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Trauma-Informed Care Within the Homeless Service Milieu: Practical and Conceptual Considerations

Martina Mihelicova
DePaul University, mmiheli1@depaul.edu

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Department of Psychology

College of Science and Health

DePaul University

Chicago, Illinois

Dissertation Committee

Molly Brown, Ph.D., Chairperson

Anne Saw, Ph.D.

Megan R. Greeson, Ph.D.

Suzanne Carlberg-Racich, PhD, MSPH

Maria J. Ferrera, Ph.D., LCSW

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Biography

Martina Miheličová was born in Prešov, Slovakia and immigrated to the United States as a child with her immediate family. She graduated with a Bachelor of Science degree from DePaul University in Chicago, where she ultimately selected to return for her doctoral studies.

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Abstract

Research indicates that most individuals in the general population experience some form of trauma (Kilpatrick et al., 2013) and that factors such as homelessness place individuals at higher risk of experiencing traumatic events (Deck & Platt, 2015; Ellsworth, 2019; Kushel, Evans, Perry, Robertson, & Moss, 2003). Considering that environments may both promote and impede the trauma recovery process, Trauma-Informed Care (TIC) is a service framework intended to create a culture of trauma awareness and responsiveness (Fallot & Harris, 2006). Preliminary research demonstrates that TIC has positive outcomes for clients and staff (Damian, Mendelson, Bowie, & Gallo, 2018; Hales et al., 2018; Kusmaul et al., 2018). Service environments such as homeless service providers often create settings, or milieus, in which relational and interpersonal factors among clients may impact experiences of TIC. The present qualitative study explores how client-to-client interactions (a) impact client and staff experiences of TIC in homelessness services and (b) highlight TIC principles and their dynamics. The following inductive themes were identified based on 29 client and staff interviews: accessibility, confidentiality and privacy, conflict and conflict management, general environment, individualizing care, mutual support and community building, and policies and policy enforcement. All five TIC principles based on the Fallot & Harris (2006) framework were identified within the dataset: safety, trustworthiness, choice, empowerment, and collaboration. Findings also highlighted inter-principle and intra-principle dynamics, and how they occurred. Specifically, how and the extent to which TIC principles were implemented at times had additional effects for TIC principles. Findings have practical implications for issues relevant to TIC within milieu settings and conceptual implications for ways in which TIC principles interact.

Trauma-Informed Care Within the Homeless Service Milieu: Practical and Conceptual Considerations

Due to the high prevalence of trauma histories among individuals experiencing homelessness (Deck & Platt, 2015; Ellsworth, 2019; Kushel et al., 2003), there is a growing need for service environments sensitive to trauma. In response, homeless service organizations have been implementing trauma-informed care (TIC) as a service philosophy (Hopper et al., 2010). Research indicates that TIC is promising as a framework for service provision (Damian et al., 2018; Hales et al., 2018; Kusmaul et al., 2018). TIC is often implemented within group settings that compose the milieu, or the social environment of a therapeutic setting. Within homelessness services, TIC has been implemented within milieus such as drop-in centers (Hopper et al., 2010). However, practical guidelines often center on direct service staff implementation of TIC principles in one-on-one interactions with clients (e.g., Butler et al., 2011). Within milieu settings, client interactions may impact how TIC is experienced by clients whether through behaviors of other clients or staff responses. For staff, implementing TIC within milieus may give rise to unique practice benefits and challenges. By focusing specifically on interpersonal-level factors within milieu settings, the present study addresses practice-level gaps in the literature. Secondly, the present study also aims to address conceptual gaps in the TIC literature, by exploring how interactions within the milieu highlight TIC principles and their dynamics.

Overview of Trauma

Trauma is often conceptualized as a distressing event such as physical or sexual violence that threatens an individual's life or the life of someone whom they witness or learn about (American Psychiatric Association, 2013). A broader definition focuses on threat to physical,

psychological, or emotional safety and results in psychophysiological responses (American Psychological Association, 2017). As such, trauma is the distress caused by an activating event. However, clinical definitions of trauma often do not acknowledge trauma occurring at institutional levels and historical or transgenerational trauma. Becker-Blease (2017) argues, "Because trauma is inextricably linked to systems of power and oppression, history tells us to pay particular attention to how trauma is defined, who is and who is not defining trauma, and how victims/survivors are affected by those definitions" (p. 131-132). Providers serving trauma survivors exist within the structures that may perpetuate institutional trauma and, as such, service providers may contribute to the traumatic experiences they aim to change (Bloom & Farragher, 2013). Without the consideration of trauma definitions, service institutions may unintentionally reinforce practices that victim-blame and retraumatize (Becker-Blease, 2017).

Homelessness has long been conceptualized as trauma. Losing housing or surviving the conditions of homelessness may produce significant distress and pose threats to safety and security (Goodman et al., 1991). Additionally, many individuals experiencing homelessness have survived other traumas such as interpersonal violence (Goodman et al., 1991). Goodman and colleagues (1991) outline two types of psychological trauma often reported by individuals experiencing homelessness including (a) social disaffiliation and increased distrust, and (b) learned helplessness. Social disaffiliation refers to the severance of social bonds and roles. Members of a trauma survivor's support network may withdraw due to perceiving the survivor as unpleasant. For the trauma survivor, such reactions can reinforce perceptions of isolation. Homelessness may also involve a disruption of roles, such as due to separation of family members within shelters. Such practices may decrease opportunities to maintain typical social connections and support, and increase distrust. Learned helplessness is a sense of powerlessness

due to the belief that an individual lacks control. Homelessness may involve diminished control over access to basic needs or reliance on others to fulfill those needs. Additionally, homelessness may serve as a vulnerability to psychological distress (Castellow et al., 2015). Responses to homelessness reflect posttraumatic stress through common coping responses such as substance use or changes in belief systems such as learned helplessness (Castellow et al., 2015). Having a history of homelessness predicted levels of psychiatric distress and alcohol use endorsed by individuals experiencing psychiatric disabilities receiving supported housing services (Castellow et al., 2015). The number of months experiencing homelessness also related to distress levels (Castellow et al., 2015). Additionally, there is tension in the PTSD literature regarding defining trauma, specifically within the context of diagnosis PTSD (i.e., criterion A) as a discrete event as opposed to chronic experiences as is the case for homelessness. The most common "worst" or index event identified by Veterans with any history of homelessness was homelessness (Tsai et al., 2020). This is important as it speaks to the survivors' own conceptualization of homelessness as trauma; another conceptualization is that homelessness places individuals at higher risk for Criterion A defined traumatic events. In sum, homelessness may be caused by trauma, lead to additional traumas, and may itself be traumatic.

Trauma Prevalence

Trauma prevalence is high with 89.7% of the general population in the United States reporting experiencing a traumatic event based on DSM-5 criteria (Kilpatrick et al., 2013). Trauma intersects with power and privilege, in that individuals who have less access to resources or are of lower socioeconomic background may be at higher risk of experiencing traumatic events and subsequent Posttraumatic Stress Disorder (PTSD). For example, approximately a third of 2,577 individuals experiencing homelessness or marginal housing in San Francisco

reported surviving sexual or physical assault in the preceding year (Kushel et al., 2003). A review of the literature indicated that rates of past year victimization among individuals experiencing homelessness (3% - 65%) were consistently higher than within the general population (0.1-7.2%; Ellsworth, 2019). Among 152 men experiencing homelessness in a midwestern Metropolitan area, 23-30% screened positive for PTSD (Deck & Platt, 2015). A third of military Veterans with a history of homelessness were found to screen positive on the PCL-5 for lifetime prevalence of PTSD. Relatedly, homelessness was related to a five times higher odds of screening positive on the PCL-5 for past-month PTSD (Tsai et al., 2020). Additionally, accessibility to services such as insurance may impact whether individuals engage in services and, therefore, outcomes (Hale et al., 2017). Trauma rates are also higher when considered with intersections of mental health, gender, and other factors; for example, among a sample of 99 women experiencing serious mental illness and homelessness, 97% reported experiencing lifetime sexual and physical abuse (Goodman et al.,1995). Furthermore, racial-ethnic disparities in homelessness are tied to systemic trauma. Black/African American individuals in particular are overrepresented in homelessness prevalence rates (above 40%) despite representing a minority of the general population (13%, Olivet et al., 2019). Such racial-ethnic differences are seen even when controlling for poverty, highlighting the relation between systemic racism and homelessness (Olivet et al., 2019). Housing policies and practices have racialized histories (e.g., redlining, Olivet et al., 2019). Such acts of discrimination and other historical traumas form collective memories of harms. These collective memories combined with ongoing experiences of racism may be traumatic (Franklin et al., 2006). Given the high prevalence of trauma among individuals experiencing homelessness, trauma sensitivity within homelessness services is especially important.

The Impact of Service Environments on Recovery

Recovery post trauma is dependent on a variety of interactions between the individual and the surrounding environment (Harvey, 1996). Therefore, considering ways in which service systems create an environment conducive to recovery is essential. However, service environments may unintentionally impede recovery and disengage individuals from services due to lack of trauma awareness and sensitivity. This may manifest as perpetuating inequitable power structures. Findings based on a community organizations' database of over 600 interviews with individuals experiencing homelessness coalesced around two major themes of individuals feeling infantilized and objectified within homelessness services, which for some led to disengagement (Hoffman & Coffey, 2008). Participants described being treated as children, staff making assumptions about their needs or experiences, treating clients with disrespect or as a number rather than a human being (Hoffman & Corey, 2008). Negative experiences within service systems may interact with trauma in that traumatic events are representative of a loss of control and choice; therefore, settings that take away autonomy in particular ways may be retraumatizing. A qualitative study with 15 women experiencing homelessness and identified as having a serious mental illness found a theme of the shelter environment negatively impacting well-being (Bonugli, Lesser, & Escandon, 2013). More specifically, women reported feeling devalued or degraded due to invasive policies (i.e., being searched) and lack of safety measures or an unsafe surrounding environment that resulted in at least one woman reporting experiencing sexual assault near the shelter.

Research has also identified ways in which service environments can be conducive to recovery. For example, participants in Bonugli and colleagues' (2013) study identified aspects of shelter environments they found helpful, including "practices that were clear, structured, and

consistent" (p. 832) and flexibility in being able to come and go. A subset of individuals within Hoffman and Corey's (2008) study who described positive experiences spoke to caring and respectful staff, rule flexibility, and accessibility to relaxing spaces. As such, considering not only interpersonal interactions with staff but also the environmental context of services, such as organizational policies, is important for trauma recovery.

Organizational Barriers to Providing Recovery-Oriented Care

When creating recovery-promoting environments, service organizations are situated within a backdrop of larger systemic structures that may place social service organizations at a disadvantage due to a lack of resources such as funding. These systemic factors trickle down to interpersonal interactions among clients and staff. For example, due to lack of resources and, as a result, inability to provide adequate care to their clients, staff may be left feeling hopeless and experience negative outcomes such as burnout and compassion fatigue. Limited resources within homelessness service organizations may relate to high turnover given low pay (Olivet et al., 2009). Additionally, turnover intent has been found to be predicted by role-related stress and associated burnout (Kim & Stoner, 2008). High turnover and staff burnout is likely to impact service quality. Further, given the high prevalence of trauma among individuals experiencing homelessness, staff working with this population may be at higher likelihood to witness or otherwise vicariously experience trauma by listening to traumatic stories. Rates of vicarious traumatization and burnout may interact with personal experiences of trauma experienced by staff. Witnessing trauma may lead to PTSD-like symptoms, or Secondary Traumatic Stress, which also have the potential to impact the quality of services. A third of 472 homeless shelter staff working directly with clients in Canada screened positive for PTSD and about a fifth

reported significantly elevated rates of vicarious traumatization and burnout (Waegemakers Schiff & Lane, 2019).

In sum, homeless service organizations are composed of a substantial proportion of clients and staff who may be struggling with distress that may impact interactions. For instance, witnessing trauma near or at a service setting could lead to avoidant behaviors to manage distress. Physiological reactions, such as being easily startled, could communicate distrust. Understanding that such reactions are tied to trauma exposure and developing policies and practices that are reflective of this trauma awareness may improve experiences for clients and staff.

Trauma-Informed Care

Addressing the need for trauma sensitive service environments, trauma-informed care (TIC) is an organizational culture shift that establishes trauma awareness, promotes trauma sensitivity, and creates an environment that is physically and emotionally safe for clients and staff. The Substance Abuse and Mental Health Services Administration (SAMHSA; 2014) identifies the following organizational structures and activities in which TIC should be implemented: (a) investment of leadership making organizational changes to promote TIC; (b) reflection of TIC within policies and protocols, and the physical environment; (c) inclusion of service users, people in recovery, survivors of trauma, and family; (d) collaboration across sectors; (e) trauma screening and trauma-specific services or referral to trauma-specific services (i.e., evidence-based group or individual therapy for trauma-related disorders); (f) continual trauma training and staff support; (g) funding; and (h) quality assurance and evaluation. Bloom and Farragher (2013) outlined the need for democratic decision-making as a way to share power, commitment to TIC through organizational policy change and organizational missions, and

support of leadership. As an example, the Sanctuary Model (Bloom & Farragher, 2013) involves recruitment of a steering committee of staff at various levels who are trained and tasked with leading organizational change. In sum, implementation of TIC occurs across all levels of an organization and involves embedding TIC within a number of organizational activities.

Models of Trauma-Informed Care

TIC is implemented through a set of guiding principles, which may also be conceptualized as a group of interrelated frameworks or models. Varying models of TIC exist, in that different sets of principles are highlighted across different scholars and government agencies (see examples in Table 1). For clients, the safety principle may manifest as universal trauma screening, clarity around expectations, and sufficient personal space; choice can mean non-contingent services and choice around starting and stopping services; and empowerment can mean client involvement in organizational planning and evaluation (Hopper et al., 2010; Fallot & Harris, 2006).

As apparent, there is substantial overlap of principles across the varying conceptualizations. Despite the overlapping nature of TIC principles across models, certain TIC models have been developed in the context of working with specific populations. For instance, Elliot and colleagues' (2005) model is specific to women who have survived trauma and may struggle with mental health and substance use issues. This raises questions about whether TIC requires conceptual adaptation to specific contexts (i.e., work with specific populations) or whether consensus on broad overarching TIC principles is needed.

Table 1

Overview of Trauma-Informed Care Frameworks

Source	Guiding Principles	Definitions

Fallot & Harris, 2006	Safety	Physical and emotional safety
	Trustworthiness	Informed consent; clarity & consistency
	Choice	Choice in services and control
	Empowerment	Skill building; recognizing strengths
	Collaboration	Shared power; clients are involved in goal-setting
Hopper et al., 2010	Trauma awareness	Trauma education and training, and TIC within the program philosophy
	Safety	Physical and emotional safety
	Choice and empowerment	Client control; skill building
	Strengths-based approach	Emphasize strengths & resiliency
SAMHSA, 2014	Safety	Physical and psychological safety
	Trustworthiness and transparency	Organizational practices are transparent to build trust
	Peer support	Mutual support is facilitated through inclusion of people with lived experience
	Collaboration and mutuality	Shared power and decision-making
	Empowerment, voice, and choice	Acknowledge and build strengths; collaborative treatment

Cultural, historical, and gender issues	Policies are responsive to racial/ethnic, cultural, or gender-based needs

Outcomes of Trauma-Informed Care

Limited research exists explicitly evaluating the outcomes of trauma-informed organizations and systems. Studies investigating outcomes of TIC have focused on measuring outcomes such as: (a) client retention, satisfaction, and mental health symptoms; (b) staff knowledge, attitudes, satisfaction, negative and positive outcomes such as compassion satisfaction and compassion fatigue; and (c) organizational outcomes such as climate, staff support, and safety culture. For example, Hales et al. (2018) examined outcomes of TIC implementation within a residential treatment center providing substance use, mental health, and homelessness services. The TIC implementation process involved training, selecting staff to deliver ongoing training, developing client trauma groups, reviewing and revising agency policies and procedures, etc. (Hales et al. 2018). Significant improvements over time were observed in staff-reported organizational climate, policies and practices, client retention, client satisfaction, and certain aspects of staff satisfaction. Decreases were observed in a few staff satisfaction items such as being well-informed of agency changes or experiencing the work environment as safe. In another study, staff at a non-profit agency providing mental health services reported higher satisfaction on all but the pay/benefits subdomains of the satisfaction measure one year post TIC implementation (Hales et al., 2017). However, it should be noted that statistical differences were not reported due to lack of access to raw data. Additionally, given that

elements of TIC implementation were not measured, drawing parallels to outcomes is difficult (Hales et al., 2017).

In terms of examining TIC in larger systemic contexts, the National Center for Trauma Informed Care (NCTIC) implemented and evaluated a nine-month citywide initiative across law enforcement, health, social and education services in Baltimore (Damian, Gallo, Leaf, & Mendelson, 2017; Damian, Mendelson, Bowie, & Gallo, 2018). Findings indicated pre-post changes in organizational factors, such as improved staff perceptions of safety culture, and staff factors, including increased compassion fatigue, improved trauma knowledge and attitudes towards trauma survivors, but no difference in the belief in ability to provide TIC and trauma-specific referrals (Damian et al., 2017; Damian et al., 2018). Qualitatively, a subset of 16 staff in the NCTIC initiative described the helpfulness of learning from other participants and of the TIC framework overall, improved collegiality, management, physical environments, and policies in terms of their flexibility and punitiveness, increased appreciation of direct service workers by upper-level management including in policy change, and increased self-awareness of workplace stress and self-care needs (Damian et al., 2017; Damian et al., 2018).

Certain studies have investigated outcomes of trauma-informed care that include trauma-specific interventions combined with other service frameworks such as integrated care. The Women, Co-occurring Disorders, and Violence Study (WCDVS) was specifically designed to respond to the needs of women with comorbid mental health and substance use issues given the high rates of trauma experienced by this population (Morrissey et al., 2005). The study was conducted across nine agencies with over two-thousand women and the intervention included trauma-informed staff, integrated mental health, substance use, and trauma treatment, involvement of women in service delivery and on advisory boards, and a variety of services such

as trauma treatment and advocacy. Findings indicated improvement in general mental health and PTSD symptoms but no differences in substance use symptoms (Morrissey et al., 2005). Generally, preliminary research indicates that implementing TIC has positive outcomes, although not all expected outcomes indicated change and some staff outcomes have shown negative impacts on compassion fatigue or aspects of staff satisfaction.

Barriers and Facilitators to Trauma-Informed Care Implementation

Research has investigated needs, barriers, and facilitators to creating recovery-oriented environments. For instance, the NCTIC evaluation of a system-wide TIC implementation mentioned above identified challenges including a "(a) need for outreach to upper-level management, (b) a lack of real-life applicability, and (c) a lack of guidance regarding next steps" (Damien et al., 2018, p. 5). These findings highlight challenges in TIC implementation. Developing more context-specific guidelines for trauma-informed interventions may address such challenges.

A qualitative study on TIC and trauma-specific services in Canada was conducted with 19 service users as well as service providers and research experts, and addressed implementation challenges (Kirst et al., 2017). Service users were interviewed primarily regarding their satisfaction with trauma-specific services. Key themes included the need for an overall organizational change and leadership that would promote trauma-informed and trauma-specific service delivery, interagency collaboration to facilitate systems of care, the need for training and supervision to increase trauma awareness, creating a safe environment for people of diverse backgrounds, support for staff, and a need for consumer involvement in services. Importantly, the study highlighted barriers to TIC and trauma-specific service implementation, such as service inaccessibility, hesitance in addressing trauma, and systems-level barriers such as

under-resourced organizations and staff burnout. Service users spoke to lack of negative judgment, positive aspects of peer support, skill building, as well as discouragement or lack of comfort in discussing trauma, lack of choice such as physical restraint in hospital services, as well as systems issues such as lack of resources or limited service lengths (Kirst et al., 2017).

TIC implementation has also been explored within settings that have not explicitly been trauma-informed. Wolf and colleagues (2013) conducted a qualitative study of 10 focus groups and six individual interviews with staff across a diverse set of social service agencies that did not explicitly implement TIC. The authors used Fallot and Harris' TIC conceptualization to assess TIC implementation with the assumption that given the overlap of TIC with social work values, most social service agencies would be suffused with tenets of TIC despite not formally having implemented TIC (Wolf et al., 2013). Results indicated varied levels of TIC implementation, such as some agencies describing policies or practices that aligned with TIC for clients but not for staff. Although the authors do not highlight this as an important finding, results regarding level of physical and emotional safety indicated that implementation of one aspect of TIC at times diminished another. The example provided was that cameras were used as a physical safety measure, but diminished emotional safety for some clients. Regarding lack of choice, participants described that service availability or court-mandated services decreased the ability to provide choice around service engagement.

Similarly, Kusmaul and colleagues (2018) conducted semi-structured interviews based on Fallot and Harris'(2006) TIC conceptualization. Interviews were conducted with 26 clients receiving refugee, substance use, older adult, and maternal-child health services that did not provide trauma-specific interventions and did not explicitly provide TIC. Findings indicated ways participants experienced safety, empowerment, choice, collaboration, and trustworthiness;

interestingly, two additional themes were found regarding negative treatment by other clients and conflicts among TIC principles, such that implementing one principle diminished another or implementation of a principle was experienced differently across clients. One example was room checks being perceived as intrusive but ultimately as increasing safety (even by the same participant). Authors concluded that not all principles need to be implemented in each policy or interaction but recommend identifying ways to promote other principles to increase TIC when one principle is diminished (Kusmaul et al., 2018). The authors further concluded that a single agency cannot fully implement each TIC principle for all individuals; therefore, the goal should be the majority. However, a possible unintended consequence of this approach could be systematic rather than random preference for implementation of TIC towards certain individuals or groups given that service systems exist within broader oppressive systems and can unintentionally perpetuate such patterns.

Including client voices in evaluating TIC may facilitate identifying challenges that arise in practice. Previous research has emphasized that TIC principles generally facilitate one another (Kusmaul et al., 2015). However, implementing TIC may also have negative impacts for subgroups (Kusmaul et al., 2018; Wolf et al., 2013). A single action intended to promote a TIC principle for an individual can impact others negatively. As such, TIC can manifest differently across clients given the nature of the trauma, coping mechanisms, belief systems (and ways beliefs have been culturally shaped). Future research can investigate how staff manage such challenges as well as ways to engage clients in maintaining and implementing TIC principles within their own interactions.

Contextual Considerations for TIC Implementation in Milieu Settings

As an organizational cultural change, TIC aims to create a therapeutic environment. This is particularly and explicitly apparent in Bloom's Sanctuary Model of TIC, which is in part based on a milieu setting framework (Bloom, 1997). Milieu settings, or therapeutic communities, grew out of the conception that inpatient psychiatric hospitals represent a microcosm of larger society which can be therapeutically relevant (Jones, 1968). From a social-ecological perspective, a milieu acknowledges that behavior is not static but determined in some part by the environment (Moos, 1974). Within the environment, each member (both client and staff) is understood as being essential to the therapeutic nature of community, thereby the mutual influence among clients is acknowledged and actively utilized in the therapeutic process (De Leon, 2000). In essence, "quality of life is perceived in large part as a function of the people that share the milieux" (Gottlieb, 1979, p. 470). Essential components of milieu settings include flattening of power among clients and staff such as in decision-making, open communication, and relationships among members of the therapeutic community (Lawson, 2018). In the context of homelessness service settings, milieus may include shelters and drop-in centers (Glasser & Zywiak, 2003; Hopper et al., 2010; Rollinson, 1998).

The therapeutic aspect of milieus may occur in both formal and informal settings. Oftentimes, mutual peer support occurs within formal group settings intentionally created within therapeutic communities, such as group meetings that focus on relationships among members of the community and facilitate social learning (Jones, 1968). However, peer influence may occur in informal ways outside of structured groups. Findings from a qualitative study examining the therapeutic factors in an inpatient unit milieu that was not explicitly trauma-informed identified peer interactions in a smoking room as a key ingredient given the lack of guidelines within the

room and informal social support among clients (Thomas, Shattell, & Martin, 2002). As such, the milieu context refers to both formal interactions, such as structured groups, and informal interactions outside of structured therapy. Therefore, delivering TIC in milieu settings has its benefits, such as the opportunities for mutual support among clients (Kirst et al., 2017). Given that TIC is an organizational culture change focusing on altering the environment, the involvement of clients is often highlighted as a need and key implementation domain to promote client democratic participation (Bloom & Farragher, 2013; Kirst et al., 2017; SAMHSA, 2014). For instance, clients may be involved in developing or delivering services such as peer support (SAMHSA, 2014). More broadly within the homelessness literature, group memberships are considered an important predictor of recovery in terms of exiting homelessness and positive well-being given the risk of loss of social connections as part of homelessness (Johnstone et al., 2016). Findings from an Australian study with transitional and temporary housing residents at a Salvation Army identified the benefits of relatability and mutual support (Johnstone et al., 2016). Similarly, a Canadian study centered on service use experiences with individuals experiencing current and past homelessness identified a subtheme of relatability that facilitated a sense of belonging (Kerman et al., 2019). It is clear that relationships among clients are an essential component of the homeless service milieu.

Alternatively, the presence of other clients in a milieu may have its challenges. Clients reported that their experiences were negatively shaped by other clients, such as being the subject of discriminatory comments, clients not cleaning up after themselves, and other conflicts (Kusmaul et al., 2018). In transitional housing, some clients reported limited social connections at times to avoid others' substance use, conflict, feeling different, not trusting others, or wanting to limit exposure to others' problems which could be draining (Johnstone et al., 2016). The

presence of others impacted views of safety among individuals experiencing current and past homelessness, and participants described issues of conflict, varying from verbal to physical, or being triggered or made to feel unsafe by others who used substances. In response, some individuals limited their social interactions with individuals from whom they felt dissimilar (Kerman et al., 2019). Experiences with other service users may also impact perceptions of the environment as a whole. Some individuals described a sense of chaos or one in which there are limited interactions (Kerman et al., 2019). Although the aforementioned studies were not based in settings explicitly providing TIC (Johnstone et al., 2016; Kusmaul et al., 2018), it is possible that similar challenges may arise in trauma-informed homeless service milieus.

Additionally, there is the possibility that clients will differentially experience TIC principles (Kusmaul et al., 2018). Needs are often individualized and the population of people experiencing homelessness is heterogeneous, as such, certain policies for instance may be perceived as too restrictive by some while others may appreciate the structure (Johnstone et al., 2016). Such tensions may be particularly pronounced in milieu settings. As such, the context in which TIC is implemented, whether individual psychotherapy or a milieu setting, likely impacts how TIC is experienced.

Current Limitations in the Trauma-Informed Care Literature

The movement toward implementation of TIC has been welcomed, yet additional research is needed to address current gaps in the literature. Practice-level recommendations often focus on ways in which TIC can be implemented within one-on-one interactions between clients and staff such as through single client case scenarios (e.g., Butler, Critelli, & Rinfretti, 2011; Hopper et al., 2010.) However, little attention is paid to dynamics that may play out in group

settings. Within milieu environments, the presence of multiple clients results in additional considerations for TIC implementation.

Conceptually, TIC poses challenges given that multiple TIC frameworks exist (e.g., Hopper et al., 2010; SAMHSA, 2014). Additionally, TIC is at times described as a component of empowerment philosophy in domestic violence shelters (Nnawulezi et al., 2018b), which calls attention to broader conceptual issues given that empowerment is considered a component of various TIC models. The various TIC frameworks are largely overlapping, which is theoretically advantageous in terms of developing systems of care that align conceptually. However, differences in TIC frameworks raise questions about whether or under what circumstances the differences matter. Differences in TIC frameworks also highlight the tension of broad, flexible as compared to context-specific frameworks. Services that are too specific to certain populations or social issues may unintentionally lack an intersectional perspective; individuals within a context-specific setting such as homelessness services may have very different needs. Although broad principles may be flexibly applied across various settings, the lack of specificity to particular populations creates confusion about how TIC should manifest in a particular context (Kusmaul et al., 2018). Given that TIC is a framework rather than a testable theoretical model, evaluation of specific operationalized models within TIC would allow us to understand a particular program theory or more broadly how aspects of TIC within a particular context work together to produce intended outcomes. As such, one way of addressing this tension is to utilize a contextual perspective to understand TIC implementation, such as focusing explicitly on milieu setting interactions within homelessness services.

A second conceptualization issue is tension across and within TIC principles. Generally, research on TIC focuses on the interrelatedness of TIC principles as being mutually beneficial.

This is due to factor analytic studies demonstrating moderate to strong correlations among principles and conceptual congruities among principles (Kusmaul et al., 2015). Authors emphasize the need for implementing all principles and suggest that implementing one principle may facilitate another (Kusmaul et al., 2015). Although principles may influence one another positively, negative effects across principles are possible and should be acknowledged. There is limited focus on the possibility of conceptual and practical interactions among principles that may impact implementation. For instance, increasing safety may mean the need for decreasing choice. Beyond research indicating positive correlations among principles (Kusmaul et al., 2015), Kusmaul and colleagues (2018) uniquely highlighted themes of conflicts among principles as well as how negative experiences with other clients shaped service users. Dynamics among principles, whether mutually facilitating or impeding, may arise in implementing TIC in a group context such as a homeless service milieu given that the presence of and interaction among clients is impactful. Kusmaul and colleagues (2018) highlight the possibility that a practice intended to be trauma-informed may be perceived as both a safety measure and intrusive practice that decreases safety or perhaps even choice or autonomy. As such, considering how implementing one aspect of TIC impacts other aspects or principles of TIC may be particularly relevant to delivering TIC in a milieu setting.

Rationale

Given the high prevalence of trauma among individuals experiencing homelessness, the fact that homelessness itself can be traumatic, and the possibility of retraumatization within homeless service settings, successful implementation of TIC within homeless service milieus could promote positive well-being and recovery. Further, the homeless service milieu is an appropriate context within which to explore broader conceptual issues. The population of

individuals experiencing homelessness is heterogenous with diverse barriers and facilitators to recovery. Homelessness services therefore often address various barriers (e.g. housing, health, etc.) and by their nature create milieu settings in which participants interact, such as in shelters, day centers, or groups.

The present study seeks to address various gaps within the existing literature. Practically, literature on TIC is often focused on individual interactions among clients and staff or considerations for single clients. Moving away from individual factors as considerations for TIC implementation, the interpersonal level of a social-ecological approach to TIC allows the exploration of additional considerations for practice and conceptual considerations for TIC. As such, the present study aims to focus explicitly on unique features within the milieu: how client-to-client interactions can impact experiences. For the purpose of this study, *client-to-client interactions* are defined as any social interactions that occur among clients or involve multiple clients. This includes direct interactions among clients, such as a conversation or exchange between clients, and indirect interactions, such client observations of other clients and/or observations of staff behaviors towards other clients. Additionally, milieus create formal and informal settings in which peers interact. More specifically, formal settings refer to spaces in which direct interactions among clients are intended to occur (e.g., group therapy) and are viewed as a key ingredient aimed to benefit clients. Moreover, milieus also create informal settings in which client interactions may be impactful. Informal settings refer to spaces or times of day that occur outside of scheduled treatment or services, such as an exchange among clients over coffee in a hallway or while smoking outside of the agency's building. In sum, the present study focuses on how homeless service clients and staff are impacted by such interactions involving clients.

Secondly, the present study also seeks to explore how TIC principles and their dynamics are represented within the context of milieu setting interactions. The aim is to understand which TIC principles are relevant, how they are experienced and implemented, and ways in which the principles of TIC operate and affect one another. Although the literature has not explicitly focused on TIC principle dynamics, principles may be both mutually facilitating or create intra- and inter-principle conflicts in practice (Kusmaul et al., 2015; Kusmaul et al., 2018; Wolf et al., 2013). *Inter-principle dynamics* refer to effects across TIC principles (e.g., how choice might impact safety). *Intra-principle dynamics,* or effects within TIC principles, can occur because each TIC principle definition has multiple components as well as because an action intended to be trauma-informed can impact two different groups of individuals differently (e.g., promoting one group's choice impacting another group's choice negatively) or be perceived ambivalently by the same individual as noted by Kusmaul and colleagues (2018). *Facilitation* refers to situations in which the addition of a TIC principle positively impacts the implementation or experience of another principle (e.g., giving choice increases trustworthiness). *Impediment* refers to situations in which the addition of a TIC principle decreases the implementation or experience of another principle or vice-versa (e.g., giving choice decreases trustworthiness). The study will address this gap by exploring such dynamics.

The present study aims to inform both practice and the conceptualization of TIC. Findings can provide additional practice guidance beyond individual considerations for TIC implementation. Dynamics that may play out within client interactions and their impact on clients as well as staff may raise attention to challenges as well as successes. This study also has implications for theory in that although strong correlations do show quantitative and theoretical

relatedness, qualitative nuances shed light on the variance unaccounted for when principles are viewed as static, acontextual variables.

Research Questions

Research Question I

How do client-to-client interactions impact client experiences of trauma-informed care within a homeless service organization?

Research Question II

How do client-to-client interactions impact staff experiences of trauma-informed care within a homeless service organization?

Research Question III

How do client-to-client interactions highlight TIC principles and their dynamics?

Methods

Setting

The current study is part of an existing exploratory qualitative study on TIC within a homelessness service organization located in a large Midwestern city in the United States. The organization serves individuals experiencing homelessness, mental illness and/or substance use disorders, or chronic physical illnesses. A range of services are provided, including health services (mental health, dental, and nutrition services, and primary care), on-site and scattered site housing services, outreach services, and case management. The organization implements a TIC service philosophy alongside harm reduction, strengths-based care, promotion of human rights, and a commitment to diversity. The organization did not use a specific TIC model in initial implementation. Within its TIC philosophy, the organization's definition of trauma encompasses a variety of experiences that includes homelessness and poverty, violence, and

racism. Being trauma-informed is defined as involving changes within policies and practices such as to address barriers to accessing services for trauma survivors, incorporation of TIC within hiring, inclusion of trauma survivors on staff and in informing services, trauma and safety assessment, respecting choice around discussing traumatic experiences, reducing risk of retraumatization, providing interventions that build skills, and offering support and training around staff vicarious traumatization. Staff are introduced to TIC at orientation and receive once yearly half-day training on TIC which includes a focus on ways TIC manifests within interpersonal interactions such as setting boundaries, consistency and predictability, and burnout and vicarious trauma. The organization offers voluntary monthly TIC consultation meetings, during which staff can discuss challenges and questions. Staff may also earn continuing education credits through consultation meetings. The organization also offers an optional trauma-specific group intervention for clients.

Research Participants

Convenience samples of 17 homeless service clients and 12 staff members were recruited from the partnering homeless service organization. Inclusion criteria for clients included: adults who were current service users at the agency at the time of the study and who have received services for at least 6 months. Clients included individuals with current or past histories of homelessness. Inclusion criteria for staff included adults who have worked at the agency for at least a year. Sample demographics are presented in Table 2.

Table 2
Demographic Characteristics

Characteristic	Total	Clients	Staff
	N = 29	n = 17	n = 12
Age M (*SD*)	47.41 (11.46)	52.59 (7.51)	40.08 (12.35)

Female n (%)	18 (62.1%)	10 (58.8%)	8 (66.7%)
Race/Ethnicity n (%)			
African American	15 (51%)	13 (76.5%)	2 (16.7%)
Indigenous	1 (3.4%)	1 (5.9%)	0
Latinx/Hispanic and Multiracial/White	5 (17.2%)	1 (5.9%)	4 (33.3%)
White, Non-Latinx/Hispanic	8 (27.6%)	2 (11.8%)	6 (50.0%)
Highest Education Level			
Grade K-12 or less	10 (34.5%)	10 (58.8%)	0
Some College, Trade School, or Associate's	8 (27.6%)	6 (35.3%)	2 (16.7%)
Bachelor's	5 (17.2%)	1 (5.9%)	4 (33.3%)
Master's	6 (20.7%)	0	6 (50%)
Currently Employed	14 (48.3%)	2 (11.8%)	12 (100%)
Years Employed at Agency (*SD*)	-	-	7.85 (7.48)
Position at Agency			
Administrative	-	-	2 (16.7%)
Direct Service	-	-	8 (66.7%)
Managerial/Supervisory	-	-	2 (16.7%)
Ever Experienced Homelessness	-	-	2 (16.7%)

Measures

A paper and pencil demographics survey was administered by an interviewer to clients and staff (see Appendices A and B). The survey included general characteristic questions (e.g., age, gender, race, ethnicity, sexual orientation), Veteran status, education, employment, and history of homelessness and contributing factors to homelessness (e.g., criminal justice issues, interpersonal or domestic violence, physical health issues). The client survey included additional questions about homelessness (e.g., year of last permanent residence and whether the individual

experienced homelessness as a teenager) and services received at the agency (e.g., case management, primary care, group therapy).

Two semi-structured interview protocols were developed—one for clients and one for staff (see Appendices C and D). The interview protocols asked participants to describe needs around trauma sensitivity and how the agency whose services they utilized demonstrated trauma sensitivity within its training, policy, and practices. Rather than aligning the protocols with a particular TIC framework, the protocols focused on asking participants about trauma sensitivity across various implementation areas to facilitate the exploratory nature of the study. As such, protocols included probing questions for TIC within interactions among clients, outside of specific services, and within the physical environment. Broad, opening questions included, "What can agencies do to be sensitive to people's experiences of trauma?" Items specific to the agency included, "Tell me about policies you're aware of that [agency name] has in an attempt to be sensitive to the fact that people may have experienced trauma." Client-specific items included, "Based on your experiences at [agency name], how knowledgeable is staff about trauma?" Staff-specific items included, "How prepared do you feel in addressing trauma-related issues?

Procedures

The partnering organization provided support around participant recruitment. Clients were recruited through flyers distributed by staff and posted at the agency. Staff were recruited through recruitment emails. Eligibility criteria were assessed as interested individuals contacted us about the study. Interviewers met with potential participants at a private location convenient to them such as the host agency, at DePaul University, at the participant's home, or at a public library meeting room. Participants were engaged in the consent process at the time of the

interview. Semi-structured, audio-recorded interviews were conducted. On average, interviews lasted 79 minutes (*SD* = 21 minutes). Staff and clients received $20 Visa gift cards for their participation in the research study.

Data Analysis

Audio-recorded interviews were transcribed for data analysis. Data were analyzed using thematic analysis (Braun & Clarke, 2006) under a constructivist paradigm (Creswell, 2013). Constructivism refers to the conceptualization of multiple realities or truths that are socially influenced, or constructed (Creswell, 2013). Given the focus on the interactions among clients in group contexts, the study lends itself to a constructivist paradigm that highlights how experiences are shaped by social interactions. Deductive and inductive coding can be complementary when the aim of the study is both exploratory (as in the existing study) and more narrow and directed based on specific research questions (Fereday & Muir-Cochrane, 2006). As such, deductive coding is appropriate when a specific aspect of the data is to be coded based on pre-existing ideas or theory (Braun & Clarke, 2006). A mixed deductive and inductive coding approach was used as described for each research question below.

Research Questions I and II

A deductive approach was used to identify the study dataset. Two analysts initially read all client and staff interviews transcripts and used a checklist of rules (see Appendix E) to deductively code all interview transcripts for any data that related to milieu interactions involving clients, or client-to-client interactions. *Client-to-client interactions* were defined as anything relating to the mention, presence, or interaction of two or more clients. The checklist included the following rules: at least two of the individuals mentioned must be clients. If, for example, a client is describing a situation that arose between themself and a staff member, this

would not count. However, if the client described a situation that arose between themself, another client, and a staff member, this would count. Situations in which clients described interactions among a staff member and another client also counted, but only when it related back to their experience somehow. In an effort to represent participant perspectives, data were coded based on the participants' experience of the situation or behavior rather than necessarily the behavior itself (or analyst perceptions of the situation/behavior). Both analysts read and coded all client interviews using the checklist and agreement was obtained using a consensus process. More specifically, any differences were reviewed and discussed until agreement was achieved. All client and staff data that were coded using the Appendix E checklist and agreed upon were considered the present study dataset.

Through an inductive process, each analyst was then assigned a portion of the reduced dataset to open code within Microsoft Word. Individual open codes represent the smallest data excerpts that form single, coherent ideas (Braun & Clarke, 2006). Analysts organized their open codes thematically to begin identifying similar patterns across interviews. Analysts also referred to the larger study codebooks during this process to further promote consensus on themes and theme definitions. The larger study codebooks were developed through an inductive process by multiple coders. The present study author was involved in developing the larger study client codebook. The present study working themes and the open codes were reviewed and combined through a consensus process that ensured each open code was captured within a working theme. The themes identified within the staff dataset were merged with those within the client dataset given substantial overlap.

A codebook was developed which included the final themes combined across staff and client data, their definitions, exclusion criteria when applicable, and sample quotes

(DeCuir-Gunby, Marshall, & McCulloch, 2011). Although the present study themes reflected superordinate themes of the larger study, their definitions were unique to the subgroup of data coded (i.e., client-to-client interactions within the homeless service milieu). The codebook was transferred into NViVo12. The two analysts then used the codebook to independently code the dataset (the client and staff data that had been previously identified as the dataset using checklist Appendix E). Discrepancies in coding among the two analysts were resolved through discussion until consensus was achieved. More specifically, each transcript was coded by both analysts so that consensus could be reached regarding how each idea within the transcript was coded. Saturation within the present study dataset was achieved. The last few client and staff interviews did not yield new themes or substantially change the themes identified, but rather added nuances.

Subsequently, theme summaries were written for the final themes. More specifically, data coded at each theme were extracted, read, and summarized in a way that captured the essence of the data, provided examples including quotations representing client and staff perspectives, and discussed any interactions among themes when applicable. From here on, these themes are referred to as "inductive themes" to facilitate clarity.

Research Question III

The dataset—all client and staff data identified as milieu interactions involving clients using the Appendix E checklist—was deductively coded for TIC principles and their dynamics as follows. Two analysts utilized the Appendix F checklist to code the dataset for TIC principles. The Fallot and Harris (2006) principles were selected as a basis for the checklist given that they are not context-specific and there is sufficient description within the literature to develop coding criteria. Other TIC frameworks, such as the Hopper and colleagues (2010) consensus-based model and SAMHSA's (2014) model are based on other frameworks such as the Fallot and

Harris (2006) model and their principle definitions are not as detailed. Fallot and Harris (2006) offer descriptions and a set of questions defining each principle that were used to develop the Appendix F checklist. For instance, Fallot and Harris write, "How would you describe the reception and waiting areas, interview rooms, etc.? Are they comfortable and inviting?" This was summarized as the following in the Appendix F criteria: "the comfort of shared spaces." Analysts coded for TIC principles from the perspectives of participants which allowed for opposing perspectives. This means that participants may have discussed similar situations in different ways that reflected different principles. More specifically, ideas were coded based on how a participant described their experience rather than an analyst assumption of what the *intended* principle may have been.

Simultaneously, two analysts also utilized the criteria in Appendix G to code for intra- and inter- principle dynamics. This included facilitation within and among principles, and impediments within and across principles. *Facilitation* refers to positive effects, such as implementing a principle having a positive effect on the implementation or experience of another principle. *Impediment* refers to negative effects, such as that implementation of an aspect of a principle had a negative effect on another aspect of that same principle. Pilot coding highlighted the overlap among theme definitions, such as that one idea could be coded with multiple principles. As such, data were coded for "overlapping definition" when one idea was represented by two or more principles (see Appendix G). Principle dynamics were only coded when multiple actions occurred or multiple ideas influenced one another, such as an aspect of one principle influenced an aspect of another principle or a different aspect of the same principle. The TIC principles and dynamics are referred to as "deductive themes" from here on for clarity. Within Nvivo 12, data were extracted and reviewed both by dynamic type and by inductive themes for

analysis. To avoid redundancy and to ensure principles without dynamics are represented, principles and their dynamics are highlighted within the summaries of the inductive themes.

Data Triangulation

Consolidating data among client and staff stakeholder groups involved a process of triangulation, or seeking aspects of agreement and disagreement (Patton, 2015). Themes and their definitions were developed to capture opposing perspectives, facilitating triangulation across perspectives. Additionally, two important issues were considered in triangulation: power differentials among stakeholder groups and proportion of data that came from clients vs. staff. Staff perspectives inherently contain power as staff voices are often privileged and elevated as experts. As such, client data were analyzed first to center client voices. Initial coding indicated that much more client data were identified as relevant to the present study than staff data. As such, client perspectives were more likely to be centered in the findings. In an attempt to capture varying perspectives, each theme included separate summaries of client and staff data, supported by quotations from participants. Aspects of convergence or dissonance among groups (among staff and clients) and within groups (such as among clients) were described within each theme.

Triangulation also occurred across inductive and deductive data analytic methods. This is reflective of theory triangulation in which multiple frameworks are used to analyze a single set of data (Patton, 2015). Inductive themes were developed based on the data. An existing TIC framework and deductive themes (principle dynamics) developed based on the literature were used to analyze the data a second time. The process first involved extracting data by inductive theme and writing summaries of inductive themes. Data were then pulled by each TIC principle dynamic, reviewed, and annotated to review trends in dynamics. Data coded at each inductive

theme were also extracted to review and annotate coded principles and dynamics within each theme.

Analyst Positionality

Meaning arises from different aspects of our identities (as cited in Bourke, 2014). Positionality involves understanding how researcher identity and background impacts the research (Bourke, 2014; England, 1994). This includes an awareness of the self and the other, insider and outsider identities, and our attempts at navigating or responding to these identities (Bourke, 2014; Pillow, 2003). Two analysts were involved in the present study analyses, including the first author (MM) and a co-analyst (GH). GH is a Bachelor-level research assistant with limited prior knowledge of TIC and no prior knowledge of the agency involved in this study. GH has prior experience conducting interviews and analyzing qualitative data. GH was introduced to the study by reading a few key articles on TIC and the study background. Here, I (MM) describe aspects of my identity and background that have been salient to me while conducting this research to provide some context. I also highlight how my awareness of my positionality impacted my decisions within this research.

I have prior knowledge of TIC literature and practice across contexts (homelessness services, rape crisis response, and police-mental health collaboration). I have familiarity with the agency involved in this study, co-conceptualized and coordinated the larger study, conducted approximately half of the interviews, and co-analyzed the full larger study client dataset. As such, I was involved in the development of the larger study interview guide and client codebook, which impacted the development of themes for the present study. I am also a student clinician having worked in community mental health and medical settings specializing in severe mental illness. I was motivated to conduct the present study through witnessing the interrelatedness and

impact of trauma, homelessness and poverty, and mental health/substance use issues situated within systemic issues such as service inaccessibility and institutionalized trauma. I believe that having a trauma-informed lens may improve services, the way services are experienced, and therefore how we as clients and staff engage in services.

In alignment with a constructivist epistemology, I believe in the importance of valuing varied realities. This motivates me to seek and highlight tensions among experiences, such that similar situations could be experienced very differently across individuals based on their beliefs, background, identities, etc. I appreciate that my own identities, background, and biases impact this research. As a cis-gendered, White woman without personal experience of homelessness, my identities afford me a host of privilege. Although I have learned about homelessness through academic scholarship and providing clinical and volunteer services to individuals with past and current experiences of homelessness, there is inherent power in my position as an observer and limitation to my awareness of the lived experience of homelessness. Additionally, other aspects of identity may have impacted interview dynamics. For instance, given that the majority of the participants, particularly clients, in the present study identified as Black, Indigenous, and People of Color (BIPOC) while both interviewers (MM and KC) were White women, differences in racial-ethnic identification may have impacted disclosure among participants (e.g., Samples et al., 2014). There is the possibility that differences in identity influenced comfort in discussing how race, ethnicity, or experiences of racism, for example, impacted individual experiences of TIC. As such, based on various aspects of my identity, my experience of this research reflected studying the unfamiliar (Berger, 2014). A challenge of this positionality is identifying research questions relevant to population studied and capturing more subtly expressed themes (Berger, 2014).

A research relationship is inherently hierarchical (England, 1994). At the data collection stage, my assumptions were tested as hypotheses through verbal reflections offered for participant disputation or agreement. Likewise, I am aware of the power dynamics involved in the way data are interpreted and individuals' experiences written about. As an outsider to being a client of homelessness services, for example, I initially felt more aligned to direct service staff. My choice to dive into client data first was partially borne out of this awareness and a desire to prioritize client perspectives. At the same time, I am also aware of how participants perceive me. It is likely that some clients perceived me as aligned with the organization, which may have impacted their comfort about speaking honestly. During data analysis, decisions about how to code when uncertainty arose were resolved by coding closer to the data and less interpretatively. This was intended to preserve participant perspectives, viewing participants as experts on their own experience (England, 1994).

Results

The present study sought to investigate how client-to-client interactions (1) impact client experiences of TIC within a homeless service organization, (2) impact staff experiences of TIC, and, (3) highlight TIC principles and their dynamics. Given the overlap in identified themes among client and staff datasets in response to research questions 1 and 2, the results were merged. Four percent of the staff data and 27% of the client data were coded using the criteria for client-to-client interactions in the homeless service milieu (Appendix E). This indicates that clients more often spoke to how their experiences within a trauma-informed environment were impacted by interactions with other clients. However, all 12 staff member interviews and all 17 client interviews are represented in the themes, meaning all participants at least mentioned how client peer interactions impact experiences of TIC. The following seven inductive themes were

developed based on thematic analysis: accessibility, confidentiality and privacy, conflict and conflict management, general environment, individualizing care, mutual support and community building, policies and policy enforcement. Each theme highlights ways in which interactions among clients impact experiences of TIC.

To address research question 3, the data were also coded deductively for TIC principles and various types of principle dynamics: intra-principle impediments, inter-principle impediments, intra-principle facilitation and inter-principle facilitation. Relevant principles and their dynamics are summarized within the main seven inductive themes to avoid redundancy in content and facilitate triangulation of inductive and deductive data analytic methods. As such, results for all research questions are synthesized and presented together. For clarity, anytime a TIC principle was coded and was relevant, the principle itself is italicized. All principles were represented within the data. All dynamics were also present in the client data. Two of four types of dynamics were present in the staff data: inter-principle facilitation and inter-principle impediments. Certain data did not contain any principle dynamics; oftentimes, this was a situation in which only one principle was present or the situation reflected an overlap among two principle definitions. Principles and their dynamics are described within each inductive theme. Table 3 provides a summary of inductive themes, theme definitions, and example TIC principle dynamics.

Table 3

Inductive Themes, Theme Definitions, and Examples of TIC Principle Dynamics

Theme	**Definition**	**Example**	**TIC Principle Dynamic**
Accessibility	How client service engagement impacts other clients' ability	"I'm allowed one load [of laundry] a week and if it's	**Inter-principle impediment:** *Choice* to access

	to access services and staff responses	somebody who's actually homeless, they come before me on the list...even if I'm the first one … if there are three or four homeless people that come in after me, I get bumped all the way down behind them." (client, 5)	services is limited to one group to maintain *trustworthiness* for another more vulnerable group given limited resources.
Confidentiality and privacy	How client information is kept secure in a group context and ways security has been breached among peers or by staff in ways that impacts peers	"[Staff] have meetings and they sit there and discuss so and so and so and so … you won't have me sittin up there tellin a, b, c, and d about my business when I'm talkin to you… Because that's between me and you…But staff, no. I don't feel comfortable with them… Some people they love it, I don't like it. To each his own" (client, 25).	**Inter-principle impediment:** Lack of *trustworthy* boundaries impacts client comfort in sharing (*safety).*
Conflict and conflict management	Any tension, violence, abuse occurring among clients or impacting clients; staff responses to conflict and tension; staff training on conflict and conflict management	"the other girl was still coming and still getting robbed...They don't wanna create that kind of atmosphere—'then we'll call the police'— but sometimes you need that type a attitude with these uh, unruly clients… because that, that's, that's called safety and security" (client, 24)	**Intra-principle impediment:** Maintaining a *safe* environment by keeping police out impeded a client's *safety* from harm

General environment	How the overall social or physical environment impacts clients based on direct or indirect interactions with other clients	"kitchen supplies like knives and stuff, big knives need to be up to a safe place, because you dealing with a mental illness, you're dealing with people who dealing with trauma, domestic violence, and all that stuff, it need to be put up in a safe place, instead of out open, out like that, where anybody could come in there and they mad at each other or whatever, and go in the kitchen, you know, so, that's not too safe" (client, 10)	**Inter-principle impediment:** Accessibility to basic utensils promotes *choice* (autonomy) but may diminish sense of *safety* for others
Individualizing care	How services implemented in a standardized way are catered to differing client needs, including ways policies are individualized	"some of our [clients]... would rather have the door open, of course it makes it a little more sensitive because people can walk by" (staff, 2)	**Inter-principle impediment:** Client *choice* to individualize care can impact their *trustworthiness*
Mutual support and community building	Positive aspects of peer relationships, ways in which positive interactions among clients are built, and recommendations for improving community building	"[in community meetings] we talk about what...did anything happen good over the weekend and pretty much we all comment, you know, as we please...It's up to you if you choose to wanna talk about it...it kinda gives you uh insight about whose livin' ...around you...helps me to uh	**Inter-principle facilitation:** *Choice* to engage socially during housing community meetings facilitates *safety* in that clients get to know one another and may seek support when in need.

		be able to...be at ease…knowin' that um, there's someone here to help me if I need.." (client, 7).	
Policies and policy enforcement	Policies relevant to client interactions and ways they promote TIC; needs around policy changes; the level to which policies are enforced among clients	"sometimes they treat people better… certain people… they give people certain things like even if it's food or whatever. You say 'can no food be tooken' today, you give people food. It's like, certain things they do for other people they won't do for others (client, 14).	**Intra-principle impediment** Services are not *trustworthy* across clients.

General trends within principle dynamics were also identified. Table 4 summarizes circumstances under which TIC principle dynamics occur. Circumstances include staff and client behavior, and experience of TIC.

Table 4

Summary of Circumstances Under Which TIC Principle Dynamics Occur

Principle Dynamics	Circumstances Under Which Dynamics Occur
Inter-Principle & Intra-Principle Impediment	● Implementing TIC for client(s) negatively affects other individual(s)' experience of TIC ● Implementing TIC for a client(s) negatively affects that client(s) in other ways (when considering other TIC principles) ● Limiting TIC for client(s) to ensure TIC for another client(s) (e.g., due to resource constraints or in resolving conflict) ● Limiting an aspect of TIC to promote another (e.g., limit choice in service engagement to promote empowerment) ● Not fully implementing TIC has a negative impact on client(s) experience of TIC (e.g., could be due to inconsistent application across clients or

	implementing a particular principle) ● Not fully implementing TIC could be due to staff past experiences with clients ● Client behaviors impact experience of TIC of other client(s)—this may include a lack of staff responsiveness to client behaviors ● Different perspectives on what is TIC
Inter-Principle & Intra-Principle Facilitation	● Implementing TIC positively affects individual(s)' experience of an aspect of the same or a different principle ● Implementing TIC positively impacts client behavior ● Client behavior that aligns with TIC principles contributes to facilitating TIC (e.g., could be through mutually supporting others or involvement in service delivery)

Accessibility

Accessibility referred to how clients' ability to receive services was impacted by other clients' needs or service use. Clients described how their ability to access services was impacted by other clients' level of engagement or ways clients were prioritized in services due to limited

resources. Some clients reported concern about the larger impact of other clients' low or lack of engagement. One client said,

> I saw so many people come in there and just, [the agency] like, 'we here to help you, we gonna get you this again', and [the client] get the lil' things and turn around and do the same old knucklehead stuff that brought them in the first time, I just look at them and shake my head and said, 'why'd you waste the people time like that… 'cuz there somebody out there could really use this services that you blocking them' (24).

This sentiment also highlighted a broader tension in opposing client perspectives on unconditional accessibility to services. Clients receiving second chances was presented as a positive—in that this agency uniquely allows people to return despite making "mistakes"— and a negative—in that, as the quoted client explained, this may limit already scarce resources. This reflects a tension between promoting *trustworthiness* by providing consistent services and *choice* about how clients are permitted to engage. Such a tension highlights how systemic factors, such as limited agency resources, may manifest in interpersonal issues among clients.

Some clients spoke to more specific ways in which they perceived other clients as having limited service engagement. This included pulling others into substance use, representing a lack of *safety*. Another client explained that there is a need for trauma-specific groups, as group services often lose focus, diminishing access to the support clients were seeking:

> the topic would always swing towards people trying to score, whatever drug of choice. They never really dealt with like trauma. So it never really dealt with like if somebody was going through physical abuse, or emotional abuse, or sexual- it didn't deal with those kind of traumas. It would deal with, today I had to go steal a roll of toilet tissue 'cause I had no toilet tissue in my house 'cause I smoked up all my money last week (13).

This issue was also presented as a lack of agency on the part of staff. Staff did not re-direct clients to focus on trauma topics and rather gave clients *choice and control* over what they wished to discuss. This, in effect, impacted other clients' access to the type of service they expected (*trustworthiness):* a space focused on growth through mutual support (*empowerment).* This issue is also complicated by an agency rule that group attendance is required for a hot lunch, which may impact how clients engage.

Clients also mentioned attempts to increase accessibility for the high volume of clients through specific staff behaviors or overall agency policies. For instance, one client mentioned a staff member often invited multiple clients when going to a social security office as a way to ensure clients receive the service (*trustworthiness)* despite insufficient staff to support clients one-on-one.

Staff similarly described challenges in how clients impacted one another's service accessibility. This at times created challenges in how to respond when a client's actions or service use somehow limited another client's ability to use services, reflecting lack of *trustworthiness*. This included high client volume and insufficient staff leading to busy staff and wait time for clients. One staff member explained,

> a lot of participants have to wait a really long time for their appointments and, you know, I know the providers only get twenty minute slots for, for every visit, so a lot of times it can run pretty behind and I think, I know that can be pretty difficult for [clients] to wait and they get frustrated so …when they have to sit in the waiting area and it can, I know it's been a barrier for some people to even wanna come here (17).

Clearly high client volume coupled with short appointment times may lead to decreased accessibility and service engagement.

Mutual Support and Community Building

Clients and staff described ways that positive interactions among peers were promoted, positive aspects of peer relationships, and recommendations around community building and ways to improve settings in which mutual support occurs like groups. Overall, clients described ways they connected with other clients through common shared experiences, supported one another, and learned from one another and shared resources. These types of interactions were facilitated by structures to promote community building such as therapy groups, social events, community meetings within the agency's housing program, and also informal opportunities for clients to interact. Mutual support reflected varying TIC principles. Clients discussed ways mutual support is *empowering* such as through skill building, offers emotional *safety* such as when other clients pick up on demeanor changes among clients, increases *trustworthiness* when other clients offer clarity around service types, and that the agency overall offers *choice* regarding which services and how much clients may be involved. Most commonly these themes facilitated one another. For instance, involving clients in community meetings where they could provide feedback on the agency overall (reflecting *collaboration* and *empowerment)* facilitated information sharing and a growth emphasis (*empowerment.)*

Within group therapy, clients described experiencing a sense of *empowerment,* such as hope and goals for the future due to listening to others' stories, groups as a way to avoid substance use, and relating through shared experiences and bonding with other clients. One client explained the sense of comfort and *safety* associated with mutual support,

> But I think there does become somewhat of a commonality upstairs here. When you have ...all joined one group and you stay regular in there and then you then somewhat

> vulnerable in a group. And I think when you have real-relatability I think that that becomes somewhat a bonding moment…we've been there we know what it's like (1).

The impact was at times quite visible. One client explained, "I see people every morning-- I know they see it in me, a lot of us look real tired, worn out and depressed… talking about it helps. A lot of times we leave group, might you even see somebody smiling" (3). This client highlights the mutual facilitation among *safety* and *empowerment*. The sense of *safety* of the environment allows clients to feel comfortable sharing, which facilitates positive change and growth. Another client explained how having *choice* to select the discussion topic within groups facilitated a sense of *safety*,

> Monday we have men's group… when you go to the barber shop you can talk about anything. That's just like when we're here… and it just makes a person feel like, ok, now, I'm feelin a lot better goin to that group because there are things I wanted to say and couldn't say em and you get that opportunity to do it and it just makes you open up…it makes me feel like ...I just lifted a ton of bricks off of my shoulder (9).

This quote also highlights the overlap between mutual support and individualizing care themes, in that providing gender-specific services created unique opportunities for mutual support. Clients were at times also involved in service delivery in ways that promoted mutual support, demonstrating an overlap between *collaboration* and *empowerment*. One client described being asked to speak in groups, "they have people come up to 'em all the time and say, 'Hey, we really appreciate hearing him talk in these meetings because that gives me hope" (27). Clients also mentioned that lack of funding detracted from community building. One client explained, "we then lost so many things, you know, that we was doing activity-wise...because of the budget" (24).

Staff similarly described ways in which clients have needs for or provide mutual support to one another, which can contribute to a sense of belonging and community through shared experience. Most often, staff data represented the TIC principle of *empowerment* and principles that facilitated *empowerment* such as *safety.* One staff member highlighted the importance of relating to others with similar lived experience: "recovery doesn't happen in isolation … so the idea is like you need to be able to connect with people and and part of that is being able to connect with people who have similar experiences"(12). Such *collaborative* and *empowering* services indicate that clients are viewed as experts whose strengths are recognized given the inclusion of clients in services is viewed as a key component of recovery. Another staff member explained how groups promote skill-building, an aspect of *empowerment:* "There's other groups that they have where participants talk about their uhh how to cope in a social environment" (4). Staff also described ways the agency promotes mutual support and community building through peer groups, social events, or community rooms. Staff similarly highlighted that supportive interactions among clients could be through formal activities but also occur informally. One staff member described informal interactions among clients: "anytime you walk into the program, you will, you will notice that…they're sitting around at the table – they're engaging" (19). Promoting positive relationships among clients is a topic discussed by staff within training, such as promoting client skills in recognizing the impact of trauma on themselves and others. This demonstrates how *empowerment* of staff facilitated client *empowerment.* One staff member offered a suggestion for improving client interactions through client education on TIC:

> I don't know that um, uh, that [clients] are sort of educated or informed enough about what that means… certainly not, uh, certainly trauma-informed care… would be important for them to, to be educated in or trained or informed about it is so they, they

> can have a understanding of our approach to it… and how they engage with each other… (16).

This recommendation highlights additional needs for *empowering* clients through skill building, which in turn may improve client-to-client relationships.

Confidentiality and Privacy

The theme of confidentiality and privacy referred to the level in which security of any personally identifying information related to participants was maintained. Issues of confidentiality and privacy inherently reflect the TIC principle of *trustworthiness*. Although a few clients mentioned ways staff maintained confidentiality, others highlighted confidentiality issues. Clients described other clients sharing private information. Clients also described staff members disclosing information in a way that impacted relationships among clients or led to others clients learning private information. Such experiences led to diminished trust and willingness to open up. A client explained, "it was a staff member here who told me some confidential information…if they talk about them, they might talk about me. So that's a person I wouldn't, you know, confide in" (11). Other clients reported that confidentiality breaches led to conflict or clients' words being used against them. Therefore, lack of *trustworthiness* often led to diminished *safety*. Lack of confidentiality also impacted clients' experience of *empowerment*, such that confidentiality breaches limited their access to services they felt would promote healing. Clients mentioned policies intended to facilitate privacy and confidentiality, such as keeping information shared in groups private and having guest visiting policies that limit *choice* around when or who can visit the premises. Despite such attempts to build *trustworthiness*, group policies were often not followed by other clients, particularly in keeping information shared in groups private. One client explained,

> I had a therapeutic breakthrough and was able to talk, partially, about one of my traumas. Within a half an hour I get a phone call with somebody yelling at me 'cause they thought I was talking about them, when I was talking about something that happened way before I even made it to [this agency]. But they wasn't even in that group… it shouldn't take 21 months for me to finally feel ready to say a little bit about ... my personal trauma, just for it to be leaked back into the milieu 10 minutes after the group is over. (13)

Additionally a policy aimed to build privacy was unclear and its application seemed inconsistent. Two clients also mentioned how stigma impacted the need for privacy. Clients did not want other clients to know they're involved in certain services or that they take certain medications due to fear of stigmatizing reactions. One client explained,

> that is a big stress for the people going up in there confidentiality, 'cuz they don't want nobody knowing they go to this certain group and, [clients] say, if you go to the group … you gotta be kinda crazy …I heard that when I first came there, if you go to [the center] you got to be handicapped in some way form way or fashion (24).

As such, one way to protect one's own *safety* was to maintain strict boundaries.

Staff reported that confidentiality and privacy is a challenge that arises in working in a group context in which clients interact. When one client reported sexual assault perpetrated by another client (a lack of *safety)*, this led to challenges in maintaining both clients' access to services while maintaining confidentiality (*trustworthiness)*. The staff member explained that

> it was something that I think I struggled with, but we as an entire staff struggled with. Because while she was reporting it, the other party involved didn't report it, so there were barriers in terms of confidentiality and how do you address the situation? How do we protect her safety when he's still actively living here? (2).

Two staff members shared how providing clients *choice* may impact their privacy. For instance, offering the *choice* to keep doors open during private conversations with clients could diminish *trustworthiness* if others overhear. Another staff member explained: "I would love to talk to them [clients] because I'm a people person...I just don't know wouldn't wanna, get in trouble or you know maybe somebody might hear them that's down the down the hall or patients" (8). Giving clients the *choice* to speak in a hallway could mean a breach of confidentiality and decrease *safety* if other clients overhear confidential information. It is important to consider that this is the perspective of the staff and it is possible that the client would not perceive their safety threatened in this instance. On the other hand, another staff member shared that discussing clients among staff was fairly common as a way to complain or debrief.

Individualizing Care

Participants described ways that standardized services or policies may not work for individuals due to diverse needs and how individual differences have been acknowledged within services. Clients described the need for services to be individualized given observations of their peers having varying needs. Overwhelmingly, this theme represented ways that the principle of *choice* was implemented. This included offering clients *choice* to select the type of services and approach to engagement in services appropriate for their needs, and limiting *choice* for certain groups to prioritize others who are deemed more vulnerable. Either case often impacted the way other TIC principles were experienced. Some clients provided examples of ways services or policies have been catered to individuals. One client provided an example of how needs might differ, "Some of the people don't like when the door closes… and it depends what type of trauma they experiencing door is open, they don't want to be alone with nobody, so it depends" (10). As such, having *choice* can facilitate a sense of *safety.* Demonstrating the interrelatedness of themes,

individualizing care to clients by meeting with open doors led to concerns about confidentiality and privacy. In this way, *choice* may inhibit *trustworthiness*. Catering services to clients could be accomplished through *collaboration* or *empowerment*, such as when clients were involved in determining their goals. Clients highlighted how needs may vary based on possible traumatic experiences and potential triggers. At times, clients felt that services were not appropriately individualized and staff made assumptions about the experiences of clients. One client highlighted an example in which a clients' affect and behavior was dismissed as substance use:

> I have seen it on a case where someone was having a trigger due to trauma, and they thought they was intoxicated. Even though they were acting out of character, they made the wrong diagnosis without getting the information first. I've heard people that sit behind the desk say, 'oh he's drunk', and then coming to find out...his daddy had died (13).

This client highlighted that staff trauma knowledge varies; such inconsistency indicates a lack of *trustworthiness* that diminishes a sense of *safety.* Mislabeling reactions to trauma as substance use demonstrates a lack of *safety* given that safety reflects attention to client discomfort. This also demonstrates an overlap with lack of *collaboration* as this scenario demonstrates some staff make assumptions without client input.

Individualizing care often co-occurred with policies, in that either policies were developed to cater to the needs of particular subgroups or that policies may be enforced based on individual need. More specifically, certain policies were developed to prioritize services based on specific needs given limited resources. In that sense, policies at times promoted individualizing care. For instance, one policy prioritized chairs for individuals currently experiencing homelessness. This meant that *choice* to engage in services for one group was diminished to

promote the consistency of access, or *trustworthiness*, for another group. Staff attempts to individualize care also facilitated *empowerment* such as when staff attempted to educate clients about clients having different needs.

Staff similarly described how needs might vary across participants and actions they have taken to cater services to unique individual needs. In practice, staff helped clients problem-solve in a way that considered their individual preferences and needs, particularly in situations that may impact other clients or the ways in which the client may be impacted by others. This often involved promoting client *choice* about how they engaged in services and when they received services. For instance, one staff member described flexibility in rules by attending to individual needs or affect of clients when deciding how to prioritize their requests. Promoting client *choice* when individualizing care can promote *safety.* Similarly to client data, one staff member mentioned clients having *choice* to keep doors open when meeting with staff to feel more comfortable, but this can also raise *trustworthiness* issues. Promoting *choice* at times impacted other clients' *trustworthiness* to access expected services if individualizing one clients' care led to delays for others. Another staff also recommended that services overall should be individualized:

> providing [sigh] like resources I guess at the level of care that's appropriate for you know for different people… so that like somebody who is at one level of care is not necessarily like put together with somebody who needs more care or less care like just make sure like the level of care is appropriate for everybody (2).

Highlighting an organizational level barrier, staff also reported that the agency being under-resourced impacted the ability to be flexible in providing care.

General Environment

Participants described aspects of the overall social or physical environment, and ways the environment impacted them. This included descriptions of the overall population within the environment and the environment created by those present. Broadly, this theme highlighted the level to which the overall environment was experienced as *empowering, collaborative, trustworthy*, and *safe*. Common interactions occurred between the *choice* and *safety* principles, such as ways *choice* facilitated or impeded *safety*. Lack of *trustworthiness*, or receiving services as expected, also impeded *safety.* On the other hand, *choice* was also found to facilitate *empowerment*.

Clients described the overall client population as diverse but also sharing some commonalities in terms of experiences, such as struggling with substance use and mental health issues. At times clients tied these identities to negative aspects of the environment, which included disruption, a sense of chaos, and arguing and fighting. Demonstrating a lack of emotional *safety*, one client reported that they often needed a break from the depressing environment at the agency, "these peoples here is like it's not – it's very depressing here. So when I stay away a week or two, or two or three days, I'm more happy stayin away than I am here" (26). Another client mentioned that part of the negative environment included staff being burned out. Witnessing disruption, in particular, was described as triggering, a threat to *safety*. Clients commonly expressed concern about substance use or intoxication and its relation to a disruptive milieu. One client explained,

> at the program they have it where they call harm reduction, and I have seen with my own eyes, clients come in intoxicated or high off their drug of choice, and they act out under the influence and they dominate the whole entire facility. And instead of being isolated

> and taken to a place where they can be safe and taken care of, they're allowed to roam the milieu and disrupt groups and other participants and, for me it's very stressful…It makes me angry, and sad at the same time… you never know what someone's triggers is, my trigger is someone who's acted- who acts erratic and who is loud and what I perceive threatening. And if I feel that way, due to some of the things I've been through, if that person comes at me the wrong way I may attack, in self-defense. (13)

This scenario highlights how giving clients the *choice* to be intoxicated on site in an effort to promote their *safety* (by offering a safe environment to be when intoxicated), may impede others' sense of *safety* when intoxication results in disruption or conflict.

Clients also described the environment as positive at other times, although some clients described the environment as consistently negative or consistently positive. Some clients described the environment as a relaxing, comfortable, and *safe* milieu both physically and emotionally. One client explained how the *safe* environment facilitated openness,

> the majority of the people have some sort of mental illness on top of a crack habit… and they'll tell you some of the shit that they had to go through to get a rock you know and if you can be that open and that honest, with yourself, and about yourself to you know a room full of people … obviously that's because of the environment that you're in and you know the staff who have helped you (5).

Clients also described ways the physical environment impacted client interactions. Some clients wanted more *safety* features to prevent or manage conflict they have already witnessed or experienced. One client explained,

> kitchen supplies like knives and stuff, big knives need to be up to a safe place, because you dealing with a mental illness, you're dealing with people who dealing with trauma,

> domestic violence, and all that stuff, it need to be put up in a safe place, instead of out open, out like that, where anybody could come in there and they mad at each other or whatever, and go in the kitchen, you know, so, that's not too safe (10).

In contrast, another client reported that they liked that "they don't child proof the place" (13), highlighting different needs and preferences related to trauma. As such, accessibility to basic utensils may promote *choice* and autonomy, but diminish sense of *safety* for others. Clients also highlighted other aspects of the physical environment that were helpful, such as freedom to move around spaces, which was helpful when needing to move away from triggers or the fact that possible triggers were removed (like religious symbols). Such instances indicated that *choice* and control over one's environment can facilitate a sense of *safety.*

Staff described the need for a safe, supportive, and peaceful environment, and efforts to create a welcoming environment without triggers such as "peaceful...be without violent movies" (29). Regarding relevant TIC principles, staff highlighted the level of *safety* or *empowerment* of the overall environment, and ways to build *safety* through *choice* or *trustworthiness.* Implementing *safety* or *trustworthiness* principles can also facilitate *empowerment.* This theme is also facilitated by and may facilitate other themes. For example, such physical spaces also facilitated community building like the community room and a kitchen. Additionally policies dictating norms for interpersonal interactions were described as facilitating a sense of control over the environment. Norms were set through other ways: "We have signs up, you know, it's a safe place. Whether you're, um, transgender, straight, gay, bi, whatever" (15). Staff also described the homeless service provider as being composed of individuals (clients and staff) of diverse backgrounds and experiences. At times, the environment is disruptive which can feel threatening and *unsafe* to visitors:

> a great case study would be our waiting room and how negatively trauma can affect trauma, um, cuz patients are talking to themselves and responding to who knows what that sets off the person next to them because they made a certain sound or they smelled a certain way who sets off the person next to them. It's like a domino effect… it's a lot of traumatized, very sensitive people… dealing with their stuff… I would say there's, like, always an elevated level of, like, energy in the room. Like, everyone's always kind of on edge …the clinic's always 90 degrees because the air conditioning's always broken and has a million different smells and personalities and people, and it's just a very charged environment…being in that space can be traumatizing (28).

Witnessing or being involved in such conflict was described by staff as triggering to clients.

Conflict and Conflict Management

Participants described specific incidents of conflict among clients, ranging from tension to verbal and physical abuse, and ways staff managed or resolved conflict. As such, this theme primarily reflected a lack of *safety* and attempts at building *safety.* Additionally, this theme also broadly reflected the level of staff *trustworthiness* and *collaboration* in addressing issues, the extent to which they did or did not limit *choice* in situations involving *safety* concerns, and ways in which *empowerment* facilitated *safety.* Clients often reported that substance use escalated conflict. Some clients reported wanting substance use on premises decreased as a result. This reflects how providing *choice* may diminish a sense of safety. One client also reported witnessing staff discriminatory comments towards other clients in interracial relationships, reflective of both lack of boundaries (*trustworthiness)* in that the staff member discussed other clients and, as a result, a sense of *safety* was impacted as the client became privy to the staff member's discriminatory, racist beliefs.

Clients had different perceptions regarding how well staff managed conflict among clients; successful conflict management appeared to depend on the staff member and possibly the client as certain participants had a more consistently negative or positive view. Resolving conflict through discussion was generally preferred over staff relying on policy enforcement, such as asking clients to leave. One client example highlights how staff attempts to maintain *safety* diminish *choice:*

> the staff sometimes just goes… 'you guys separate' instead of trying to find out the root cause of the problem and how to solve it so that it doesn't reoccur …I don't think it solves anything … I think that the… staff is quick to judge a situation and react a certain way (6).

Similarly, another client highlighted ways staff utilized their power to enact consequences as a way to manage conflict,

> don't flex your authority when you don't really know what the whole conversation is about when two clients is interacting … 'wait a minute I'm the case manager you're clients, y'all gotta get out of here or either shut the hell up', you know, that right there is throwing up a brick wall. Now I feel that if you take both of them clients and pull them to the side... or one-on-one, to find out what is the problem ... I think that is more professional than telling a person, 'Well you disruptive in the group you have to get out. And we going get you barred from this place' (24).

Such resolution led clients to feeling powerless given that in an attempt to create a *safe* environment, client *choice* and control over the situation was removed. Such staff behavior was also perceived as *untrustworthy* because it was inconsistent with the clients' expectation of professionalism. On the other hand, another client recommended stricter consequences to

manage conflict when clients disrupt the milieu: "if they intoxicated…[or] don't take their medication... [staff] need to bring them outside that door and tell them to go away...or think of it as a way to come back tomorrow...it can escalate really fast" (21). From this perspective, *choice* to should be limited to promote the overall *safety* of the environment. This demonstrates that clients have varying preferences around how conflict is resolved.

At times, clients hinted or more explicitly indicated that they felt they did not have the right to respond when they were being disrespected by another client. Clients also expressed that there were insufficient *safety* measures to prevent conflict among clients, such as cameras not being watched, lack of staff on duty, staff being unresponsive when conflict occurred, or even staff prioritizing the wrong type of crisis. One client provided an example,

> It is distracting when you see a person still suffering and acting … and the staff is sitting right there and not addressing that issue, that's when I get kind of upset…Y'all just sitting there, you know, word puzzling or talking and... that person is reaching out (10).

Staff not responding to *safety* concerns is perceived as *untrustworthy*. One client also shared how *untrustworthiness* could occur due to inappropriate boundaries:

> [staff] get personally caught up in peoples, uh affairs… the little drama that goes on, you know, a- and in the building or something … and then they comment on it, but they're not trying to help you out of it … and bein' interested in the wrong things.. that could cause a staff member to take sides and make m-, possibly make living there for another person uncomfortable (23).

Such *untrustworthy* behavior can impede client *safety.* Clients also identified the need for private spaces to de-escalate situations as a better way to manage conflict. Despite staff explaining to clients that they are short-staffed, one client argued the need for decreasing certain clients'

choice to create a *safe* environment for others, "they're short staffed, but you could spend 30 minutes making a perimeter around somebody who comes... intoxicated. But you will not remove them from the situation so they don't disrupt the flow" (13). One client explained how a client's safety was impeded by an attempt to maintain *safety* within the overall environment by keeping police out:

> there was this one girl and they was just taking her money and I thought, I think- she came up there and told them …"[two clients] always take my money when I go to cash it" - they should've called the authorities in on that … The only thing they do was bar the… [two clients], but the other girl was still coming and still getting robbed, you know, so I think that was just a waste of time…they like kinda shy of bringing the police, you know. They don't wanna create that kind of atmosphere—"then we'll call the police"—but sometimes you need that type a attitude with these uh, unruly clients… because that, that's, that's called safety and security (24).

Attempts to maintain *safety* of the overall milieu by keeping police out impeded *safety* for the client who was robbed, reflecting an intra-principle impediment.

In contrast, clients felt that conflict was handled well when staff resolved conflict quickly, de-escalated situations, or taught clients conflict resolution skills. One client explained that when individuals are disruptive, *trustworthy* rule enforcement is "done in a very compassionate manner … and not a punishing manner like where it's like 'okay well take a rest and if you can't hold yours or whatever would you mind'…whereas you'd go to a counselor's office and you act out, psh she'll call security" (22). This particular client compared negative responses in traditional services (calling security) to a compassionate conflict management approach at the present agency, reflecting *empowerment.* Some clients also described staff as willing to support

clients despite being harmed by clients. This demonstrates how attempts to provide consistent, *trustworthy* services to clients impeded staff *safety.*

Staff spoke to witnessing and resolving conflict among clients ranging from disruption to physical violence and sexual assault. Staff also acknowledged that substance use was commonly a factor. Managing conflict among clients involved staff consultation, agreeing on plans of action, problem-solving *collaboratively* with clients one-on-one, helping clients engage in coping, removing clients from the situation, reminding clients of group interactional policies, and discussing coping with trauma in group settings. For instance, a staff member highlighted how interactions among clients may pose a threat to *safety*:

> we have some people who um like yell or swear...participants have said … 'it reminds me of like when I was in this relationship and there was a lot you know yelling and swearing' um [sigh] so to like still work with that person … whose behavior is inappropriate um you know without like alienating him and you know 'you're bad' … and um at the same time also recognizing and addressing that it, it's causing y'know negative intera-or negative emotions with other peers (20).

One staff member also mentioned at times relying on police to manage physical violence given that staff cannot use physical restraint to resolve conflict. Some staff spoke to receiving training on ways client interactions may be traumatizing such as witnessing disruption or hearing trauma stories, and conflict management through training such as crisis de-escalation and discussions about scenarios.

Policies and Policy Enforcement

Participants described peer interaction policies, the extent to which they're enforced, and suggestions for new policies or ways they should be implemented. Participants also spoke to how

policies were or should be applied, such as staff differentially enforcing policies across clients. This created a tension in that some participants perceived differential enforcement as favoritism or preferential treatment or, conversely, that rules are being individualized to client needs.

Clients described specific group/interpersonal policies intended to promote TIC and their consequences. Overall, policies reflected an intent to promote *trustworthiness* through setting expectations and creating consistency. Policies were often intended to promote *safety* and included being respectful, not disrupting or harming others, confidentiality, guest visiting policies, non-judgment and sensitivity towards people of various backgrounds, and others. Both facilitating and impeding interactions were present within this theme. Policies may limit *choice* of one group or all individuals to promote *safety* (guest policies for housing units), *trustworthiness (*others' consistent access to services), or *empowerment* (through rules intended to facilitate skill building.) One client explained that participating in specific services means agreeing to rules, an aspect of *choice*. Certain clients described the transparency of policies; for instance, group rules were often clearly outlined at the beginning of the group. Demonstrating differing experiences of rule *trustworthiness*, other clients were unclear on rules or consequences or at times described rules differently. This at times led to feeling that they were treated unfairly if they experienced a consequence based on a rule of which they were unaware. One person explained the lack of policy transparency, "Rules – whatever they decide to make up. Right at that given time" (26). Although some clients acknowledged the agency's overall harm reduction approach to substance use within the agency, certain clients wanted stricter rules on substance use on premises. This demonstrated a desire to limit certain individuals' *choice* through rules to promote *safety*.

Additionally, clients spoke to the level of policy enforcement. Demonstrating the interrelatedness of themes, policy enforcement was also described as a way to manage conflict. Clients primarily described wanting unilateral rule enforcement and some even described inconsistent enforcement by staff as favoritism. However, other clients described situations in which policies were differentially enforced for certain clients in a positive manner. One client described such a situation:

> If you don't go to group, you can't get a hot lunch… but this [client] doesn't like to use the showers … they can't get his clothes to wash...they made a side agreement with him, you come in there early, you take a shower, get cleaned up, we'll wash your clothes and that'll be a group, be one of your groups so you can come in for hot lunch you know… He's comin in early you know every couple of days he'll get cleaned up uh which in turn keeps down mayhem and chaos wherever he's at you know now and that's due to the ingenuity, the patience, of staff... it kinda caused a problem in the beginning, because…you got people who are just sitting back… 'God damnit I know he didn't go to group why they feedin him?' … Staff doesn't want it to be common knowledge because you know you have certain agitators...who would you know would start pickin at him you know with that knowledge and that would blow the whole deal (5).

Demonstrating another overlap with the theme of individualizing care, inconsistent rule enforcement could be interpreted, in some cases, as an attempt to individualize services to specific client needs. Clearly, however, although this particular participant described the differential rule enforcement as "ingenuity" of staff, other clients did not agree. This highlights how *collaborative* agreements with clients may facilitate client *empowerment* but also impact others' sense of rule *trustworthiness* negatively. Clients who perceived differential rule

enforcement as favoritism at times tied leniency to clients' education level or mental health issues. One client explained,

> it depends on the person and the staff… I feel they are more caring to certain people over others…I hate to say favoritism, I feel that way…You dealing with the majority of the population here, uhh, I would say probably, barely graduated high school… they're more… More uhh forgiving to those participants as opposed to others (6).

This reflects differing experiences of *trustworthiness* among clients. Such descriptions highlight a tension between standardizing care through rules and consistent rule enforcement, and catering rules to individuals. Some people preferred consistency: "rules for everybody, treat everybody as equal, the same, don't individualize people" (10). This was justified as needing consistency and consequences; if rules were not enforced consistently, people might engage in that behavior again. Other times clients highlighted the need to differentially enforce rules. Differential enforcement was particularly viewed positively if the behavior was not disruptive to other clients. However, differences across participants were also noted in whether a particular behavior was viewed as disruptive.

Staff described policies that specifically relate to peer interactions, such as mutual respect, no yelling, and no disruption. Staff described ways to build *safety,* such as through *choice* or *trustworthiness*. For instance, clarifying rules, a *trustworthy* practice, can create a sense of *safety* when expectations are clear and clients and staff follow those rules. One staff member explained the purpose of standard policies,

> at the start of a group they'll say these are the rules for the group… there is a sense of order, there is an expectation of like how people will behave and how they'll treat each

> other in this space and that increases people's sense of safety and their sense of control over the environment (12).

As such, staff described setting expectations by going over policies, clients signing a document detailing their rights, and creating accountability for behavior. Agency policies that impact client interactions may also be based in federal policy, such as that staff are not permitted to touch clients when responding to client fights. Instead, staff are to rely on de-escalation skills. However, one staff member appeared unclear whether this was a policy. Policy enforcement involves some type of follow through on peer interactional issues. This could include clarifying policies as a method of conflict management or following through on consequences, which may involve decreasing *choice* to promote *safety.* One staff member explained how removing *choice* was intended to promote *safety*.

> if they are disruptive or you know, being a hindrance to care then we do have behavioral contracts... in place, um, where, you know, either they won't be able to come to certain parts of the program, or, um, that altogether they won't be able to come because they're, they're either are traumatizing or re-traumatizing other participants (18).

This example demonstrates how removing choice to participate in the program for an individual is intended to increase *safety* of other individuals who might be harmed by their behavior. Other staff similarly reported that when *safety* is threatened, *safety* may be built through de-escalation strategies such as removing individuals. This can also build *safety* for the individual being removed if they are isolated and provided with individualized intervention.

Discussion

The present study investigated how client interactions impacted client and staff experiences of TIC within a homeless service agency. The following themes were identified:

accessibility, confidentiality and privacy, conflict and conflict management, general environment, individualizing care, mutual support and community building, policies and policy enforcement. The study also explored how TIC principles (Fallot & Harris, 2006) operated within this context. Analyzing the data through both an inductive approach and a deductive approach offered a unique perspective on considerations for TIC in group settings. The dialectics revealed in this study reflect tensions among TIC principles, such as how promoting choice may impact others' safety or ability to receive consistent services, an aspect of trustworthiness.

A key tension emerging in the current study included individualizing care versus standardizing care through rules and policies highlighted by both clients and staff. Past literature has highlighted ways in which policies and their enforcement may be problematic and re-create traumatic experiences (Gregory et al., 2017; Kulkarni et al., 2019). A qualitative study with clients of domestic violence shelters argued that shelter rules may inhibit empowerment, such as when rules are applied inconsistently across circumstances (Gregory et al., 2017). Similar to the present study, some participants described staff as bending rules and other described staff as being rigid, demonstrating some inconsistency across staff and potentially client experiences; at times, participants tied inconsistent rule enforcement to favoritism (Gregory et al., 2017). Some participants described not following rules, which may be an attempt to maintain agency and control (Gregory et al., 2017), which was possibly a response to clients not having buy-in to policies. Lack of buy-in suggests that collaborating with clients when developing, reviewing, or altering policies is essential to ensure the policies' continued utility. Highlighting the tension between standardizing and individualizing care, another study described the process of reducing rules in shelters; relieving staff of rule enforcement facilitated individualizing care (Kulkarni et al., 2019). Flexible policies and choice in service engagement were also found to promote

empowerment in domestic violence shelter settings (Nnawulezi, et al., 2018a; Nnawulezi, et al., 2018b).

Study findings highlighted how clients impact each others' service engagement and experience. Both clients and staff spoke to the importance of sense of belonging and relatability to recovery which occurred in both formal and informal settings. Staff also mentioned learning through training about ways to promote positive relationships among clients. Similar to the present study, existing literature describes the utility of mutual support among clients (Kerman et al., 2019; Johnstone et al., 2016).

Despite the positive aspects of mutual support that may be facilitated in homelessness services, receiving services in group settings may come with challenges. Consistent with the literature describing negative experiences with other clients in settings that were not explicitly trauma-informed (Kusmaul et al. 2018; Johnstone et al., 2016), the present study found that interactions with clients at times involved tension, conflict, or trauma triggers described by both staff and clients. This at times impacted their sense of the overall environment of the service setting. Previous research similarly described experiences of the overall environment across social and health services as chaotic and that other clients at times impacted a sense of safety (Kerman et al., 2019). When specific conflicts were noted, clients and staff in the present study described similar conflict management strategies. The present study findings also found that peer interactions impacted sense of trustworthiness when breaches of confidentiality occurred. Staff discussed challenges in maintaining confidentiality when specific issues involved multiple clients. Staff sometimes described staff consultation or debriefing as an important strategy. When clients described breaches of confidentiality by staff, it is possible that certain—but not all—of these instances involved staff attempting to consult. Additionally, findings also indicated that

clients perceived their accessibility to services to be impacted by other clients' service engagement, especially if clients perceived others' service use negatively. Clients expressed differing perspectives on whether unconditional access to services was positive when they viewed other clients' service engagement negatively. Overall, both clients and staff highlighted the high client need for services. Balancing scarce resources with high demand was a challenge for staff.

The present study illuminates important considerations for implementing TIC in a group, or milieu, context. TIC in group contexts involves balancing different preferences and needs among clients while trying to create some sense of consistency and clear expectations. Due to systemic and organizational barriers coupled with high service demand, certain types of needs are prioritized in practice. Participants highlighted various such needs, including harm reduction for substance use, managing conflict or arguments over personal issues, and supporting people who may be more functionally impaired. Due to needs changing for clients with time or needs differing among clients, homelessness service organizations may see a constant flux in clients as such changes may impact service engagement. This is often coupled with constant change in staff as direct service roles within human services see high turnover.

Regarding broad patterns across the client and staff datasets, clients more often spoke to client interaction issues than staff. Given that staff members were familiar with TIC to varying levels, this may reflect the tendency for TIC to focus on considerations for individual clients (e.g., Butler, et al., 2011). This also likely reflects that interactions among clients compose a large proportion of client experiences when receiving homelessness services. This includes mutual support as well as conflict.

Overall, findings also highlight varying experiences of similar types of services. For instance, some participants described group therapy as helpful due to mutual support, although others criticized groups as unproductive and called attention to confidentiality issues. Additionally, some clients discussed inconsistent policy enforcement as favoritism. On the other hand, certain staff and clients conceptualized certain instances of inconsistent policy enforcement as a positive way to individualize care. Some of these differences may be related to issues highlighted above, including how scarce resources lead to prioritization strategies, client factors such as their level of functioning, as well confidentiality preventing staff from being transparent. For instance, explaining why a particular rule was not enforced for a particular client might involve divulging private client information.

There were notable demographic differences among clients and staff, such as racial and ethnic identification and education level. More specifically, most of the clients (58.8%) reported their highest level of education as grade K-12 or less, while all of the staff had at least some college, trade school, or an Associate's degree. Additionally, most of the clients (88.2%) identified as a member of a racial or ethnic minority group, primarily African American (76.5%), compared to half of the staff identifying as a member of a racial or ethnic minority group. Although the present study research questions did not directly ask individuals to reflect on how their identities and or cultural backgrounds impacted their experiences of TIC within the group contexts of the agency, such lenses should be explicitly elicited in future research. Cultural humility and an awareness of cultural, historical, and gender issues informing practice and policies are important aspects of TIC, particularly within SAMHSA's model (2014). Indeed, past research has highlighted the importance of a culturally-informed TIC approach (Kirst et al., 2017) and the possibility that individuals may have different experience of how trauma-informed

a particular intervention is (Kusmaul et al. 2018) which may be reflective of differences in experiences among individuals of diverse identities and backgrounds. Based on the present study, experiences of TIC could depend on aspects of identity, cultural background, or history. Participants highlighted different policies based on current housing status (individualizing care), differential policy enforcement potentially tied to functional or educational level, witnessing discriminatory comments based on race (conflict), and staff challenges in maintaining confidentiality when responding to gender-based violence that occurred among clients at the agency. Creating a trauma-informed space for individuals of various cultural backgrounds and identities manifested in various ways such as in norm setting within the general environment of the agency as a safe space for people of diverse identities and backgrounds. Having services specific to aspects of identity (such as groups for men and for women) was often discussed within the context of positive aspects of TIC implementation.

Implications

Findings have implications for practice, policy, and TIC conceptualization. Homelessness organizations serve heterogeneous populations who often vary demographically, in terms of their health needs, access to resources, etc. As such, the individuals that compose homelessness service settings may require unique operationalization of TIC.

Study findings highlight the importance of mutual support among clients as an aspect of recovery within the homeless service milieu. This provides additional support for current conceptualizations of TIC. Peer support is a key principle of SAMHSA's model of TIC (2014). Beyond support among clients, agencies may also create roles for peer supporters (Barker et al., 2018). Peer supporters spoke to how they similarly helped through shared experience, which they believed offered hope for clients (Barker et al., 2018). Peer support was also found to

positively impact both the peer supporters and clients, such as through skill building which is an aspect of empowerment (Barker et al., 2018; Barker & Maguire, 2017). Additionally, findings also indicated that client engagement can negatively impact other clients. Clients may not necessarily be aware of or follow TIC principles. This provides support for involving clients in the implementation of TIC to the extent possible. An obvious challenge is difficulty engaging individuals currently in crisis such as homelessness. Individuals who are involved in service delivery likely have more stability. However, it is also possible that for some individuals being engaged in service delivery can positively impact their own recovery.

Study findings also highlight key considerations when implementing TIC in a group setting. When taking a particular action or creating a policy, it is important to consider the impact it will have on the groups that the action or policy are not necessarily intended to benefit. In practice this may involve a cost-benefits analysis, such that the benefits may outweigh the costs. In the present study, allowing intoxication in a service setting may negatively impact certain individuals' sense of safety. At the same time, taking this harm reduction approach may prevent leaving individuals experiencing substance use issues in unsafe settings. When unintended negative effects are identified, one strategy is to rely on the implementation of other principles to mitigate effects (Kusmaul et al., 2018). For instance, clients recommended the availability of private rooms for de-escalation when disruption does occur. Clearly, implementing TIC involves considering how limited resources are utilized. The present study also highlights considerations for staff training on TIC. For instance, staff mentioned that past training has helped them learn strategies to promote client community building and resolve conflict. Other findings may also be relevant to training, such as how to handle tensions between policies and the need to individualize care.

This study also highlights that implementing TIC may have challenges and iatrogenic effects. Creating a trauma-informed environment for one individual may be in opposition to creating trauma sensitivity for another client. Practices meant to be trauma-informed may be perceived and experienced differently than intended, potentially leading to retraumatization. Findings revealed a range of perspectives on differential policy enforcement as a way to individualize care. For instance, promoting harm reduction as a way to maintain choice for individuals struggling with substance use issues was identified as leading to a lack of safety by some participants due to trauma being reactivated when substance use led to disruption. As such, there is a need for creating processes to address harm caused by a staff member or client, such as restorative justice. Additionally, it is possible that perspectives among some clients and staff may differ on staff consultation. What may be viewed as a collaborative practice—consulting with other staff on client issues—may be perceived as a breach of confidentiality. This perspective differs across clients, highlighting the need for transparency around confidentiality limits and attention to individual preferences when possible. As such, being explicit about limits to confidentiality and any procedures around staff consultation should be explicitly discussed during an informed consent process as part of treatment. It is important to acknowledge that maintaining confidentiality in a group context in which issues may involve multiple clients was identified as a challenge by staff. This, again, highlights the need for processes to address any harm experienced and perpetrated within the agency.

Ultimately, there is a need to develop clear, consistent processes for improvement and monitoring of iatrogenic effects rather than focusing on perfecting policies. In practice, this means developing a process for policy change. Policies should be contextual and open to change based on feedback from those individuals who currently compose that particular environment.

This emphasizes the need for democratic participation and Jones' ever-changing "living-learning environment" (Bloom and Farragher, 2013; Jones, 1968). Bloom and Farragher also emphasize the parallel process of organizations being in a constant state of crisis or hyperarousal, which impacts individuals and their interactions. Chronic organizational hyperarousal does not allow for a focus on change.

Awareness of the possibility that implementing TIC may have negative effects under certain circumstances has implications for TIC conceptualization. The literature often presents TIC principles in a solely positive light; but as mentioned above, implementing TIC may have unintended, negative effects. Conversely, facilitating TIC may involve removing an aspect of TIC. For instance, participants discussed that client empowerment was facilitated through removing choice. This indicates that an impeding principle dynamic may have a positive outcome. The intention of TIC is not necessarily to experience all TIC principles to the highest extent possible at all times as this may not always be feasible or useful. Overall, the present study highlighted various circumstances under which such dynamics occur. Principle dynamics highlighted in the present study indicate that implementing TIC often has cascading effects. Previous research has highlighted that implementing one TIC principle is difficult without others because principles are highly correlated (Kusmaul et al. 2015). Conversely, implementing one component without considering others can limit TIC implementation (Kusmaul et al., 2015). The present study adds to the literature by highlighting that implementing components of TIC may also diminish other components. In other words, TIC principles may have both positive and inverse relationships. Negative or inverse relationships occur under specific circumstances, in particular when client needs are in conflict, when resources are limited and a prioritization system is required, and when intended TIC implementation is received or experienced differently

by clients. As such, conceptualization of TIC should allow for inverse relationships among components of TIC (Mihelicova et al., 2017).

Limitations

Although the exploratory nature of the study is a strength, aspects of the study dataset bear limitations. Participants were not explicitly asked about how client interactions impact their experiences within the agency. However, their responses were often probed for how trauma sensitivity was present within client-to-client interactions. Similarly, participants were not asked explicitly about how TIC principles are represented within their experiences. Instead, this study was based on a dataset that relied on participant definitions of trauma sensitivity. It is possible that additional information or themes would be identified if participants were asked questions more direct to the present study research questions. Coding TIC principles and their dynamics was also completed for a subset of the data to answer the research questions specific to client-to-client interactions. It is possible that additional patterns would be identified among the larger study dataset within other contexts such as individual interactions among clients and staff. As such, the present study may not capture principle interactions that may occur across contexts/ecological levels. Additionally, most of the clients interviewed had housing at the time of the interview. It is possible that having a larger representation of clients currently experiencing homelessness would have yielded differing or additional themes. Additionally, agency staff indicated that the agency did not use a specific model of TIC and, as such, the basis for TIC implementation for this agency is unclear. Although models primarily overlap, there is the possibility that different types of dynamics among principles would be identified based on different models of TIC.

Regarding trustworthiness criteria for qualitative studies, this study lacked a member check process that could enhance validity of findings. This was not feasible given time limitations. Additionally, it is important to consider that these findings represent one organization and generalizability is limited. It is possible that participants at other homeless service settings may have different experiences or additional considerations for TIC in the client interpersonal context. Lastly, impression management among certain participants is also possible. For instance, two participants seemed hesitant to share negative commentary. These two individuals differed in terms of race and religious identification, but reported the same gender and similar age on the demographics survey. Both also reported either within the interview or the demographics survey that they currently had housing. It is possible that other participants felt similarly cautious about sharing criticisms, potentially fearful this might lead to unwanted changes in the agency services. This hesitancy may relate to housing status (i.e., participants fearing stating negative commentary if they had obtained housing); however, such a hypothesis would have to be explored in a larger sample. There were other participants who did obtain housing who did share negative comments about the agency. Given that perspectives may vary based on cultural background and aspects of identity, another limitation of the study is that such lenses were not explicitly elicited via the protocol.

Directions for Future Research

Future research could further explore challenges in creating a trauma sensitive environment while balancing the needs of multiple clients. Additionally, the present study found that certain individuals' needs may be preferenced in TIC implementation. Future research may explore this issue more systematically to identify how TIC implementation may be individualized based on client presentation, needs, engagement style, demographics, etc. More

specifically, future research should explicitly elicit how aspects of identity and cultural background (e.g., race, ethnicity, gender) shape individuals' interactions and the impact on experiences of TIC. Other diversity variables not captured by the demographics survey but discussed within the present study interviews may also be relevant to explore, such as personal history of substance use issues given differences in how clients differentially experienced policies on substance use. Further, it may be important to consider predictors of individuals ultimately having a positive experience despite experiencing a lack of choice, lack of safety, etc. For instance, within the specific context of mutual support within groups, future research may explore who is most benefited. Individuals who share trauma and receive negative reactions are most at risk of being harmed, given that reactions to trauma disclosure impact recovery. Additionally, while gender-specific groups were at times noted as helpful, there was a significant underrepresentation of individuals identifying with a sexual orientation minority group. It is possible that there are unique needs among individuals who identify with a minority sexual orientation identity. Another possible direction for future research is to include individuals with lived experience on the research team, including interviewers and data analysts (Berger, 2015).

Conclusion

The present study utilized a qualitative methodology of mixed inductive and deductive methods. The study investigated how client-to-client interactions impact how people experience services in a trauma-informed homeless service setting. Findings largely reflected dialectics within the existing literature. A unique aspect of the study was examining dynamics among TIC principles. TIC principle dynamics indicate that policies and practices presumed to be trauma-informed may have unintended effects despite being beneficial or sensitive to a particular group. TIC implementation should account for such possibilities. Implementing TIC involves not

only considering which principles are implemented but how they operate together. As such, this study has implications for how TIC is conceptualized, infused in policy, and practice.

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Appendix A: Client Demographics Survey

Study ID_____ Survey Date_____

1. Year of Birth_____

2. Gender: M F Transgender M to F Transgender F to M Other:

3. Primary Race: African American Asian White Native American Pacific Islander Multiracial Other:

4. Ethnicity: Non-Hispanic Hispanic, identify region of origin:_____

5. Primary Language: English Spanish Arabic Other:

6. Religion: Christianity Islam Judaism Hinduism Buddhism Non-religious Other:

7. Sexual Orientation: Bisexual Heterosexual Homosexual Lesbian Other:

8. Marital Status: Single Married Divorced Separated Widowed Civil Union Partnered Other:

9. Do you have children? Yes No

9a. If yes, how many? _____

Veteran Information

9. Veteran: Yes No

10. Served in war zone? Yes No

Education

11. Highest level of education you completed? Some Grade K-12 Grade K-12 Trade School One Year of College Associates Degree Bachelors Degree Masters Degree Doctoral Degree Other:

Employment

12a. Are you currently employed? Full Time Part Time Retired Unemployed

12b. Type of Employment_____

13. If want to be employed, what prevents you from working? _____

Legal Issues

14. Ever been arrested? Yes No Unknown

Homelessness Questions

H0. When did you last have a permanent residence (e.g., own apartment/house, living steadily with family or friends, living in transitional housing) (month/year)?_____

H1c. What kind of housing is/was this? Own Rent Friend's home Family's home Permanent Supportive Housing Transitional housing Nursing Home Other:

H2. What is the longest period of time you have been continuously homeless on the street or in shelters?

H3. In last 3 years, how many episodes (14 days or more) of street or shelter homelessness have you had?

H4. Were you homeless as a teenager? Yes No

H5. Was your family ever homeless when you were growing up? Yes No Unknown

H6. Have you ever been evicted? Yes No

H6b. If yes, how many times? _____

Contributing Factors: Did any of the following cause you to become homeless?

C1. Criminal Justice issues: Yes No Don't Know

C2. Natural/Man-made Disaster: Yes No Don't Know

C3. Household composition change: Yes No Don't Know

C4. Interpersonal or domestic violence: Yes No Don't Know

C5. Doubled-up and can no longer live there: Yes No Don't Know

C6. Eviction/foreclosure: Yes No Don't Know

C7. Physical health issues: Yes No Don't Know

C8. Mental health issues: Yes No Don't Know

C9. Expenses exceed income: Yes No Don't Know

C10. Substance abuse: Yes No Don't Know

Services: Please check off any of the services listed below that you have received at [organization name] in the *past 6 months.*

_____ case management

_____ outpatient mental health treatment

_____ primary care

_____ group therapy

_____ supportive housing

_____ supportive housing community meetings

Which locations have you received services at? _____

Appendix B: Staff Demographics Survey

Study ID_____ Survey Date_____

1. Year of Birth_____

2. Gender: M F Transgender M to F Transgender F to M Other:

3. Primary Race: African American Asian White Native American Pacific Islander Multiracial Other:

4. Ethnicity: Non-Hispanic Hispanic, identify region of origin:_____

5. Primary Language: English Spanish Arabic Other:

6. Religion: Christianity Islam Judaism Hinduism Buddhism Non-religious Other:

7. Sexual Orientation: Bisexual Heterosexual Homosexual Lesbian Other:

8. Marital Status: Single Married Divorced Separated Widowed Civil Union Partnered Other:

Veteran Information

9. Veteran: Yes No

10. Served in war zone? Yes No

Education

11. Highest level of education you completed? Some Grade K-12 Grade K-12 Trade School One Year of College Associates Degree Bachelors Degree Masters Degree Doctoral Degree Other:_____

Employment

12. What is your position at [organization name]?

Direct Service Administration Manager/Supervisor Other:_____

12b. How long have you worked in your current position?_____

12c. How long have you worked at [organization name]?_____

12d. Which [organization name] location(s) do you currently work at _____

12e. Have you held any other positions in the agency? Y N

12f. If so, which role(s) have you held?

Direct Service Administration Manager/Supervisor Other:_____

12g. Which [organization name] locations did you work at while you held these positions? _____

Homelessness Questions

H1. Have you ever personally experienced a period of homelessness? Yes No Prefer not to answer

H2. What is the longest period of time you have been continuously homeless on the street or in shelters?_____

Contributing Factors: Did any of the following cause you to become homeless?

C1. Criminal Justice issues: Yes No Don't Know

C2. Natural/Man-made Disaster: Yes No Don't Know

C3. Household composition change: Yes No Don't Know

C4. Interpersonal or domestic violence: Yes No Don't Know

C5. Doubled-up and can no longer live there: Yes No Don't Know

C6. Eviction/foreclosure: Yes No Don't Know

C7. Physical health issues: Yes No Don't Know

C8. Mental health issues: Yes No Don't Know

C9. Expenses exceed income: Yes No Don't Know

C10. Substance abuse: Yes No Don't Know

Appendix C: Client Interview Protocol

Participant ID: _____
Interviewer Name: _____
Date: _____

PARTICIPANT PROTOCOL

I want to mention a few things before we get started:

- *I'll ask you some follow-up questions to make sure I understand or to or to have you elaborate. You can also ask me questions if there's something I say that isn't clear.*
- *At times I'll redirect the conversation to make sure we stay on track with time and that I respect your time here.*
- *I'll also be taking notes to catch everything you're saying. Any questions before we start?*

Start recording

"This conversation is being recorded for research purposes. Please let me know now if you do not agree to being recorded. You may request that the recording stop at any time."

Section 1: INTRODUCTION

A lot of people who walk in the door at [ORGANIZATION NAME], including staff and [clients], may have had bad or traumatic experiences. We want to know what you think people who experience trauma need. This can be based on you or other people you know, but were not asking for you to tell us any experiences of trauma.

[If needed:] Trauma is any bad experience like something that's really distressing or disturbing. Something that may have significant long-term outcomes.

[If needed:] Some people think about homelessness or loosing housing as trauma. OR Some people have experienced bad things growing up.

1. What do you think people who experience trauma need when they come to a service organization like [ORGANIZATION NAME] as [clients] or staff? Thinking about staff and [clients] at [ORGANIZATION NAME], what do you think people who experience trauma need? Why?

   [Remind:] There is no right or wrong answer.

   - ☐ [If unclear:] When you talk about trauma, can you tell me the kinds of things you are referring to just so I'm on the same page?
   - ☐ What kind of environment or atmosphere do people who have experienced trauma need when they come to service organizations?

2. What can agencies do to be sensitive to people's experiences of trauma? Why?

   - ☐ What can agencies do to support [clients] who may have experienced trauma?
   - ☐ What can agencies do to support staff who may have experienced trauma?

Section 4: PRACTICE

We talked generally about what people need and how agencies can respond. Now, I'd like to ask you about how [ORGANIZATION NAME] can be sensitive to people's experiences of trauma. For these, please think of as many examples as possible covering things like interactions with [clients], other staff members, both within and outside of service delivery, in supervision, and in terms of the physical environments.

1. What does [ORGANIZATION NAME] do to be sensitive to the fact that people who come here may have experienced trauma? *For each example provided, probe for whether this is supported by policy or not.*

- ☐ What do they do to be sensitive to this for [clients]?
  - ☐ Interactions
    - Between [clients] and staff?
    - Between [clients] and other [clients]?
  - ☐ What about outside of service delivery?
  - ☐ What about in terms of the physical environment? Things like the physical layout or appearance of building and office spaces.

- ☐ What do they do to be sensitive to this for staff?
  - ☐ Interactions with other staff?
  - ☐ What about outside of service delivery?
  - ☐ What about in terms of the physical environment? Things like the physical layout or appearance of building and office spaces.

2. [If outside experience with other service providers mentioned:] How do [ORGANIZATION NAME]'s practices compare to other homeless service providers you might be familiar with?

3. Based on your experiences at [ORGANIZATION NAME], how knowledgeable is staff about trauma?
   - ☐ How much does staff know about how to create an environment that is sensitive to people who may have experienced trauma?

4. In terms of being sensitive to individual's experiences of trauma, what, if anything, is [ORGANIZATION NAME] doing well?

5. In terms of being sensitive to individual's experiences of trauma, what, if anything, could [ORGANIZATION NAME] do better?

6. What, if any, specific trauma-related issues have come up for you that [ORGANIZATION NAME] had trouble addressing?

Section 5: POLICY

Now I'll ask you about policies, or rules, at [ORGANIZATION NAME]. This might include things like written materials provided to you.

1. Tell me about policies you're aware of that [ORGANIZATION NAME] has in an attempt to be sensitive to the fact that people may have experienced trauma.
    - ☐ What policies do they have in place to be sensitive to this for [clients]?
        - ☐ Interactions
            Between [clients] and staff?
            Between [clients] and other [clients]?
        - ☐ What about outside of service delivery?
        - ☐ What about in terms of the physical environment? Things like the physical layout or appearance of building and office spaces.
    - ☐ What policies do they have in place to be sensitive to this for staff?
        - ☐ Interactions with other staff?
        - ☐ What about outside of service delivery?
        - ☐ What about in terms of the physical environment? Things like the physical layout or appearance of building and office spaces.
2. How did you learn about these policies?

Section 6: Improvement

Lastly, I'd like to ask about ways things could be improved.

1. What could be improved in [ORGANIZATION NAME] in terms of being sensitive to people who may have experienced trauma?
    - ☐ Staff knowledge
    - ☐ Policies
    - ☐ Practicing TIC

Section 7: Closing

1. Is there anything you'd like to share I didn't ask you about?
2. Do you have any questions for me?
3. Before we wrap up, is there anything I could do to improve the interview?

Thank you for your time today and answering my questions.
Interview Length: _____

Appendix D: Staff Interview Protocol

Participant ID: _____
Interviewer Name: _____
Date: _____

STAFF PROTOCOL

I want to mention a few things before we get started:

- *I'll ask you some follow-up questions to make sure I understand or to or to have you elaborate. You can also ask me questions if there's something I say that isn't clear.*
- *At times I'll redirect the conversation to make sure we stay on track with time and that I respect your time here.*
- *I'll also be taking notes to catch everything you're saying. Any questions before we start?*

Start recording

"This conversation is being recorded for research purposes. Please let me know now if you do not agree to being recorded. You may request that the recording stop at any time."

Section 1: INTRODUCTION

For this first part of the interview, I would like to get to know you a bit and your role and responsibilities at your organization.

1. What motivated you to work in your organization?

    - ☐ Why they chose to work at/ stay with [ORGANIZATION NAME] over other organizations

2. What are some of your daily responsibilities in your position?

Section 2: THEORY/UNDERSTANDING OF TIC

A lot of people who walk in the door at [ORGANIZATION NAME], including staff and [clients], may have had bad or traumatic experiences. We want to know what you think people who experience trauma need. This can be based on you or other people you know, but were not asking for you to tell us any experiences of trauma.

[If needed:] Trauma is any bad experience like something that's really distressing or disturbing. Something that may have significant long-term outcomes.

[If needed:] Some people think about homelessness or loosing housing as trauma. OR Some people have experienced bad things growing up.

1. What do you think people who experience trauma need when they come to a service organization like [ORGANIZATION NAME] as [clients] or staff? Thinking about staff and [clients] at [ORGANIZATION NAME], what do you think people who experience trauma need? Why? *[Remind:]* There is no right or wrong answer.

    - ☐ [If unclear:] When you talk about trauma, can you tell me the kinds of things you are referring to just so I'm on the same page?

    - ☐ What kind of environment or atmosphere do people who have experienced trauma need when come to service organizations?

2. What can agencies do to be sensitive to people's experiences of trauma? Why?

    - ☐ What can agencies do to support [clients] who may have experienced trauma?

    - ☐ What can agencies do to support staff who may have experienced trauma?

3. What, if anything, does the term trauma-informed care mean to you?

    ☐ How does trauma-informed care apply to you as a staff member?

    ☐ How does trauma-informed care apply to [clients]?

    [If needed:] It can also mean anything an organization does to be sensitive to people's experiences of trauma or things that an organization does to make people feel more comfortable, considering that people might have experienced trauma. It can also mean things that make staff more comfortable considering they are working with people who have experienced trauma or that staff may have experienced trauma themselves.

    [One or all to check understanding:]
    ☐ Does that make sense for you?
    ☐ Would you add anything to that?
    ☐ Can you think of an example?
    As I move forward in the interview, I'm going to be referring to these types of practices.

4. There are multiple models or ways to define trauma-informed care, each with their own set of key principles or key components. What are the key components of trauma informed care to you?

    [If no TIC definition:] what do you think are the most important things an organization can do to create an appropriate environment for someone who has experienced trauma?

5. How did your definition of trauma-informed care develop?

    ☐ How did [ORGANIZATION NAME] influence how your definition developed?
    [If no TIC definition:] How, if at all, did [ORGANIZATION NAME] influence what you think people who have experienced trauma need when they come to an organization like [ORGANIZATION NAME]?

6. If at all, how is your definition different from how [ORGANIZATION NAME] defines trauma-informed care? [Skip this question if no TIC definition]

7. [If outside experience with TIC not mentioned:] Outside of your work at [ORGANIZATION NAME], what previous experience do you have with TIC?
   - ☐ [If interviewee mentioned other organizations:] How is [ORGANIZATION NAME]'s definition different from the other places you mentioned?

Section 3: TRAINING

We talked a lot about defining trauma-informed care/ (OR: how [ORGANIZATION NAME] can be sensitive to people's experiences of trauma). The next section of the interview will be divided into three parts related to trauma-informed care: training, policies, and practice. For these, please think of as many examples as possible covering things like interactions with [clients], other staff members, both within and outside of service delivery, in supervision, and in terms of the physical environments. First, I'll ask you about what trauma-informed care looks like in training.

1. Tell me about how, if at all, you've been trained on trauma-informed care. [If no TIC definition:] How, if at all, have you been trained at [ORGANIZATION NAME] on being sensitive to people's experiences of trauma?
   - ☐ What about training in terms of being sensitive to trauma for [clients]?
     - ☐ Interactions
       - Between [clients] and staff?
       - Between [clients] and other [clients]?
     - ☐ What about outside of service delivery?
     - ☐ What about in terms of the physical environment? Things like the physical layout or appearance of building and office spaces.

   - ☐ What about training in terms of being sensitive to trauma this for staff?
     - ☐ Interactions with other staff?
     - ☐ What about outside of service delivery?
     - ☐ What about in terms of supervision?
     - ☐ What about in terms of the physical environment? Things like the physical layout or appearance of building and office spaces.

Section 4: PRACTICE

Now I'll ask you about what trauma-informed care looks like in practice. Oftentimes organizations develop philosophies or policies that are intended to guide practices but they don't actually work out in practice for any number of reasons. So, I'm going to ask you about how trauma-informed care actually plays out here at [ORGANIZATION NAME]. This may or may not match exactly with some of the things we've already talked about and that's totally okay.

1. Tell me about what trauma-informed care looks like in practice at [ORGANIZATION NAME]. *(Interviewer: If they mention extra or added things they do, probe for how that practice was developed. If they mention policies that are altered or not practices at all, probe for why that is.)* [If no TIC definition:] What does [ORGANIZATION NAME] do to be sensitive to that fact that people who come here may have experienced trauma?

    - ☐ How does trauma-informed care apply to [clients]?
      What does [ORGANIZATION NAME] do to be sensitive to trauma for [clients]?
        - ☐ Interactions
          Between [clients] and staff?
          Between [clients] and other [clients]?
        - ☐ What about outside of service delivery?
        - ☐ What about in terms of the physical environment? Things like the physical layout or appearance of building and office spaces.

    - ☐ How does trauma-informed care apply to you as a staff member?
      What does [ORGANIZATION NAME] do to be sensitive to this for staff?
        - ☐ Interactions with other staff?
        - ☐ What about outside of service delivery?
        - ☐ What about in terms of supervision?
        - ☐ What about in terms of the physical environment? Things like the physical layout or appearance of building and office spaces.

    [If applicable:] Why do you think differences exist between training/policies & practice

2. How prepared do you feel in addressing trauma-related issues?

3. What, if anything, makes it easier for you to practice trauma-informed care? [If no TIC definition:] What, if anything, makes it easier for you to be sensitive to people's experiences of trauma?

4. Can you think of times when trauma-informed care is difficult to implement? [If no TIC definition:] When, if ever, has it been difficult for you to be sensitive to people's experiences of trauma?

5. What specific trauma-related issues have come up that you've had trouble addressing?

6. Now, I'd like to ask you a little bit about self-care. In what ways does [ORGANIZATION NAME] approach self-care?
   - ☐ Training
   - ☐ Policies
   - ☐ Practicing TIC

7. How do you practice self-care?

Section 5: POLICY

Now I'll ask you about formal policies, or rules, related to trauma-informed care at [ORGANIZATION NAME]. This might include things written in your employee manual, included in your benefits package, or written materials provided to [ORGANIZATION NAME] [clients].

1. Tell me about policies you're aware of that are related to trauma-informed care. [If no TIC definition:] Tell me about policies you're aware of that [ORGANIZATION NAME] has in an attempt to be sensitive to the fact that people may have experienced trauma.
   - ☐ What policies do they have in place to be sensitive to trauma for [clients]?
     - ☐ Interactions
       - Between [clients] and staff?
       - Between [clients] and other [clients]?
     - ☐ What about outside of service delivery?
     - ☐ What about in terms of the physical environment? Things like the physical layout or appearance of building and office spaces.
   - ☐ What policies do they have in place to be sensitive to trauma for staff?
     - ☐ Interactions with other staff?
     - ☐ What about outside of service delivery?
     - ☐ What about in terms of supervision?
     - ☐ What about in terms of the physical environment? Things like the physical layout or appearance of building and office spaces.
2. How did you learn about these policies?

Section 6: Improvement

Lastly, I'd like to ask about ways things could be improved.

1. In what ways could trauma-informed care be improved at [ORGANIZATION NAME]?
[If no TIC definition:] What could [ORGANIZATION NAME] do to improve the ways they are sensitive to people who have experienced trauma?
   - ☐ Training
   - ☐ Policies
   - ☐ Practicing TIC

Section 7: Closing

1. Is there anything you'd like to share I didn't ask you about?
2. Do you have any questions for me?
3. Before we wrap up, is there anything I could do to improve the interview?

Thank you for your time today and answering my questions.
Interview Length: _____

Appendix E: Coding Rules Checklist for Client-to-Client Interactions in the Homeless Service Milieu

- ❑ Code for any situation involving two or more clients.
    - ❑ Include situations in which a client describes a situation that arose between themself and another client or clients.
    - ❑ Include situations in which a client describes a situation that arose between themself, another client or clients, and a staff member or staff members.
    - ❑ A situation may be a direct interaction or indirect circumstances. Indirect circumstances can include interactions that are observed or learned about. In the case of indirect circumstances, a situation involving a different client and a staff member must somehow relate back to the client.
    - ❑ Exclude situations involving one client and one staff member.
    - ❑ Exclude situations involving one or more staff members and no clients.
    - ❑ Exclude situations involve one or more staff members and a single client.

Appendix F: Coding Rules Checklist for TIC Principles

Based on Fallot and Harris' (2006) framework, code for the following principles within the dataset, whether the principle is promoted or impeded. All principles relevant to a particular situation should be coded.

- ❏ **Safety:** anything related to the way in which the physical or emotional safety is promoted or impeded. This includes the presence of security personnel; whether doors are locked, open, and accessible; the comfort of shared spaces; accessibility of restrooms; how welcoming first contact/desk staff are; staff attentiveness to signs of client discomfort; adequate personnel; sensitivity to unsafe situations such as interpersonal violence in interactions with clients, and events that pose threat to safety such as conflict and assault.
- ❏ **Trustworthiness:** anything related to how trustworthiness is promoted or impeded, such as through consistency, clarity regarding services and tasks, and boundaries. Examples include providing clear information about the program and expectations, such as what will happen, who will do what, why, when, what the costs are; whether information about expectations is realistic as the agency may not have control over certain situations, etc.; how professional or personal the boundaries are such as whether money is loaned or home phone number exchanged; whether informed consent is obtained, providing clear information about benefits and risks, whether informed consent respected, and whether clients have choice around consent.
- ❏ **Choice**: anything related to the way choice and control are promoted or impeded, such as in regards to services received (including when and by whom, who is present, starting and discontinuing services, how clients are contacted, whether they are provided information about options, whether client priorities are emphasized, whether clients are

provided information about responsibilities and rights, and whether there are negative consequences to exercising choice).

- **Collaboration**: anything related to the ways in which power is shared among clients and staff, such as clients having roles in service planning, goal setting, and evaluation, and their opinions are given significant weight, presence of a Consumer Advisory Board, involvement of clients in service planning meetings, and perception of clients as experts on their experience.
- **Empowerment**: anything related to the level to which clients are empowered and their skills are built. This includes the recognition of strength and skills, emphasis on growth over maintenance, and ensuring that clients have significant voice and are involved whenever possible in planning, implementing, and evaluating services.

Appendix G: Coding Rules Checklist for Principle Dynamics

- ❑ **Inter-Principle Facilitation:** one principle facilitates another principle, in that implementation of a principle positively impacts implementation of another principle or serves as a catalyst for the secondary principle occurring for the same or different individual or group. There is explicit mention of the secondary principle—not necessarily by naming the principle—but by the mention of something that fits its definition. (This is to prevent making any assumptions of what principle *could have* been implemented by the researcher.)
- ❑ **Intra-Principle Facilitation:** implementation of a principle facilitates additional implementation of that principle, either in a different manifestation of that principle or for a different individual or group.
- ❑ **Inter-Principle Impediment:** one principle impedes another principle, in that implementation of one principle negatively impacts or prevents the implementation of another principle for the same or different individual or group. There is explicit mention of the secondary principle—not necessarily by naming the principle—but by the mention of something that fits its definition.
- ❑ **Intra-Principle Impediment:** implementation of a principle impedes additional implementation of that principle, either in a different manifestation of that principle or for a different individual or group.
- ❑ **Overlapping Definition:** code when one idea is represented by two or more TIC principles.