statements regarding the receipt of evidence as an engagement strategy to Engaging: Key Stakeholders.

Exclude or double code descriptions of use of results from local or regional pilots to Trialability.

- **Barrier/ Facilitative Factor: intervention (model) characteristics, Intervention Source**

Definition: Perception of key stakeholders about whether the intervention is externally or internally developed.

Inclusion Criteria: Include statements about the source of the innovation and the extent to which interviewees view the change as internal to the organization, e.g., an internally developed program, or external to the organization, e.g., a program coming from the outside. Note: May code and rate as "I" for internal or "E" for external.

Exclusion Criteria: Exclude or double code statements related to who participated in the decision process to implement the innovation to Engaging, as an indication of early (or late) engagement. Participation in decision-making is an effective engagement strategy to help people feel ownership of the innovation.

- **Barrier/ Facilitative Factor: intervention (model) characteristics, Relative Advantage**

Definition: Stakeholders' perception of the advantage of implementing the intervention versus an alternative solution.

Inclusion Criteria: Include statements that demonstrate the innovation is better (or worse) than existing programs.

Exclusion Criteria: Exclude statements that demonstrate a strong need for the innovation and/or that the current situation is untenable and code to Tension for Change.

- **Barrier/ Facilitative Factor: Intervention (model) characteristics, Trialability**

Definition: The ability to test the intervention on a small scale in the organization [8], and to be able to reverse course (undo implementation) if warranted.

Inclusion Criteria: Include statements related to whether the site piloted the innovation in the past or has plans to in the future, and comments about whether they believe it is (im)possible to conduct a pilot.

Exclusion Criteria: Exclude or double code descriptions of use of results from local or regional pilots to Evidence Strength & Quality.

⊗ **Barriers AND Facilitative Factors related to outer setting**

4 Codes:

- **Barrier/ Facilitative Factor: outer setting, Cosmopolitanism**

Definition: The degree to which an organization is networked with other external organizations.

Inclusion Criteria: Include descriptions of outside group memberships and networking done outside the organization.

Exclusion Criteria: Exclude statements about general networking, communication, and relationships in the organization, such as descriptions of meetings, email groups, or other methods of keeping people connected and informed, and statements related to team formation, quality, and functioning, and code to Networks & Communications.

- **Barrier/ Facilitative Factor: outer setting, External Policy and Incentives**

Definition: A broad construct that includes external strategies to spread interventions including policy and regulations (governmental or other central entity), external mandates, recommendations and guidelines, pay-for-performance, collaboratives, and public or benchmark reporting.

Inclusion Criteria: Include descriptions of external performance measures from the system.

- **Barrier/ Facilitative Factor: outer setting, Patient Needs & Resources**

Definition: The extent to which patient needs, as well as barriers and facilitators to meet those needs are accurately known and prioritized by the organization.

Inclusion Criteria: Include statements demonstrating (lack of) awareness of the needs and resources of those served by the organization. Analysts may be able to infer the level of awareness based on statements about: 1. Perceived need for the innovation based on the needs of those served by the organization and if the innovation will meet those needs; 2. Barriers and facilitators of those served by the organization to participating in the innovation; 3. Participant feedback on the innovation, i.e., satisfaction and success in a program. In addition, include statements that capture whether or not awareness of the needs and resources of those served by the organization influenced the implementation or adaptation of the innovation.

Exclusion Criteria: Exclude statements that demonstrate a strong need for the innovation and/or that the current situation is untenable and code to Tension for Change.

Exclude statements related to engagement strategies and outcomes, e.g., how innovation participants became engaged with the innovation, and code to Engaging: Innovation Participants.

- **Barrier/ Facilitative Factor: outer setting, Peer Pressure**

Definition: Mimetic or competitive pressure to implement an intervention; typically because most or other key peer or competing organizations have already implemented or in a bid for a competitive edge.

Inclusion Criteria: Include statements about perceived pressure or motivation from other entities or organizations in the local geographic area or system to implement the innovation.

⊠ **Barriers AND Facilitative Factors related to process**

8 Codes:

- **Barrier/ Facilitative Factor: Process, Engaging**

Definition: Attracting and involving appropriate individuals in the implementation and use of the intervention through a combined strategy of social marketing, education, role modeling, training, and other similar activities.

Inclusion Criteria: Include statements related to engagement strategies and outcomes, i.e., if and how staff and innovation participants became engaged with the innovation and what their role is in implementation.

Exclusion Criteria: Exclude statements related to specific sub constructs, e.g., Champions or Opinion Leaders.

Exclude or double code statements related to who participated in the decision process to implement the innovation to Innovation Source, as an indicator of internal or external innovation source.

- **Barrier/ Facilitative Factor: Process, Engaging- Champions**

Definition: Individuals who dedicate themselves to supporting, marketing, and ‘driving through’ an [implementation]” [101](p. 182), overcoming indifference or resistance that the intervention may provoke in an organization.

Inclusion Criteria: Include statements related to engagement strategies and outcomes, e.g., how the champion became engaged with the innovation and what their role is in implementation.

Exclusion Criteria: Exclude or double code statements regarding leadership engagement to Leadership Engagement if a champion is also an organizational leader, e.g., if a director of primary care takes the lead in implementing a new treatment guideline.

- **Barrier/ Facilitative Factor: Process, Engaging- External Change Agents**

Definition: Individuals who dedicate themselves to supporting, marketing, and ‘driving through’ an [implementation]” [101](p. 182), overcoming indifference or resistance that the intervention may provoke in an organization.

Inclusion Criteria: Include statements related to engagement strategies and outcomes, e.g., how the external change agent (entities outside the organization that facilitate change) became engaged with the innovation and what their role is in implementation, e.g., how they supported implementation efforts.

Exclusion Criteria: Note: It is important to clearly define what roles are external and internal to the organization. Exclude statements regarding facilitating activities, such as training in the mechanics of the program, and code to Access to Knowledge & Information if the change agent is considered internal to the study, e.g., a staff member at the national office. If the study considers this staff member internal to the organization, it should be coded to Access to Knowledge & Information, even though their support may overlap with what would be expected from an External Change Agent.

Distinguished from outer setting, external policy and incentives because this code is talking about a specific person and not so much systemic requirements of an external agency or system.

- **Barrier/ Facilitative Factor: Process, Engaging- Formally Appointed Internal Implementation Leaders**

Definition: Individuals from within the organization who have been formally appointed with responsibility for implementing an intervention as coordinator, project manager, team leader, or other similar role.

Inclusion Criteria: Include statements related to engagement strategies and outcomes, e.g., how the formally appointed internal implementation leader became engaged with the innovation and what their role is in implementation.

Exclusion Criteria: Exclude or double code statements regarding leadership engagement to Leadership Engagement if an implementation leader is also an organizational leader, e.g., if a director of primary care takes the lead in implementing a new treatment guideline.

- **Barrier/ Facilitative Factor: Process, Engaging-Opinion Leaders**

Definition: Individuals in an organization who have formal or informal influence on the attitudes and beliefs of their colleagues with respect to implementing the intervention.

Include statements related to engagement strategies and outcomes, e.g., how the opinion leader became engaged with the innovation and what their role is in implementation.

- **Barrier/ Facilitative Factor: Process, Executing**

Definition: Carrying out or accomplishing the implementation according to plan.

Include statements that demonstrate how implementation occurred with respect to the implementation plan. Note: Executing is coded very infrequently due to a lack of planning. However, some studies have used fidelity measures to assess executing, as an indication of the degree to which implementation was accomplished according to plan.

- **Barrier/ Facilitative Factor: Process, Planning**

Definition: The degree to which a scheme or method of behavior and tasks for implementing an intervention are developed in advance and the quality of those schemes or methods.

Include evidence of pre-implementation diagnostic assessments and planning, as well as refinements to the plan.

- **Barrier/ Facilitative Factor: Process, Reflecting and Evaluating**

Definition: Quantitative and qualitative feedback about the progress and quality of implementation accompanied with regular personal and team debriefing about progress and experience.

Inclusion Criteria: Include statements that refer to the implementation team's (lack of) assessment of the progress toward and impact of implementation, as well as the interpretation of outcomes related to implementation. Reflecting and Evaluating is part of the implementation process; it likely ends when implementation activities end. It does not require goals be explicitly articulated; it can focus on descriptions of the current state with real-time judgment, though there may be an implied goal (e.g., we need to implement the innovation) when the implementation team discusses feedback in terms of adjustments needed to complete implementation.

Exclusion Criteria: Exclude statements related to the (lack of) alignment of implementation and innovation goals with larger organizational goals, as well as feedback to staff regarding those goals, e.g., regular audit and feedback showing any gaps between the current organizational status and the goal, and code to Goals & Feedback. Goals and Feedback include organizational processes and supporting structures independent of the implementation process. Evidence of the integration of evaluation components used as part of "Reflecting and Evaluating" into on-going or sustained organizational structures and processes may be (double) coded to Goals and Feedback.

Exclude statements that capture reflecting and evaluating that participants may do during the interview, for example, related to the success of the implementation, and code to Knowledge & Beliefs about the Innovation.

⊞ **Bioecological Systems, Outer Setting Facilitative Factors or Barriers**

6 Codes:

- ****Bioecological Systems Theory Bidirectionality**

Definition: Variations in developmental processes and outcomes as a joint function of the characteristics of the environment and of the person (Bronfenbrenner, 2005, p. 115).

- **Facilitative Factor or Barrier: outer setting, Chronosystem**

Definition: The chronosystem is indicative in each other layer and related to the passage of time, such as a values shift across generations related to more insular families or the trend of more single-female-headed households; changes over time in the political structure and system, and phenomenon such as neoliberalism.

- **Facilitative Factor or Barrier: outer setting, Exosystem**

Definition: A layer in one's ecological context that is comprised of places/ groups that the individual has no direct contact with but that affect them nonetheless (i.e. a trickle-down effect). For example, various social and economic policies that impact families experiencing homelessness are part of the families' exosystem.

- **Facilitative Factor or Barrier: outer setting, Macrosystem**

Definition: A layer in one's ecological context that contains the values, attitudes, beliefs, and cultural background of an individual.

- **Facilitative Factor or Barrier: outer setting, Mesosystem**

Definition: A layer in one's ecological context formed by the linkages or processes taking place between two or more microsystems containing the person. In other words, the mesosystem is created through the interaction between two microsystems.

- **Facilitative Factor or Barrier: outer setting, Microsystem**

Definition: One's ecological setting in which they experience life, for example, people and places that a person comes into contact with on a regular basis such as the home and immediate family, workplace, church, or a homeless shelter.

⊗ Social Work Practices

3 Codes:

- ****Social Work Practice: general**

Definition: The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation, administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations,

communities, and other social institutions to individuals' needs and social problems.

NASW Preamble, Retrieved from:

<https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English>

- ****Social Work Practice: Person-Centered**

Definition: According to the NASW, Person-Centered services within a case management practice involve engaging the client and family members in “all aspects of case management and tailoring services to the client’s needs, preferences, and goals” (p. 17, Retrieved from, <https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo%3d&portalid=0>)

- ****Social Work Practice: Use of person-in-environment perspective**

Definition: The person-in-environment perspective in social work is a practice-guiding principle that highlights the importance of understanding an individual and individual behavior in light of the environmental contexts in which that person lives and acts. Retrieved from, <http://socialwork.oxfordre.com/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-285>

As distinguished from Bronfenbrenner’s Bioecological Systems Theory: Person-in-environment is about considering the context of a person’s life and all of the social systems and forces that impinge on a person. Bronfenbrenner’s theory provides different contextual layers or levels that help to classify the forces that either facilitate or obstruct implementation of TIC (i.e. micro, meso, macro, exo, chrono).

Note: only one instance coded that was a more general quote that didn’t fit into Bronfenbrenner’s Bioecological Systems Theory.

⊗ Social Work Values

6 Codes:

- ****Social Work Value: Competence**

Definition:

Ethical Principle: Social workers practice within their areas of competence and develop and enhance their professional expertise.

Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

Retrieved from: <https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English>

- ****Social Work Value: Dignity and Worth of the Person**

Definition:

Ethical Principle: Social workers respect the inherent dignity and worth of the person.

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

Retrieved from: <https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English>

- ****Social Work Value: Importance of Human Relationships**

Definition:

Ethical Principle: Social workers recognize the central importance of human relationships.

Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities.

Include: This code captures the construct of the helping relationship or working/therapeutic alliance nicely.

Retrieved from: <https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English>

- ****Social Work Value: Integrity**

Definition:

Ethical Principle: Social workers behave in a trustworthy manner.

Social workers are continually aware of the profession's mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.

Retrieved from: <https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English>

- ****Social Work Value: Service**

Definition:

Ethical Principle: Social workers' primary goal is to help people in need and to address social problems.

Social workers elevate service to others above self-interest. Social workers draw on their knowledge, values, and skills to help people in need and to address social problems. Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service).

Retrieved from: <https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English>

- ****Social Work Value: Social Justice**

Definition:

Ethical Principle: Social workers challenge social injustice.

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

Retrieved from: <https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English>

Staff Practices and Program Attributes Underlying TIC

13 Codes:

- **Barriers to cultural, historical and gender inclusivity**

Definition: “The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender- identity, geography, etc.); offers, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.” (SAMHSA, 2014, p. 11)

- **Barriers to empowerment, voice, and choice**

Definition: “Throughout the organization and among the clients served, individuals’ strengths and experiences are recognized and built upon. Operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice, and choice and are often recipients of coercive treatment.” (SAMHSA, 2014, p. 11)

- **Barriers to safety**

Definition: “Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.” (SAMHSA, 2014, p. 11)

- **Barriers to trustworthiness and transparency**

Definition: “Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.” (SAMHSA, 2014, p. 11)

- **Practices that bring about collaboration and mutuality**

Definition: “Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making.” (SAMHSA, 2014, p. 11)

- **Practices that bring about cultural, historical and gender inclusivity**

Definition: “The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender- identity, geography, etc.); offers, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of

individuals served; and recognizes and addresses historical trauma.” (SAMHSA, 2014, p. 11)

- **Practices that bring about empowerment, voice, and choice**

Definition: “Throughout the organization and among the clients served, individuals’ strengths and experiences are recognized and built upon. Operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice, and choice and are often recipients of coercive treatment.” (SAMHSA, 2014, p. 11)

- **Practices that bring about peer support**

Definition: “Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing.” (SAMHSA, 2014, p. 11)

Inclusion: Use of the “community meeting” tool from the Sanctuary Model of TIC was coded here because the format is designed to share feelings and goals with peers and to identify who they can ask for support.

- **Practices that bring about safety**

Definition: “Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.” (SAMHSA, 2014, p. 11)

- **Practices that bring about trustworthiness and transparency**

Definition: “Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.” (SAMHSA, 2014, p. 11)

- **Resistance to re-traumatization**

Definition: Seeks to actively resist re-traumatization of clients as well as staff. Staff who work within a trauma-informed environment are taught to recognize how organizational practices may trigger painful memories and re-traumatize clients with trauma histories. (SAMHSA, 2014, p. 10)

- **Systematic response to trauma**

Definition: Full integration of knowledge about trauma into policies, procedures, and practices. (SAMHSA, 2014, p. 10)

- ****Too poor for the luxury of self-care**

In Vivo Code

ⓧ Understanding of TIC

19 Codes:

- **Barriers to recognition of trauma symptoms**

Definition: Identifies or acknowledges “the signs and symptoms of trauma in clients, families, staff, and others involved with the system” (SAMHSA, 2014, p. 9).

Inclusion: Within this category, there is recognition of trauma symptoms in staff as well as recognition in clients. There could also be recognition of trauma in systems.

- ****It sort of just been this metamorphosis**

In vivo code

- ****Lack of affordable housing is traumatic**

In vivo code

- **Defining TIC**

Definition: "Responses to the questions, “how would you describe TIC” and “how does your agency define TIC”?”

- **Lack of understanding of trauma theory**

Definition: (Lack of) Having a basic realization about trauma and understanding the impact of trauma. People’s experience and behavior are understood in the context of coping strategies designed to survive adversity in the past or present including secondary traumatic stress experienced by direct care professionals. An understanding that trauma should be systematically addressed in prevention, treatment, and recovery settings because it can underlie various behavioral health issues and can serve as a barrier to success in other human service systems such as child welfare. (SAMHSA, 2014, p. 9)

- ****Meeting people where they are**

In vivo code

- ****Mindfulness is really one of the key principles**

In vivo code

- ****Poverty is traumatizing**

In vivo code

- ****Recidivism into homelessness as a traumatic experience**

- **Recognition of trauma symptoms**

Definition: Identifies or acknowledges “the signs and symptoms of trauma in clients, families, staff, and others involved with the system” (SAMHSA, 2014, p. 9).

Inclusion: Within this category, there is recognition of trauma symptoms in staff as well as recognition in clients. There could also be recognition of trauma in systems.

- ****Tension between TIC and Accountability**

Definition: An assertion that TIC was at odds with accountability and staff had difficulty balancing client accountability with TIC.

- ****The deeper impact that trauma has had on families and success**

In vivo code

- ****There was always this hierarchy, this us versus them.**

In vivo code

- ****TIC as an overlapping construct with Housing First Approach**

Definition: Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness, thus ending their homelessness and serving as a platform from which they can pursue personal goals and improve their quality of life. This approach is guided by the belief that people need basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues. Additionally, Housing First is based on the theory that client choice is valuable in housing selection and supportive service participation, and that exercising that choice is likely to make a client more successful in remaining housed and improving their life.

Housing First does not require people experiencing homelessness to address the all of their problems including behavioral health problems, or to graduate through a series of services programs before they can access housing. Housing First does not mandate participation in services either before obtaining housing or in order to retain housing. The Housing First approach views housing as the foundation for life improvement and enables access to permanent housing without prerequisites

or conditions beyond those of a typical renter. Supportive services are offered to support people with housing stability and individual well-being, but participation is not required as services have been found to be more effective when a person chooses to engage. Other approaches do make such requirements in order for a person to obtain and retain housing. (Retrieved from: <http://endhomelessness.org/wp-content/uploads/2016/04/housing-first-fact-sheet.pdf>)

○ ****TIC as an overlapping construct with social work practice**

Definition: There are some overlapping elements of TIC with general social work practices.

○ ****TIC as an overlapping construct with the Empowerment Model**

Definition: Participants mentioned the Empowerment Model and/ or Empowerment Counseling as being very similar, if not the same, as TIC.

○ ****TIC is a universal approach to life**

Note: only one instance of this code.

Example: “I love the whole approach and I think it's a natural approach. I really do. I think it's the way that all humans should treat each other.”

○ ****Trauma is universal**

Note: two instances coded.

Examples: “So like I think trauma-informed care is not, is not something that is like, like a specialty novelty item that only certain people need to know about. I think it's something that will one, I think like at a basic like very macro level, I think just living in a world where you like are watching people be traumatized by whatever systems exist, whether that's capitalism, racism directly like”

“we need to create space for like working through trauma both in communal settings and individually and really like respecting how our experiences shape our lives and understanding that's so not like intangible things that don't need to be paid attention to, like these are the way we experience trauma and then the way we recover from it and the way we move on and navigate for the rest of our lives”

● **Understanding of trauma theory**

Definition: Having a basic realization about trauma and understanding the impact of trauma. People's experience and behavior are understood in the context of coping strategies designed to survive adversity in the past or present including secondary traumatic stress experienced by direct care professionals. An understanding that trauma should be systematically addressed in prevention,

treatment, and recovery settings because it can underlie various behavioral health issues and can serve as a barrier to success in other human service systems such as child welfare. (SAMHSA, 2014, p. 9)

- ****What happened to you rather than what's wrong with you**

Definition: This code is a subcode of Understanding Trauma Theory.

In vivo code.

No code group

3 Codes:

- ****Excitement around TIC**

One instance of this code.

Example: “I think people know on some level that trauma-informed care is necessary but when we start like articulating it and like just acknowledging it in public spaces, like I've always hear that people are really grateful to be able to talk about it. So it is exciting and I hope that we can grow it in society.”

- ****Homelessness is trauma**

One instance coded.

Example: “So we need to give them time, time is really important in our, in working with individuals who went through a traumatic situation and homelessness is very traumatic because it's a basic need.”

- ****TIC inspires**

Five instances coded

Example: “I believe that, it's an excellent way to go. The first time we were exposed to it, I was like, this is right on target. Because you need to look at where people are coming from, what their situation may have been, you don't know what their day was like, you don't know what their life was like and not, and this was something I always believed anyway, I just never had, I didn't have, apply this thinking to it, like trauma-informed. So It kind of like opened my eyes to this is what I believe. This is how I really approach people....”

Appendix J
CFIR Constructs

Construct		Short Description
I. INTERVENTION CHARACTERISTICS		
A	Intervention Source	Perception of key stakeholders about whether the intervention is externally or internally developed.
B	Evidence Strength & Quality	Stakeholders' perceptions of the quality and validity of evidence supporting the belief that the intervention will have desired outcomes.
C	Relative Advantage	Stakeholders' perception of the advantage of implementing the intervention versus an alternative solution.
D	Adaptability	The degree to which an intervention can be adapted, tailored, refined, or reinvented to meet local needs.
E	Trialability	The ability to test the intervention on a small scale in the organization, and to be able to reverse course (undo implementation) if warranted.
F	Complexity	Perceived difficulty of implementation, reflected by duration, scope, radicalness, disruptiveness, centrality, and intricacy and number of steps required to implement.
G	Design Quality & Packaging	Perceived excellence in how the intervention is bundled, presented, and assembled.
H	Cost	Costs of the intervention and costs associated with implementing the intervention including investment, supply, and opportunity costs.
II. OUTER SETTING		
A	Patient Needs & Resources	The extent to which patient needs, as well as barriers and facilitators to meet those needs, are accurately known and prioritized by the organization.
B	Cosmopolitanism	The degree to which an organization is networked with other external organizations.
C	Peer Pressure	Mimetic or competitive pressure to implement an intervention; typically, because most or other key peer or competing organizations have already implemented or are in a bid for a competitive edge.

D	External Policy & Incentives	A broad construct that includes external strategies to spread interventions, including policy and regulations (governmental or other central entity), external mandates, recommendations and guidelines, pay-for-performance, collaboratives, and public or benchmark reporting.
III. INNER SETTING		
A	Structural Characteristics	The social architecture, age, maturity, and size of an organization.
B	Networks & Communications	The nature and quality of webs of social networks and the nature and quality of formal and informal communications within an organization.
C	Culture	Norms, values, and basic assumptions of a given organization.
D	Implementation Climate	The absorptive capacity for change, shared receptivity of involved individuals to an intervention, and the extent to which use of that intervention will be rewarded, supported, and expected within their organization.
1	Tension for Change	The degree to which stakeholders perceive the current situation as intolerable or needing change.
2	Compatibility	The degree of tangible fit between meaning and values attached to the intervention by involved individuals, how those align with individuals' own norms, values, and perceived risks and needs, and how the intervention fits with existing workflows and systems.
3	Relative Priority	Individuals' shared perception of the importance of the implementation within the organization.
4	Organizational Incentives & Rewards	Extrinsic incentives such as goal-sharing awards, performance reviews, promotions, and raises in salary, and less tangible incentives such as increased stature or respect.

Appendix K
TIC Practices Table

Practices that engender collaboration and mutuality	Practices that engender cultural, historical and gender inclusivity (TOP 2 LEAST NOTED CATEGORY)	Practices that engender empowerment, voice and choice (TOP 2 MOST NOTED CATEGORY)	Practices that engender peer support (TOP 2 LEAST NOTED CATEGORY)	Practices that engender safety (TOP 2 MOST NOTED CATEGORY)	Practices that engender trustworthiness and transparency	Resistance to Re-traumatization	Systematic Approach to Policies/ Procedures	Systematic Approach to Practice	Manualized Staff Level Practices
Being responsive to the client	Try not to use gendered pronouns	Listening to client	Hiring people in recovery/ peers	Deep breathing exercises	Being accountable to the client	Use of techniques to help clients deescalate when triggered	Assessing space through a TIC lens (e.g. waiting areas, offices, edu materials posted); Assessment of and changes to the physical plant to promote safety and mitigate re-traumatization (e.g. peepholes, on-site security)	Taking a healing approach to every interaction	Use of Sanctuary Model tools with clients AND staff (family team meeting, community meeting, safety plan-visibly worn, SELF framework, self-care plan); being poor is a barrier to self-care

Practices that engender collaboration and mutuality	Practices that engender cultural, historical and gender inclusivity (TOP 2 LEAST NOTED CATEGORY)	Practices that engender empowerment, voice and choice (TOP 2 MOST NOTED CATEGORY)	Practices that engender peer support (TOP 2 LEAST NOTED CATEGORY)	Practices that engender safety (TOP 2 MOST NOTED CATEGORY)	Practices that engender trustworthiness and transparency	Resistance to Re-traumatization	Systematic Approach to Policies/ Procedures	Systematic Approach to Practice	Manualized Staff Level Practices
Work with client to explore their past experiences & tap into their feelings	Cultural competency and sensitivity; humility in learning directly from clients	Offering opportunities for client to talk; opportunities for clients to meet with external therapeutic org on-site to create privacy to reduce power dynamic that comes with providing housing	“Community Meeting”	Conflict resolution workshops; conflict resolution approach used	Ask client to be open and honest; be honest as a staff person; set up the conversations for openness	Knowing clients’ history of trauma and triggers to avoid re-traumatization	Making educational materials on trauma available to clients	Framing was first step in taking action to engender TIC: Recall client actions and reactions often based on trauma: “wear that lens” when interacting; “looking through the lens of Sanctuary” and apply principles and tools before reacting; framing helped with de-escalation as well	Variation of SELF-“myself boxes”- filled with tactiles designed to help connect with feelings and to create safety

Practices that engender collaboration and mutuality	Practices that engender cultural, historical and gender inclusivity (TOP 2 LEAST NOTED CATEGORY)	Practices that engender empowerment, voice and choice (TOP 2 MOST NOTED CATEGORY)	Practices that engender peer support (TOP 2 LEAST NOTED CATEGORY)	Practices that engender safety (TOP 2 MOST NOTED CATEGORY)	Practices that engender trustworthiness and transparency	Resistance to Re-traumatization	Systematic Approach to Policies/ Procedures	Systematic Approach to Practice	Manualized Staff Level Practices
Clients serving as board members	Awareness of micro-aggression	Providing clients with a journal and encouraging them to use it		Non-judgmental approach	Don't use words like should and must, can't and won't	Sensitive communication skills	Shift reports include question about safety issues that arose and staffs' feelings around the issues	Setting the tone for case management meetings by observing how the client is doing/ current challenges and use info. to set the plan and pace for session-follow lead of client; openness to structure and content of sessions	Formatted forms using SELF such as supervisory forms and house reports that summarize what happened during a shift
Open door policy	Discussing limitations of cultural backgrounds that may stigmatize participation in therapy	Identifying client strengths as a platform for progress		Consistency	Advise clients about rationale for responsibilities of program (i.e. rules related to funder requirements)	Self-awareness and use of self-talk to avoid re-traumatization	Movement and exercise classes for staff	Flexible policies to accommodate unique client needs; flexibility for staff as well	Used SELF to address program non-compliance by client

Practices that engender collaboration and mutuality	Practices that engender cultural, historical and gender inclusivity (TOP 2 LEAST NOTED CATEGORY)	Practices that engender empowerment, voice and choice (TOP 2 MOST NOTED CATEGORY)	Practices that engender peer support (TOP 2 LEAST NOTED CATEGORY)	Practices that engender safety (TOP 2 MOST NOTED CATEGORY)	Practices that engender trustworthiness and transparency	Resistance to Re-traumatization	Systematic Approach to Policies/ Procedures	Systematic Approach to Practice	Manualized Staff Level Practices
Client satisfaction surveys to get input into program operations	Acknowledging all clients in the same warm and friendly way	Education on trauma dynamics		Being open		Being mindful and respectful of all the “baggage” that clients bring with them	Address vicarious trauma and burnout with staff (e.g. staff outings, provide gift cards)	Allow client’s private time outside the purview of the program staff	Movement and exercise class for staff to address vicarious trauma; taking staff out to lunch or giving them gift cards as recognition
Use of client meetings to elicit concerns and feedback on program changes		Vision boarding activity to empower clients to envision the future they want		Outdoor garden as respite and way for children to connect with nature to mitigate trauma			Open door policy; team approach		Management having an open-door policy for staff and clients (also goes to transparency/trustworthiness)
Motivational interviewing/ conversations		Identification of client-driven and flexible goal plans		24/7 support					

Practices that engender collaboration and mutuality	Practices that engender cultural, historical and gender inclusivity (TOP 2 LEAST NOTED CATEGORY)	Practices that engender empowerment, voice and choice (TOP 2 MOST NOTED CATEGORY)	Practices that engender peer support (TOP 2 LEAST NOTED CATEGORY)	Practices that engender safety (TOP 2 MOST NOTED CATEGORY)	Practices that engender trustworthiness and transparency	Resistance to Re-traumatization	Systematic Approach to Policies/ Procedures	Systematic Approach to Practice	Manualized Staff Level Practices
The manner in which staff communicate with clients (collaborative discussion); client input can lead to a change in rules		Presenting options and resources to clients		Secure living space					
Listening, validating, re-synthesizing info. so clients' hear it in a different way		Financial empowerment services		Pacing the client work					
Belief in client's ability to succeed		Bend rules/ creativity to offer flexibility		Avoid stigmatization by refraining from calling out odd behavior					
Breaking down "us vs. them" frame		Approaching services holistically		Community comes together after incidents that threaten safety					

Practices that engender collaboration and mutuality	Practices that engender cultural, historical and gender inclusivity (TOP 2 LEAST NOTED CATEGORY)	Practices that engender empowerment, voice and choice (TOP 2 MOST NOTED CATEGORY)	Practices that engender peer support (TOP 2 LEAST NOTED CATEGORY)	Practices that engender safety (TOP 2 MOST NOTED CATEGORY)	Practices that engender trustworthiness and transparency	Resistance to Re-traumatization	Systematic Approach to Policies/ Procedures	Systematic Approach to Practice	Manualized Staff Level Practices
Explaining reasons for rules and program components including funder regulations		Person/client-centered approach to care (“following the lead of the client”)		Staff watching children while clients de-escalate					
Partnership between program, client and property management partner; program coaches property management partner				Weekly non-violent communication sessions for staff (e.g. change word choices, listen in depth); conflict resolution sessions					
				Welcoming and assisting drop-in families in crisis that were not part of the program					
				Allowing space and time					