

Specialist Homelessness Services

Like everyone else...

I've looked into eyes and I've seen joy. And I've seen surprise. And I've seen excitement. And I've seen wonder.

Often enough I've looked into eyes and seen anger. And I've seen despondency. And I've seen shame. And I've seen fear.

Naomi and Hannah are now 2-and-a-bit. When they were 1-and-a-bit, I listened as a nurse explained that a gastro-nasal tube was considered less invasive than a canula. And then I watched from the other side of the bed as one nurse held Naomi and another nurse fed a tube up through her nose. And Naomi's eyes were fixed on mine. And for the first time, I think, I looked into eyes and saw *terror*.

And I've never wanted an answer to a question more than then. "In this situation, **what can I do to make you feel safe?**"

I've fiddled around in the sector for 20-odd years, and in-and-around my current setting for more than 10. And reflecting upon whether or not becoming a parent had changed anything about the way I worked, I had to ask, "Why haven't I been asking that question more often?" That is, "What can I do to make you feel safe?" And then, "Why aren't I asking that question *all* the time?"

I thought I'd been doing the right thing...

And maybe it's at this point where everything else just becomes, frankly, a little bit embarrassing.

If we didn't know before, we've certainly known since the *Down and Out in Sydney* research from the late 90's that trauma is an issue.

And later, Catherine Robinson's *Iterative Homelessness* research talked about the impact of the *cumulative* episodes of trauma experienced by homeless people in Sydney.

And Katherine Taylor's *PTSD* research reminded us again of trauma's prevalence amongst homeless people in Sydney. Just about all had experienced at least 2 traumatic events – on average though, **6** traumatic events.

In October 2009 my team and I attended two days of training on Complex Trauma and Mental Health. We'd been looking for opportunities to learn more about trauma. We were just catching onto the fact that if there *is* something like a universal experience related to homelessness, trauma is probably it.

I had some pretty modest expectations of the training: a good opportunity for a bit of team development and maybe we'd pick up a few things about trauma while we were at it. I certainly didn't expect as an outcome of the training that I'd feel an imperative to rethink everything we did.

Every interaction... Every form... Every process... The very model and approach of the team... The design and presentation of premises... *has* to take account of trauma. It embarrasses me that it was like a new discovery – should have been the case for years.

I was lucky enough shortly after to be offered a read of the draft *Rough Living* report. That was the first I'd heard of Trauma Informed Care. It seemed like an absolute no-brainer for Homeless Services. In part it put a name to what we'd been thinking through. But it asked even more questions of us.

Some things that come up:

1. **Home**... We've been banging on for years about a "*home*" as opposed a "*house*". But it suddenly seems a bit ill-informed when thinking through the fact that home almost always provided the context for the first occasion of trauma.

Catherine pointed me to an old study by Tomas and Dittmar. They found for example that most people who have experienced homelessness struggle to define "home". It fits I think with what we see all the time. A piece of

paperwork asks the question, “In what suburb was the last place you considered to be *home*? How long ago was that? How long did you live there?” It’s almost always answered as something like “the street” or “this hostel” or “that hostel...” Sure, we need to ask the question differently, but you get the point.

Tomas and Dittmar suggest that “home” doesn’t tend to carry so much the connotations of warmth and belonging as it may do in the broader population. Rather a “house” is a shared dwelling that isn’t yours. And “home” is an environment in which you live by yourself. And because “*home*” may not have been experienced as a safe place, “homeless” maybe thought of as “*escaping home*”. If that’s true, part of our job in supporting people to exit homelessness and thrive in a place of their own may need to include reclaiming or reframing “home”.

2. Compassionate Engagement... Plenty was said about this in numerous sessions yesterday. Catherine’s report was pretty clear: **Listening** is a key starting point. It takes time and it takes skill. And if it’s going to take time, then it’s going to require adequate commitment from management and from funders to accommodate it – that is, to allow workers the time, and to provide workers the appropriate supervision (I don’t pretend that’s something we yet do well). And remember, this isn’t even about providing trauma *treatment*. This is simply about the *engagement!*

Catherine makes the point, “Those surviving both homelessness and violent victimisation do not understand themselves as precious and worthy of assistance.” Fair to say that more is said in the activity of listening and in a generosity of time than almost anything else I can think of. And maybe at the same time more is achieved in providing a ‘safe place’ too. For me it’s chilling... The question Catherine asks of our busy homeless services: “For whom and how many will compassionate engagement, will *listening*, come too late?”

About 3 years ago across the country homeless services had to do a special data collection in relation to complex needs. In part I think it was intended as a pilot for a tool. From memory it was about 13 pages, though each page only had a few pretty simple questions. I had time on my hands back then so I did it myself. There were 90 to be done in the week and I figured it’d take about 10 mins a person. Trouble was, one of the questions asked something like, “Have you ever experienced or witnessed violence?” Almost always the answer was no or dismissive. When explained a little more... Let’s just say that my 10 mins turned into something more like an hour. Two things: (1) It illustrated just how normalised violence had become as part of their experience, and (2) it highlighted what we all know: You simply can’t ask questions like that and then not be prepared to listen when the person begins to tell the story – and maybe for the first time. (Risk assessments... Intake interviews... Same deal.) It’s not just rude, it’s dangerous.

Plenty was also said yesterday about the importance of **relationship**. This is getting airtime in homelessness too. In her paper, *What makes case management work for people experiencing homelessness*, Helene Gronda from AHURI found “a persistent, reliable, intimate and respectful relationship [to be] the particular qualities which facilitate an effective working relationship.” “*Intimate*” is probably the most interesting word there. I know it’s generated some lively discussion in some settings, but it strikes me as pretty consistent with what we were hearing yesterday. She continues, “The quality of intimacy is a consequence of the genuine emotional dimension and the everyday nature of the case management activities.”

I don’t think “intimacy” in this context equals compromised professional boundaries.

In a similar way, I don’t think a client forming “attachments” with team members needs to equal dependence.

A couple of quick thoughts about case planning too:

1. The language of “**change**” can be a peril. It can infer that homelessness is a deviance. It can infer that your homelessness is your fault. It can infer that housing is not deserved until you’re a better person. And if trauma is wrapped up in your homelessness, then it might also infer that the *trauma* is therefore your fault too.

2. The point was well-made yesterday: There’s a difference between client-*centred* and **client-driven**. It’s difficult to be client-driven in time framed service provision. And funders say it’s difficult to fund open-ended support. But clients need the freedom to define the frequency and intensity of the support they receive as well as to define the support goals and the order in which they’re pursued. I *don’t* think, by the way, that this needs to be in opposition to an assertive approach, nor to motivational interviewing. I *do* think it is completely consistent with genuine Housing First and Supportive Housing approaches (I struggle with concepts such as ‘housing-readiness’ and needless transitions).

Trauma-Informed Care in SHS

	Traditional Response	Trauma-Informed Response
Impact of Trauma	Not a primary defining event in people's lives.	Central, primary events impacting everything else – all-encompassing.
Style of Service / Atmosphere	Reactive – services and systems are crisis-driven.	Proactive – services and systems focus on preventing further crisis and re-traumatisation.
Symptoms	Discrete and separate.	Inter-related and coping methods.
Worker / Client Relationship	'Objective' and 'distant'.	Shared power – <i>everyone</i> trained to respond to someone in distress and about trauma's impact on individuals
	Service-providers are the experts. Homeless clients are passive recipients of services.	People who are homeless are active experts and partners in services – they're viewed as experts in knowing what is best for them.

Trauma-Informed Care in SHS

	Traditional Response	Trauma-Informed Response
Support Goals	Defined by service providers and focus on symptom reduction.	Defined by the person and focus on recovering and healing.
Road to recovery	Clients are broken, vulnerable, damaged and needing protection from themselves. Agencies are responsible for 'fixing' the 'problem'.	Recovery is possible. Maximising choice, autonomy, self-determination, dignity and respect is central to healing.
Challenging behaviours	Difficult clients such as those with behavioral problems and substance abuse issues are excluded.	Challenging behaviours are the ordinary responses to trauma. They're opportunities to help people address the impact of their behaviours in their own lives.

I saw terror again in Naomi's eyes over the following three days. Every time a nurse entered the room, Naomi cowered in the corner of her cot.

And my wife saw it again a few weeks later when a close family friend visited. It made sense when someone noticed she wore a white shirt with blue cuffs which looked just like a nurse's uniform.

It shouldn't surprise me, then, when a client reads or hears only the bit of a message that is about when their accommodation ends – so a rent reminder is responded to as an eviction notice. I'm very uneasy about my potential to re-traumatise the people I want to serve.

We don't yet do Trauma-Informed Care – we're only beginning to scratch the surface. It *is* an aspiration.

I suspect that some in the sector would say (I would have said it myself), "We've always done Trauma-Informed Care – we just haven't called it that." Yes, to an extent... But with respect, I think that's too easy. We need to hear some of the harder questions that Trauma-Informed Care asks of us. And to keep on hearing them.

Every interaction... Every form... Every process... The very model and approach of the service... The design and presentation of premises... It's *still* an imperative to rethink everything we do. Probably needs to stay that way too.

I need to be asking a hell-of-a-lot more, **"What can I do to make you feel safe?" And to keep on asking it.**