THESIS

THE EFFECT OF INITIATING TRAUMA INFORMED CARE ON CLIENTS' PERCEPTION OF SAFETY

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J. Laural Radmore

School of Social Work

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Master's Committee:

Advisor: James W. Amell

Linda Kuk
Emily Dakin

ABSTRACT

THE EFFECT OF INITIATING TRAUMA INFORMED CARE ON CLIENTS' PERCEPTION OF SAFETY

In 2011, the Colorado Coalition for the Homeless (CCH) initiated the integration of Trauma Informed Care (TIC) concepts into the agency philosophy, policies, and procedures. Trauma Informed Care (TIC) is a model of agency operation and service delivery based on the concepts of Trauma Theory that assumes a universal trauma history in order to make services inclusive for trauma survivors and provides physical and emotional safety for the clients seeking services. The first step was to gain support from the administration with the second step in the praxis being to train every CCH employee, regardless of job title and full-time status, in the concepts of Trauma Theory and Trauma Informed Care. This involved full day trainings in non-violent crisis intervention and on-line trainings in trauma for employees with supplemental training for supervisors in order to make TIC part of the hiring process and the daily conversation in meetings, group and individual supervision with employees, program development, and service delivery. The final step was to introduce trauma screening, which began with pilot programs in July of 2012 and will be integrated into the remainder programs by the end of 2013.

Previous studies have found that the homeless population experiences trauma at a higher rate than the housed population (Clarke, Williams, Percy, & Kim,1995, Kim, Ford, Howard, & Bradford ,2010, & Perron, Alexander-Eitzman, Gillespie, & Pollio, 2008). They also report higher instances of childhood trauma than the general population. Due to these facts, it is probable that integrating TIC into service agencies that serve the

homeless will benefit the clients' feelings of safety, thus leading to better access to services. This study explores the effect of initiating a trauma informed care model on clients' perception of physical and emotional safety at the Colorado Coalition for the Homeless. Moreover, this study examines whether clients reported feeling more physically and emotionally safe after a year of TIC integration into the CCH organizational culture.

Since 2004, CCH has conducted an annual Customer Satisfaction Survey that is derived from the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey. The survey was designed to gather the most valuable information with the least amount of burden. The intention was to use the collected data to guide program improvements. Survey items assess consumer perceptions regarding the appropriateness of services, the quality of services, their participation in treatment, and outcomes they have experienced.

In an effort to better assess the level of Trauma Informed Care at The Colorado Coalition for the Homeless, three new questions were added to the 2011 Customer Satisfaction Survey. Respondents were asked if CCH staff inquired about traumatic or difficult experiences. They were also asked to rate their level of agreement with statements regarding physical and emotional safety at CCH. The answers to these questions on the 2011 survey served as a baseline regarding how clients perceived safety before any TIC initiatives were introduced at the Colorado Coalition for the Homeless. In this study, the 2011 results were compared to the 2012 results in order to see if the introduction of Trauma Informed Care at the Colorado Coalition for the Homeless had an effect on perceptions of physical and emotional safety among CCH clients.

This study found that CCH participants reported high levels of physical safety in 2011 and 2012. Similarly, CCH participants indicated high perceptions of emotional safety in 2011 to 2012. This study also compared the perception of physical and emotional safety of respondents who indicated that they were asked about traumatic events in their lives with the perception of physical and emotional safety of respondents who indicated that they were not asked about traumatic events in their lives. The respondents who indicated that they were asked about traumatic events in their lives reported higher feelings of both physical and emotional safety that respondents who indicated that they were not asked about traumatic events in their lives to a level of statistical significance.

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INTRODUCTION

The Colorado Coalition for the Homeless (CCH) is a community service agency that has been providing housing, mental health, medical, dental, case management, and substance treatment services to people who have experienced or are experiencing homelessness in the Denver metro area since 1984 (Colorado Coalition for the Homeless, 2012). All clients are homeless at the time they begin receiving services at CCH. However, with housing being a service that is offered, many clients are considered to be formerly homeless.

The mission of CCH is to create "lasting solutions to homelessness" by addressing not only emergency situations but, also, the underlying issues of homelessness (Colorado Coalition for the Homeless, 2012). As will be discussed in the literature review of this paper, trauma is a prevalent problem for persons who have experienced homelessness and is often a contributing factor to homelessness. In an effort to be true to the mission of addressing underlying issues of homelessness (one of which is trauma experience and response to trauma), CCH has begun introducing Trauma Informed Care (TIC) throughout the agency. TIC provides a framework to address the needs created through trauma experiences of the population served.

TIC is a model of agency operation and service delivery based on the concepts of Trauma Theory. Trauma Theory states that trauma experiences have a pervasive effect on the functionality of those who have experienced trauma (van der Kolk & Ducey, 2008). TIC seeks to alter the way service providers approach consumers at every stage of contact in order to minimize retraumatization through reducing the triggering of trauma responses as well as increasing feelings of emotional and physical safety (Harris & Fallot,

2001). The main concept of TIC is to stop asking "What is wrong with you?" and start asking "What happened to you?". TIC assumes that every person encountered has experienced some level of trauma and, therefore, aims to provide services with an approach that is informed about the effects of trauma experiences. The hope is that TIC can create a safe space for trauma survivors to receive services without fear of future trauma as well as a safe place to discuss their trauma experiences.

Clients of the CCH often report trauma to their professional supports. However, there is a scarcity of research on the efficacy of trauma interventions with the homeless and formerly homeless. Limited studies on the use of trauma interventions on a large scale for populations touched by homelessness leave a gap in evidence-based service interventions. Traditionally, researchers have struggled with studying homeless populations due to the transient and unstable nature of the group as a whole (Kim et al., 2010). This is especially true for homeless men since they tend to be more isolated and more severely psychiatrically impaired than their female counterparts (Kim et al., 2010). This study does not focus on differences in gender of the homeless population, but, since the majority of homeless people in the United States are men (U.S. Conference of Mayors, 2002), and men are at a higher risk than women for psychological trauma exposure (Kessler, Sonnega, Brommet, & Nelson, 1995), it follows that men comprise the largest group of unstudied, traumatized, homeless persons. Therefore, to neglect to address this sector of the population would leave a gap in the overall picture of the issue.

Due to these difficulties in research, the exact prevalence of trauma has gone largely unmeasured for those who have experienced homelessness as has the effect of trauma-based interventions on this population. This also means that there is a potential

lack of services being offered to this population for the trauma they have experienced. For practitioners, the lack of research of supportive trauma interventions, including trauma informed care, means an inability to choose an appropriate intervention. Further research on trauma, the effects of trauma, and interventions for the homeless population who have experienced trauma would benefit the homeless population and those who serve them.

The purpose of this study was to examine how consumers' perceptions of physical and emotional safety changed after the integration of the concepts of Trauma Informed Care by the Colorado Coalition for the Homeless. Since studies have demonstrated that trauma is a prevalent issue amongst persons who have experienced homelessness (Kim et al., 2010, & Perron et al., 2008), attending to trauma becomes an important goal for service providers who work with homeless populations. Trauma Theory postulates that creating an environment of emotional and physical safety for survivors of trauma provides a space in which trauma survivors can function outside of the natural fight or flight response to trauma. As a result, trauma survivors will, hopefully, feel more comfortable discussing their trauma and the effects it has had on their lives. (Bloom & Harrison, 2011). Therefore, creating an environment that consumers perceive as physical and emotionally safe is imperative for service providers.

Trauma Informed Care is a method by which service providers can create an environment of emotional and physical safety in order to help facilitate the healing process. However, the effect that initiating TIC actually has on consumers' perceptions of safety has not previously been studied. Comparing client's perceptions of safety before the initiation of TIC with client's perceptions of safety after the initiation of TIC

would help to inform the social work profession with regards to the success of this intervention on homeless persons who experience trauma.

One claim of Trauma Theory and Trauma Informed Care is that asking consumers about their trauma creates a safe environment to address trauma. This study also compared perceptions of physical and emotional safety of respondents who indicated whether they were asked or not asked about traumatic events in their lives. Comparing perceptions of safety between respondents who indicated that they were asked about traumatic events in their lives with those of respondents who indicated that they were not asked about traumatic events in their lives can inform the social work profession about the actual effect of this Trauma Informed Care principle.

LITERATURE REVIEW

The literature review provides the foundation of this study as it describes the increased rates of risk for the homeless population, explores the types of traumas experienced by this population and explains the three pathways to homelessness and its implications for trauma. This paper largely relies on research conducted by Kim, Ford, Howard, and Bradford (2010) as well as Kessler, Sonnega, Brommet, Hughes and Nelson (1995).

In 2010, Kim et al. conducted a study on a sample of 239 homeless men to assess the impact of physical and sexual trauma on their mental health. Respondents completed a self-administered survey that assessed their exposure to trauma. Study results discovered that four types of trauma exposure were significantly associated with mental health problems among homeless men. The four types of trauma exposure were childhood physical abuse, adulthood physical abuse, childhood sexual abuse, and adulthood sexual abuse. Study results also revealed that more than half of the sample reported sexual abuse (i.e. 55.6% in childhood and 53.1% in adulthood), while nearly three quarters of the sample reported physical abuse (i.e. 68.2% in childhood and 71.1% in adulthood) (Kim et al., 2010).

In 1995, Kessler et al. conducted a study on a national sample of 5,877 persons between the ages of 15 and 54 years old to assess the epidemiology of post-traumatic stress disorder (PTSD) in the general population. This study also explored trauma associated with PTSD as well as comorbidity of PTSD with other psychiatric diagnoses. Study results found that the estimated lifetime prevalence of PTSD in the general population was 7.8% and that PTSD was more prevalent among women as well as people

who were previously married. Moreover, study results revealed that trauma exposure occurred at a rate of 60.7% in men and 51.2% in women. These rates appear similar to the figures described in Kim et al. (2010), except that Kim was only looking at physical and sexual abuse rather than all traumas. Finally, PTSD was found to be most commonly associated with the following traumas: combat exposure, witnessing combat, rape, and sexual molestation (Kessler et al., 1995).

RATES OF TRAUMA AND RISKS ASSOCIATED WITH TRAUMA

Persons experiencing homelessness are victims of violent and non-violent crimes at higher rates than housed persons (Perron et al., 2008). Although this paper does not deal with trauma rates among housed persons, it is important to understand that, when speaking of trauma amongst homeless persons, what differentiates them from the general population is their housing status.

Studies indicate that there is strong association between being homeless and experiencing trauma (Kessler et al., 1995; Buhrich, Hodder, & Teesson (2000). According to Kessler et al. (1995), homeless individuals report trauma at a rate that is 50% higher than housed individuals. Another study conducted by Buhrich, Hodder, and Teesson (2000) discovered that more than 90% (n=157) of homeless people reported at least one traumatic life event, which is significantly higher than the general population. In contrast, a study by Galea, Nandi, and Vlahov (2005) reported that two-thirds of the general population (i.e. approximately 67%) reported experiencing at least one traumatic life event.

Finally, studies have also show that homeless persons appear to be at greater risk of experiencing violence which may, in turn lead to trauma. For example, women who

are homeless are two to four times more likely to have experienced physical or sexual abuse as adults than their housed counterparts (Jasinski, Wesely, Mustaine, & Wright, 2005). Moreover, men who are homeless seem to be at higher risk for experiencing traumatic stressors, particularly victimization, than their housed counterparts (Kim et al., 2010).

TYPES OF TRAUMA

The literature tends to address the trauma experiences of homeless people in the context of physical trauma as well as emotional or psychological trauma. Physical trauma is defined as trauma that results in bodily injury, such as physical assault, sexual assault, domestic violence, as well as natural disaster that result in harm, accidents, or death (Kim et al., 2010). Psychological or emotional trauma (the terms are often used interchangeably) generally refers to witnesses of trauma, sexual abuse survivors who were victims of coercion rather than physical injury, and victims of emotional abuse. The American Psychiatric Association (2000) definition of psychological trauma requires that there is a violation of bodily integrity or a direct witnessing or experiencing of life-threatening events that includes the reaction of extreme fear, helplessness, or horror that is subjective to the traumatized person.

According to Kim et al. (2010), physical trauma usually also has an emotional or psychological component. Specifically, psychological trauma often results in physical trauma, as in accidental harm that results in death or injury, which makes it difficult to differentiate between the two types of trauma. For example, rape is often categorized as physical trauma. However, rape is also widely accepted as having clear psychological trauma effects. Sexual abuse by coercion rather than force is categorized as

psychological/emotional trauma. However, this could also result in the physical trauma of disease or unintended pregnancy that meets the definition of resulting in bodily injury (Kim et al., 2010).

Psychological / Emotional Trauma

According to Kim et al. (2010), persons who experience homelessness also experience significant psychological trauma. A study conducted by Perron et al. (2008) of 13,729 homeless adults found that approximately 35% of the subjects reported non-physical victimization (i.e. theft or robbery without a physical component) while being homeless. In their study of 239 homeless adults, Kim et al. (2010) found that 55.6% of the sample reported childhood sexual abuse. To contrast these percentages with the general population, Kessler et al (1995) found that 15.1% of the general population reported experiencing the trauma of molestation.

Most risk factors for homelessness are also risk factors for PTSD, which demonstrates a strong link between homelessness and traumatic stress (Kessler et al., 1995, Shelton, Taylor, Bonner, & van den Bree, 2009). Kessler et al. (1995) found that the strongest risk factors for developing PTSD were having a substance abuse disorder, a mental health disorder; or experiencing rape, molestation, or combat. A study by Shelton et al. (2009) discovered that the highest risk factors for becoming homeless were childhood adversity (including molestation and other abuse), mental illness (including PTSD), addiction, and socioeconomic difficulties. Furthermore, the traumas experienced by persons experiencing homelessness tended to be characterized by a complex hybrid of physical and emotional/psychological effects, deterioration, as well as a combination of current trauma stressors and childhood trauma (Kim et al., 2010).

Finally, according to Kim et al. (2010), there is a significant association between trauma history and mental health problems among homeless persons. Specifically, childhood physical abuse, childhood sexual abuse, adult physical abuse, and adult sexual abuse are all associated with an "approximately two fold increase in the risk of mental health problems" (p. 43) among homeless persons. These study results prompted the authors to advocate for homelessness programs to adapt new strategies that address experiences of trauma and treatment of trauma in order to improve mental health and reduce substance abuse among persons experiencing homelessness (Kim et al., 2010).

Physical Trauma

Physical trauma is also prevalent in the homeless and formerly homeless communities, whether it is physical trauma that occurred prior to the onset of homelessness or physical trauma that occurred while being homeless. The physical experience of trauma, including trauma leading to homelessness, often results in physical deficits that inhibit work, contribute to mental illness and substance abuse, while exacerbating the barriers to housing experienced by homeless populations (Kim et al., 2010, Lysaker, Nees, Lancaster, & Davis, 2004, Morrell-Bellai, Goernig, & Boydell, 2000). Perron et al. (2008) found that approximately 22% of their 13,729 homeless study participants reported that they were physically victimized while they were homeless. In addition, a study by Clarke et al. (1995) found that 74% of the homeless men and women that they sampled also reported being physical victimized after becoming homeless.

Violent trauma in childhood also appears to be especially high among homeless teenagers, with more than half reporting childhood abuse in a study conducted by MacLean, Embry, and Cauce (1999). Moreover, being homeless carries an additional

risk of experiencing violent trauma, especially among those with a mental illness or substance abuse disorder (Perron et al., 2008, Kim et al., 2010, Kessler et al., 1995). Finally, in their study of 239 homeless adults, Kim et al. (2010) found that 68.2% of the sample reported childhood physical abuse and 71.1% reported adult physical abuse.

Pathways to Homelessness as Physical and Psychological Trauma

According to Tessler, Rosenheck, and Gamache (2001), there are three pathways to homelessness: social selection, socioeconomic adversity, and traumatic experiences. Each of these appear to have implications for psychological trauma, with the last having implications for physical trauma. The first pathway to homelessness is social selection as a result of mental illness and substance abuse (Tessler et al., 2001). More specifically, homelessness is the result of a breakdown in ability to live independently due to social isolation, economic deficits, and educational deficits that accompany mental illness and substance abuse (Tessler et al., 2001, Kim et al., 2010). Since both the onset and exacerbation of mental illness and substance abuse are associated with traumatic stress, including Post Traumatic Stress Disorder (PTSD), it follows that the psychological trauma experienced by this group of homeless individuals could be the result of social isolation, economic and educational deficits, or the experience of having a mental illness or substance abuse disorder (Chilcoat & Menard, 2003, Lysaker et al., 2004, Kim et al., 2010). The implications for the underlying causes of trauma, as it relates to homelessness in this instance, is that the traumatic stress of living with a mental health or substance abuse disorder could lead to psychological traumas; including social isolation, economic deficits, as well as homelessness.

The second pathway to homelessness is socioeconomic adversity, which involves deficits such as low education and low or declining income (Tessler et al., 2001). Such deficits are, often, associated with diminished self-efficacy, hopelessness, social isolation, and alienation (Kim et al., 2010, Morrell-Bellai et al., 2000). According to Kessler et al. (1995), people are at a higher risk for socioeconomic challenges when they are exposed to psychological trauma and PTSD, which likely means that persons experiencing homelessness have high levels of psychological trauma. The implication for trauma in this case is that the trauma, whether physical or psychological, could be the cause of the socioeconomic deficits as well as a risk factor for becoming homeless.

The third pathway to homelessness is traumatic experiences (Tessler et al., 2001). This final path directly links physical trauma as a clear cause of homelessness (Tessler et al., 2001). In this instance, specific traumas that are mainly physical in nature lead to homelessness, such as in the case of home fires or natural disasters. The traumatic experience is not veiled in this instance and there is often a psychological component to the experience, such as PTSD (Kessler et al., 2001).

Summary

Individuals who are experiencing or have experienced homelessness run a high risk of being exposed to traumatic events (Perron et al., 2008). Traumatic events can be of a physical nature, an emotional/psychological nature, or both (Kim et al., 2010). There are strong correlations between psychological trauma and various risk factors for homelessness, such as mental health problems, addictive disorders, and socioeconomic distress (Shelton et al., 2009).The psychological and emotional trauma experienced by members of the homeless population can occur in childhood or adulthood and can be a

result of homelessness (i.e. social isolation due to homeless status) or can be a contributing factor to homelessness (i.e. trauma reaction to emotional abuse) (Kim et al., 2010, Kessler et al., 1995, & Shelton et al., 2009).

The experience of physical trauma is also prevalent in homeless communities and includes trauma leading up to homelessness (i.e. an injury that prevents one from working) and trauma experienced after becoming homeless (i.e. assault while living in unsafe quarters) (Kim et al., 2010, Lysaker et al., 2004, & Morrell-Bellai et al., 2000). Violent childhood trauma is also prevalent amongst the homeless population and is often coupled with childhood emotional trauma (MacLean et al., 1999).

Furthermore, the pathways to homeless (i.e. social selection, socioeconomic adversity, and physically traumatic experiences) are associated with physical and/or emotional trauma (Tessler et al., 2001, Kim et al. 2010). Social selection is related to mental illness and substance abuse and is highly correlated with psychological traumatic stress (Tessler et al., 2001, Chilcoat & Menard, 2003, Lysaker et al., 2004, & Kim et al., 2010). Socioeconomic adversity is associated with educational and financial deficits as well as experiences of physical and psychological trauma (Tessler et al., 2001, Kim et al., 2010, & Morrell-Bellai et al., 2000). The empirical pathways that lead to homelessness and trauma, coupled with a high risk that homeless population will experience trauma, demonstrates a complex relationship between the experience of trauma and the experience of homelessness.

THEORETICAL FRAMEWORKS

This section includes a review of the theoretical frameworks of Trauma Theory and Trauma Informed Care as underlying perspectives that underscore the importance of

this study pertaining to the service provision needs of persons experiencing homelessness and or persons who were formerly homeless. Moreover, given the need for restructuring organizational perspectives in adopting a Trauma Informed Care approach, organizational theory is also reviewed.

Trauma Theory

Trauma Theory states that "traumatization occurs when both internal and external resources are inadequate to cope with an external threat" (van der Kolk & Ducey, 2008, p 393). The way we think, learn, feel, remember, and cope with the world are affected by traumatic experiences which fragment our brain by lessening the capacity for the right and left hemispheres to communicate and function together and inhibiting brain development (Stein & Kendall, 2004). According to DeAngelis (2007), the American Psychiatric Association is planning to introduce complex trauma as Developmental Trauma Disorder in the next edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) in order to capture the symptoms experienced by individuals exposed to repeated trauma, especially childhood trauma.

The complexity of trauma involves vulnerability and risk, the nature of the stressor, the immediate responses, and post-trauma responses (Bloom & Harrison, 2011). Childhood trauma is more likely to produce long-lasting and more detrimental effects than adult trauma since the child's brain is still in development (Bloom & Harrison, 2011). However, the nature and severity of the trauma experience must be taken into account (Bloom & Harrison, 2011). Individuals who are exposed to trauma, especially chronic trauma, develop hyperarousal and a chronic condition of acute fight or flight responses due to unnaturally high levels of epinephrine, cortisol, and beta-endorphins

(Bloom & Harrison, 2011, Hermann, 1992). Trauma survivors often experience symptoms of PTSD, which represents a maladaptive generalized activation of the alarm response, with symptoms representing responses including hypervigilance versus appropriate prediction of future trauma and avoidance and re-enactment of trauma versus adaptation and survival (Bloom & Harrison, 2011, Bloom, 1999).

Trauma Informed Care (TIC)

Trauma Informed Care (TIC) is informed service delivery. It is not designed to treat specific symptoms or symptoms of trauma; but, rather, to "provide services in a manner that is welcoming and appropriate to the special needs of trauma survivors" (Harris & Fallot, 2001, p 5). According to Bloom and Harrison (2011), in order to halt the progression of maladaptive trauma response and counteract the effects of trauma, service providers must recognize the fight or flight response and hyperarousal of clientele so as to minimize physiological hyperarousal, reduce threats of physical and emotional stress, increase safety, as well as restore trust. The principles of TIC include understanding trauma and its impact, promoting safety, ensuring cultural competence, supporting consumer control, choice, and autonomy; sharing power and governance, integrating care, allowing relationships that promote healing, and believing that recovery is possible (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009).

There are five requirements to creating a trauma informed system: administrative commitment to change, use of a universal screening tool throughout the organization, training and education for all staff of the organization about the trauma and its long-lasting effects, adopting hiring practices that favor employees who are sensitive to probable trauma history of the clientele, and a review of policies and procedures to

ensure that they are designed actively avoid unintentional retraumatization of individuals (Harris & Fallot, 2001). According to the National Center on Family Homelessness (2011), a trauma informed environment views symptoms and problems as part of coping mechanisms to deal with trauma and are adaptations that consumers have elegantly created to ensure that their needs are being met (Prescott, 2011). Moreover, trauma informed services adhere to Bloom and Harrison's (2011) suggested treatment for trauma by promoting autonomy, choice, control, prevention of re-traumatization, and collaboration of treatment planning (Prescott, 2011).

According to Perron et al. (2008), non-physical victimization is associated with higher levels of depression, while physical victimization is associated with lower levels of perceived safety. TIC seeks to decrease instances of retraumatization in order to decrease the trauma experiences of consumers (Harris & Fallot, 2001). In order to effectively provide services to trauma survivors, practitioners must consider the possibility that trauma is an underlying problem for all customers they encounter (Bloom & Harrison, 2011). Trauma informed services adopt a universal assumption of inclusion in order to ensure that the services are not unknowingly marginalizing trauma survivors (Harris & Fallot, 2001). Furthermore, Bloom and Harrison (2011) also recommend that practitioners ask about trauma history and be vigilant to individuals' needs for safety. This is addressed by TIC's mandate of a universal trauma screen as well as by utilizing the policies and procedures of an organization to create emotional and physical safety (Harris & Fallot, 2001).

Organizational Theory

Since TIC is essentially an organizational change aimed at changing the entire culture of the organization, it is important to note that organizational culture is highlighted in several organizational theories. Organizational culture is defined as the collective behavior of humans that are part of an organization, which is comprised of the organization's values, visions, norms, working language, systems, symbols, beliefs, and habits (Schein, 1992). It is also the pattern of such collective behaviors and assumptions that are taught to new organizational members as a way of perceiving and even thinking and feeling (Schein, 1992). Ravasi and Schultz (2006) state that organizational culture is a set of shared mental assumptions that guide interpretation and action in organizations by defining appropriate behavior for various situations. Organizational culture affects the way people and groups interact with each other, with clients, and with stakeholders (Hill, & Jones, 2001). The implementation process of TIC (i.e. administrative commitment to change, training and education for all staff of the organization about trauma and its long-lasting effects, altering hiring practices, and a complete review of policies and procedures) promotes organizational change, and, if successfully implemented, will assist in providing evidence of change that may affect the culture of the organization as a whole (Harris & Fallot, 2001, Schein, 1992).

RESEARCH QUESTIONS AND VARIABLES

The purpose of this study was to determine whether or not clients of CCH feel more emotionally and physically safe one year following the introduction of TIC policies and practices in their programs. As mentioned previously, emotional and physical safety are imperative to combating the effects of trauma on the ability to function (Bloom, 1999). Combating the negative effects of trauma for a population such as the homeless population, which has a prevalence of trauma exposure, is important for clients, professionals, and agencies in the homeless services system. Specifically, the purpose was to answer the following research questions:

1. Did perceptions of physical safety increase among CCH clients between 2011 and 2012 after the introduction of trauma informed practices?
2. Did perceptions of emotional safety increase among CCH clients between 2011 and 2012 after the introduction of trauma informed practices?
3. Are there differences in perceptions of physical safety between clients who were asked or were not asked about difficult life experiences?
4. Are there differences in perceptions of emotional safety between clients who were asked or who were not asked about difficult life experiences?

For research questions 1 and 2, the independent variable is the introduction of the elements of a TIC system into CCH between the two survey years. This is an active and categorical variable with nominal level of measurement. The 2011 surveys were before TIC policies and culture were introduced to CCH, and the 2012 surveys represent the group post introduction of TIC policies and culture. For research questions 3 and 4, the independent variable is whether or not clients reported being asked about traumatic

experiences, an element of TIC. This is a nominal variable with three levels: "Yes," "No," and "I don't know."

The dependent variables are the consumers' perception of emotional and physical safety, defined as the scores for the agency and percent of clients satisfied with their emotional and physical safety on the Likert scale answers for the following questions on the CCH Consumer Satisfaction Survey (CSat):

1. I feel physically safe at CCH, and
2. I feel emotionally safe at CCH.

The level of measurement for these dependent variables is interval and the mean and percentiles will be analyzed. The scores also yield a 'percent satisfied' index, with scores above 3.5 representing satisfaction, scores falling between 2.5 and 3.5 connoting neutral feelings about the program, and scores below 2.5 indicating dissatisfaction. Once scores are translated into a 'percent satisfied' index, they comprise a nominal level of measurement.

METHODOLOGY

DESIGN

This is a quantitative study with a positivist paradigm that focuses on describing the relationship between the introduction of TIC requirements and the reported feelings of emotional and physical safety of consumers. This study took an experimental approach with a quasi-experimental design. The specific design consists of two independent test groups: the 2011 CSats from before the introduction of TIC and the 2012 CSats after the introduction of TIC. Though the design is considered independent test groups, it is important to note that these groups are neither paired nor independent samples. Due to the survey nature of the CCH CSats, it is likely that there are some survey participants who were surveyed in both 2011 and 2012, but there are also some participants who only surveyed in one year. The voluntary and anonymous nature of the survey means that there is no way to know how much overlap there is in survey participation, and thus, the groups were treated as independent groups rather than as paired pre- and post-test groups.

SETTING

The surveys being compared were administered to adult participants of a large human service agency in the Denver Metro area, The Colorado Coalition for the Homeless (CCH). CCH is a multifaceted agency that has been providing services to homeless and formerly homeless individuals and families for more than 25 years (CCH, 2012). The agency utilizes a mixture of federal, state, city, and private funding to provide an array of services including a fully functional medical clinic and permanent supportive housing. The clientele includes customers who are participating in any

combination of the following programs and services: housing vouchers, case management, medical care, mental health care, outreach services, referral to community resources, substance abuse services, dental care, transitional housing, permanent supportive housing, family services, veteran housing services, specialized housing and advocacy, and therapy. In cases of family services, one adult from the household was surveyed. Human subjects approval for the study was obtained from the Colorado State University Institutional Review Board (IRB). Since this study utilized previously collected and de-identified data, the IRB issued an exemption.

PROCEDURES

Changing an organization to a trauma informed organization involves a paradigm shift, and change in the culture of the organization. The five requirements of creating a trauma informed system are: administrative commitment to change, use of a universal screening tool throughout the organization, training and education about the trauma and its long-lasting effects for all staff of the organization, adopting hiring practices that favor employees who are sensitive to probable trauma history of the clientele, and a review of policies and procedures to ensure that they are not designed to potentially re-traumatize individuals (Harris & Fallot, 2001). In 2010, the leadership of CCH (i.e. Board of Directors, Executive Team, and the Management Team) formalized their commitment to instituting Trauma Informed Care at CCH by creating a plan for implementation of trauma informed services, creating a core team for implementation that was trained by SAMHSA in Trauma Informed Care implementation, and investing time and money into providing the infrastructure for agency-wide change.

In the late summer and early fall of 2011, all CCH employees were trained in non-violent crisis intervention, which included introductory information about trauma and trauma effects in addition to non-threatening de-escalation techniques and crisis intervention. Moreover, CCH's employee training program implemented on-line trainings about trauma, childhood trauma, as well as trauma and homelessness through the T3 Training Program. Concurrently, trauma and trauma informed services were intentionally discussed in meetings throughout CCH, as directors and managers attempted to make the trauma training and crisis intervention part of the daily conversations for employees while beginning the process of reviewing the policies and procedures for practices that unintentionally re-traumatize consumers.

The human resources department provided training for all management staff to change the supervision and review process by implementing and becoming adept at Appreciative Inquiry (AI), a management style identified by the leadership as being in line with the principles of trauma informed care. AI is an organization development method that works to increase what an organization and employees are doing well rather than focusing on changing the negative aspects (The Center for Appreciative Inquiry, 2012). This training also included information on hiring processes that would work to identify candidates who have an understanding of trauma experienced by the homeless population. This training regimen also included information on the CCH "universal assumption of inclusion" (Harris & Fallot, 2001, p 10), which is based on the assumption that all consumers of service are survivors of trauma. This universal assumption is thought to halt practices that may be unintentionally frightening while the agency

undergoes the long process of reviewing policies and procedures (Harris and Fallot, 2001).

The final step of implementation is the adoption of a universal screening tool for trauma. The selected tool is a modified version of the Life Events Checklist (LEC). The LEC is a brief, self report survey with 17 items designed to screen for traumatic events in person's life time (US Dept of Veteran Affairs, 2009). According to the United States Department of Veteran Affairs (2009), the LEC has demonstrated both "adequate psychometric properties as a stand-alone assessment of traumatic exposure …[and] convergent validity with measures assessing varying levels of exposure to potentially traumatic events and psychopathology known to relate to traumatic exposure (US Dept of Veteran Affairs, 2009)." The CCH version of the LEC includes four additional questions that ask specifically about childhood trauma and jail time, making it a 21 item survey. For each of the 21 items, the respondent checks whether the event happened to them personally, they witnessed the event, they learned about the event, they are not sure if the item applies to them, and the item does not apply to them. Selected programs began utilizing the tool in June of 2012, only two months prior to the 2012 CSat. Once some data is collected on the success of implementation in the pilot programs, the rest of CCH will begin using the screening tool as well.

SAMPLE

The target population for this study is adults who have experienced or who are currently experiencing homelessness, with the accessible sample being those who receive services through the Colorado Coalition for the Homeless. Non-probability sampling was used for the surveys, as the goal was to offer a survey to every person who received

services during the survey time. The actual sample for both surveys was the participants who chose to complete at least one question beyond the demographic section of the surveys. Two samples were compared: the 2011 sample and the 2012 sample.

As mentioned briefly in the discussion of the design of the study, the samples are neither paired nor truly independent. First, there are some survey participants who participated in both the 2011 and 2012 surveys as well as participants who participated in only one year. Second, the sample size is in the context of surveys rather than participants as it is probable that multiple participants were asked to complete more than one survey due to participating in more than one program. The anonymous and voluntary nature of the surveys creates an inability to know how many participants completed multiple surveys as it is possible that they chose to only complete surveys for some of the programs from which they received services. The samples were treated as independent samples as that is the most accurate way statistically to handle the data. However, the samples are not truly independent from year to year or program to program.

The 2011 sample consisted of 1,543 surveys. Of those surveys, 55.5% were male, 43.2% were female, and 0.5% was transgendered or other (combined). The majority of the respondents was English speaking (97.6%) and identified as Caucasian (59.8%), with almost half identifying as non-Hispanic (44.6%). The 2012 sample consisted of 1,887 surveys. Of those surveys, 52.7% were male, 45.3% were female, and 0.9% was transgendered or other. The majority of the respondents was English speaking (97.4%) and identified as Caucasian (59.6%), with almost half identifying as non-Hispanic (47.8%). The two samples were similar with regard to gender, age, race, language, and ethnicity.

DATA COLLECTION PROCEDURES

The Colorado Coalition for the Homeless has been utilizing the CCH Customer Satisfaction Survey (CSat) agency-wide since 2004. The CSat is comprised of three sections: demographic and program participation, satisfaction scale, and open ended questions. Demographic questions were derived from the Housing and Urban Development standards (i.e. race, ethnicity, gender, and age) with an additional question asking how long the consumer had been in the program. The satisfaction scale section asks consumers to rate their level of agreement with ten statements using a five-point Likert scale (5 = strongly agree; 1 = strongly disagree). Derived from the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey, these items assess consumer perceptions about the appropriateness of services, the quality of services, their participation in treatment, and outcomes they have experienced. Finally, the open-ended questions asked participants to name two things they like most about the services they receive, two things they like least about services they receive, how they would change services to better meet their needs, and anything else they wanted the agency to know. Surveys were counted and considered valid as long as at least one question beyond the demographic data was answered.

The MHSIP Consumer Survey was designed as part of a Consumer Oriented Report Card in 1996 by a task force of consumers and their family members, researchers, and representatives of city, county, state, and federal employees. The final version of the survey was accepted in 2000 (Ganju & Smith, 2008). It was designed as a perception-of-care survey, and became a pivotal piece in the evolution of public mental health performance outcome measures (Ganju & Smith, 2008). The MHSIP Consumer Survey

is a nationally recognized survey, with 30 states using the official 28 question version and 25 states using a variation of the survey (Ganju & Smith, 2008). The CCH variation was created by the Quality Assurance Department of CCH in an effort to select questions from the official survey that will apply to all facets of CCH, rather than mental health services exclusively. The Program Committee of the CCH Board of Directors, the Consumer Advisory Board, and the Quality Improvement Committee reviewed the survey prior to its piloting among two CCH programs in 2004. The Quality Assurance (QA) Department subsequently made revisions based upon respondent feedback.

In an effort to better assess the level of Trauma Informed Care at the agency as a whole, three new questions were added to the 2011 Customer Satisfaction Survey. The additional questions were suggested by the task force for implementing Trauma Informed Care and were then reviewed and finalized by the Quality Improvement Committee and the CCH Consumer Advisory Board. Respondents were asked whether or not CCH staff inquired about traumatic or difficult experiences. Respondents were also asked to rate their level of agreement with statements regarding physical and emotional safety at CCH. The two additional agreement scale questions regarding physical and emotional safety while at CCH were not included on the surveys completed by participants in the Rural Initiatives Program since they were not seen in CCH facilities. Therefore, surveys completed by that program were not included in this study.

The surveys were administered by program to adult consumers. Throughout the two week survey period, consumers were offered the opportunity to complete a survey for each program in which they participated. The majority of the programs hand deliver the surveys to consumers at the time of service delivery with instructions to complete the

entire survey and to only evaluate the program they are visiting at that time. The consumers were then allowed private space to complete the survey and were asked to either place the survey in a collection box or utilize a stamped and addressed envelope to return the survey directly to the Quality Assurance department. This ensured anonymity in the survey process. The program staff then delivered the collection boxes, unopened, to the Quality Assurance Department.

A few select programs, who did not see their participants during the collection period, choose to mail their surveys with instructions and a pre-addressed and stamped envelope included for return directly to the Quality Assurance Department to ensure anonymity of the surveys. The programs that collected surveys at time of service administered the survey during the first two weeks of August each year and collection was cut off at that time unless an administrative error required an extension of collection time. Errors have included single sided surveys being distributed, surveys not being distributed on time, and staff being unable to perform the survey at the designated time due to illness or leave. The programs that mailed their surveys to participants did so in July and mailed in responses were no longer accepted after August 31.

Once the surveys were collected by the Quality Assurance department the quantitative data is coded (i.e. race answers are assigned numeric values) and entered into an Excel spreadsheet with no identifying data by interns, volunteers, and select staff members. The Excel spreadsheet was then transferred into SPSS software so that frequencies and descriptive statistics could be analyzed. For this study, CCH provided access to the SPSS databases for the 2011 and 2012 CSats to the researcher. No new data was collected for this study.

DATA ANALYSES

The quantitative data was be analyzed by SPSS software to find mean scores by agency for the two safety questions and to find frequency of responses for the difficult experiences questions. For the purpose of this project, the data gathered from the Likert scale responses for the following two questions for the years 2011 and 2012 were compared: "I feel physically safe at CCH" and "I feel emotionally safe at CCH" (i.e. Research Questions 1 and 2). Moreover, the responses to those questions for the 2012 surveys were compared with the 2012 responses to the statement, "Staff asked me about difficult experiences in my life" (i.e. Research Questions 3 and 4) to determine if there is a relationship between the responses and to describe the relationship.

The agency was also given a safety score for the physical safety question and the emotional safety question for each year. The safety score is the mean of the survey responses to that question and yields a score between one and five, with five representing the highest level of perception of safety. Individual scores also yield a 'percent satisfied' index, with scores above 3.5 representing satisfaction (feeling safe), scores falling between 2.5 and 3.5 connoting neutral feelings about safety, and scores below 2.5 indicating dissatisfaction (feeling unsafe).

Once the mean safety scores and 'percent satisfied index' was computed for the indicated questions for all surveys, a frequency analysis was run for both 2011 and 2012 surveys to determine the number and percentage of participants who reported feeling safe, neutral, and unsafe physically and emotionally at CCH. To address research questions 1 and 2, Independent Samples T-Test analyses were conducted to explore the

differences between the 2011 and 2012 survey groups with regard to satisfaction scores for physical and emotional safety.

The assumption of independence could not be verified with the design of this study. As previously mentioned the samples are neither perfectly paired nor perfectly independent due to overlapping participants between the years as well as overlapping consumer surveys within each year. However, since the sample sizes are large, the samples are similar in make-up, and the only uniform change across the organization was the introduction of Trauma Informed Care, it was assumed that the violation of the assumption of independence was not significant for the aggregate scores and comparisons. It should be noted, however, that this may not hold true for independent programs comparisons if that should be done in the future. The Skewness Statistic was analyzed to determine whether or not the assumption of normality had been violated, and the Levene's Test was analyzed in order to determine whether or not the assumption of homogeneity of variances had been violated.

To address research questions 3 and 4, Chi-Square Analyses was performed to examine whether or not there were statistically significant differences in perceptions of physical and emotional safety between participants of the 2012 survey who answered "yes" or "no" to the question "I was asked about difficult experiences." Responses of "I don't know" to this survey question were treated as missing. Responses of "yes" were coded as "1," and responses of "no" were coded as "0." These responses were then compared to the satisfaction scores (see Data Analysis section) with the responses to the statements "I feel physically safe at CCH" and "I feel emotionally safe at CCH." This study is concerned only with participants who reported feeling satisfied. Therefore,

responses of “Dissatisfied” and “Neutral” were both coded at “0,” and responses of “Satisfied” were coded as “1.” Once the responses were recoded, a cross tabulation with a Chi Square Analysis was run on the 2012 survey data.

RESULTS

The two sample groups were similar in demographic characteristics, including gender, age, race, and ethnicity. For gender, the majority of the surveys identified themselves as male, with the next highest group identifying as female for both groups. In 2011, 55.5% (n=857) of surveys were male, 43.2% (n=666) were female, and 0.5% (n=8) were transgendered. In 2012, 52.7% (n=1,000) of surveys were male, 45.3% (n=861) were female, and 0.7% (n=14) were transgendered. In addition to the increase of transgendered survey responses in 2012, there were also individuals who identified their gender as "Other" (0.2%, n=4). As for age, both survey years reported the largest group of participants as being from the "31-50" age group, with the "51-61" group being the next largest group. In 2011, 47.1% (n=727) of the surveys were from the "31-50" age category, 33.0% (n=509) of the surveys were from the "51-61" age category, and 11.5% (n=178) were from the "18-30" age category. In 2012, 46.4% (n=882) of the surveys were from the "31-50" age category, 33.4% (n=634) of the surveys were from the "51-61" age category, and 10.7% (n=204) were from the "18-30" age category.

For race and ethnicity both survey years reported the majority of respondents identifying as being either White/Caucasian or Black/African American for race and Not Hispanic for ethnicity. In 2011, 59.8% (n=923) of the surveys were categorized as White/Hispanic; 22.9% (n=354) of the surveys were categorized as Black/African American; and then remaining surveys were categorized as American Indian/Alaskan Native 5.8% (n=89), Asian (0.3%, n=4), Native Hawaiian/Pacific Islander (0.1%, n=2), and Other/Multiracial (8.0%, n=124). In 2012, 59.6% (n=1,131) of the surveys were categorized as White/Hispanic; 24.4% (n=464) of the surveys were categorized as

Black/African American; and then remaining surveys were categorized as American Indian/Alaskan Native 5.7% (n=108), Asian (0.1%, n=2), Native Hawaiian/Pacific Islander (0.3%, n=5), and Other/Multiracial (7.0%, n=133). As for ethnicity, both years reported a high level of missing data for this question (36.7% in 2011 and 33.5% in 2012). In 2011, 44.6% (n=688) of the surveys were categorized as Not Hispanic and 18.7% (n=289) were categorized as Hispanic. In 2012, 47.8% (n=908) of the surveys were categorized as Not Hispanic and 18.7% (n=356) were categorized as Hispanic.

The first research question examined whether or not perceptions of physical safety increased among CCH clients between 2011 and 2012 after the introduction of trauma informed practices. Table 1 presents the percentage of clients who reported feeling physically safe at the Colorado Coalition for the Homeless in 2011 and 2012. In 2011, 90.7% of respondents to the CSats indicated they felt physically safe at CCH, while 90.4% of respondents to the CSats indicated they felt physically safe at CCH in 2012.

Table 1

Level of Satisfaction with Safety Frequencies for 2011(N = 1,543) and 2012 (N=1,887)

	I feel physically safe at CCH	
Level of Satisfaction with Feelings of Safety	2011 *(N=1,543)*	2012 *(N=1,887)*
Satisfied	90.7% (n=1,353)	90.4% (n=1,643)
Neutral	7.3% (n=109)	7.4% (n=134)
Dissatisfied	1.9% (n=29)	2.2% (n=40)

Valid Percents are used to exclude missing data

The perception of physical safety outcome was tested for the assumption of normality for each survey year. For 2011 survey year, the skewness statistic was -1.87 indicating a large negative skew. According to the guidelines for skewness, the

assumption of normality is violated for the 2011 survey group. For the 2012 survey year, the skewness statistic was -1.90 indicating a large negative skew. According to the guidelines for skewness, the assumption of normality is violated for the 2012 survey group. As for homogeneity of variance, the Levene's Test was not statistically significant, $F = .35$, $p = .556$, which indicates that the two groups had equal variances. As a result, the equal variances assumed line was used to interpret the t-test results.

Table 2 displays the results of the independent samples t-test on perception of physical safety. According to the results, there were no differences in perceptions of physical safety between the 2011 and 2012 respondents ($t = -.58$, $p = .560$). However, as can be seen in Table 2, the 2012 survey respondents ($M = 4.54$) and the 2011 survey respondents ($M = 4.52$) both reported high levels of physical safety.

Table 2

Group Differences for Perception of Physical Safety between 2011 CSats Group (N = 1,543) and 2012 CSats Group (N = 1,887)

	2011 *(n=1,491)*		2012 *(n=1,817)*			
Outcome	*M*	*SD*	*M*	*SD*	*df*	*T*
Physical Safety	4.52	.75	4.54	1.17	3,306	-.58

* $p < .05$. ** $p < .01$. *** $p < .001$.

The second research question examined whether or not perceptions of emotional safety increased among CCH clients between 2011 and 2012 after the introduction of trauma informed practices. Table 3 presents the percentage of clients who reported feeling emotionally safe at the Colorado Coalition for the Homeless in 2011 and 2012. In 2011, 88.2% indicated they felt emotionally safe at CCH while in 2012 87.1% indicated they felt emotionally safe at CCH.

Table 3

Level of Satisfaction with Safety Frequencies for 2011(N = 1,543) and 2012 (N=1,887)

	I feel emotionally safe at CCH	
Level of Satisfaction with Feelings of Safety	2011 *(N=1,543)*	2012 *(N=1,887)*
Satisfied	88.2% (n=1,318)	87.1% (n=1,573)
Neutral	8.8% (n=132)	9.9% (n=179)
Dissatisfied	2.9% (n=44)	2.9% (n=53)

Valid Percents are used to exclude missing data

The perception of emotional safety outcome was tested for the assumption of normality for each survey year. For 2011 survey year, the skewness statistic was -1.70 indicating a large negative skew. According to the guidelines for skewness, the assumption of normality is violated for the 2011 survey group. For the 2012 survey year, the skewness statistic was -1.54 indicating a large negative skew. According to the guidelines for skewness, the assumption of normality is violated for the 2012 survey group.

As for homogeneity of variance, the Levene's Test was not statistically significant, $F = .35$, $p = .554$, which indicates that the two groups had equal variances. As a result, the equal variances assumed line was used to interpret the t-test results.

Table 4 displays the results of the independent samples t-test on perception of emotional safety. According to the results, there were also no differences in perceptions of emotional safety between the 2011 and 2012 respondents ($t = .44$, $p = .662$). Similar to the previous results regarding physical safety, both 2012 survey respondents ($M = 4.43$) and 2011 survey respondents ($M = 4.44$) reported high levels of emotional safety while at the Colorado Coalition for the Homeless.

Table 4

Group Differences for Perception of Emotional Safety between 2011 CSats Group (N = 1,543) and 2012 CSats Group (N = 1,887)

	2011 *(n=1,485)*		2012 *(n=1,805)*			
Outcome	*M*	*SD*	*M*	*SD*	*df*	*t*
Emotional Safety	4.44	.82	4.43	.82	3,288	.44

* $p < .05$. ** $p < .01$. *** $p < .001$.

The third research question explored the differences in perceptions of physical safety between clients who were asked or were not asked about difficult life experiences. Only the survey results from 2012 were utilized for this question. Table 5 displays the frequencies for respondents of the 2012 survey who reported that they were asked about difficult experiences in their lives. For 2012, 63.0% of respondents indicated they were asked about difficult experiences in their lives, 22.3% indicated they were not asked, and 10.4% indicated that they did not know if they were asked or not.

Table 5

Frequencies of respondents asked about difficult experiences in 2012 (N=1,887)

Asked about Difficult Experiences	2012 *(N=1,887)*
Yes	63.0% (n=1,196)
No	22.3% (424)
I don't know	10.4% (198)
Missing	4.3% (81)

A Crosstabs and Chi-Square Analysis was conducted to explore the differences in perceptions of physical safety for the 2012 survey respondents who indicated being asked about difficult experiences and those who indicated not being asked about difficult experiences. Table 6 displays the differences between respondents in the response groups on the safety satisfaction measures. There was a statistically significant difference found between the groups on their perception of physical safety rates, $\chi^2 (1) = 9.39$, $p = .002$. CCH participants who indicated that they were asked about difficult

experiences (92.3%) reported higher perceptions of physical safety at CCH than participants who were not asked about difficult experiences (87.2%)

Table 6

Differences in Perceptions of Physical Safety for Consumers in Difficult Experience Response Groups

Asked about Difficult Experiences	Yes		No			
Outcome	*N*	%	*n*	%	χ^2	*p*
Perceived Physical Safety	1,065	92.3%	355	87.2%	9.39	.002

The fourth research question explored the differences in perceptions of emotional safety between clients who were asked or were not asked about difficult life experiences. As previously reported, Table 5 displays the frequencies for respondents who reporting whether they were asked about difficult experiences in their lives during the survey year 2012. A Chi-Square Analysis was conducted to explore the differences in perceptions of emotional safety for the 2012 survey respondents who indicated being asked about difficult experiences or not being asked about difficult experiences. Table 7 displays the differences between respondents in the response groups on the safety satisfaction measures. Similar to perceptions of physical safety, a statistically significant difference was found between the groups on perception of emotional safety rates, χ^2 (1) = 8.15, p = .004. CCH participants who indicated that they were asked about difficult experiences (89.1%) reported higher perceptions of emotional safety at CCH than participants who were not asked about difficult experiences (83.7%).

Table 7

Differences in Perceptions of Emotional Safety for Consumers in Difficult Experience Response Groups

Asked about Difficult Experiences	Yes		No			
Outcome	*N*	%	*n*	%	χ^2	*p*
Perceived Emotional Safety	1,024	89.1%	339	83.7%	8.15	.004

SUMMARY OF RESULTS

This study found no significant differences in Colorado Coalition for the Homeless clients' perceptions of safety after a year of implementation of Trauma Informed Care. However, while there were no statistically significant differences in perceptions of safety between 2011 and 2012, CCH clients did report high levels of physical and emotional safety in both 2011 and 2012. This indicates that, while CCH might create an environment in which clients feel safe, the implementation of TIC does not appear to have affected their perceptions of safety. There was a statistical significance in the perceived safety between clients who reported being asked about difficult experiences in their lives and clients who reported not being asked about difficult experiences in their lives. This was true for perceptions of both physical and emotional safety.

DISCUSSION

Trauma is an established factor in the lives of the homeless population (Kim et al., 2010). In order to assist survivors of trauma, practitioners must create a safe environment for service consumers to be able to function outside of a trauma response and begin to work through the impact trauma has had on their lives. More importantly, social service agencies that address trauma must be perceived as safe by the consumers (Bloom, 1999). One proposed method to increase clients' safety and perceptions of safety in agencies that work with populations who experience trauma, including the homeless population, is through the implementation of Trauma Informed Care. This suggested framework served as the impetus for this study among clients at the Colorado Coalition for the Homeless.

Results from this study revealed no statistically significant increases in perceptions of physical or emotional safety between 2011 and 2012. However, CCH consumers' perceptions of safety were high in both 2011 and 2012. These findings are of practical significance for the Coalition, as it speaks to the competency of the agency to create a safe environment for consumers. Before the implementation of Trauma Informed Care, 90.7% of survey respondents reported feeling physically safe while 88.2% of survey respondents reported feeling emotionally safe. Such high safety scores in 2011 could be due to the client centered nature of CCH prior to the introduction of TIC. The individualized nature of services at CCH and the fact that CCH is concerned enough with client safety to decide to implement TIC may be reflected in the consumers' perception of safety at the baseline scores in 2011, thus not showing change for 2012.

The lack of significant findings in this study could also be due to the fact that the implementation of Trauma Informed Care was so complex to the organizations' staff,

administration, policies and procedures, and hiring practices; that a year of implementation was not long enough to see improvements in client's perceptions of safety. The early stages of implementation for TIC occurred at the administrative and management levels long before the clients start seeing the benefits. Overall culture change of an organization takes time to infiltrate the organization as a whole (Ravasi & Schultz, 2006). Since TIC is a change in the philosophy and culture of service rather than a rapid implementation of an intervention, the majority of the agency change affected the administration and staff more than the clientele in the first year.

The implementation step directed to clients was the introduction of a universal screening tool. As noted in the procedures section, the implementation of the universal screening for trauma has only been introduced in certain pilot programs throughout the agency. This is an example of the implementation being focused on administrative change in the first year rather than the clients, which may have affected CCH clients' perceptions of safety as well as the results of this study. It is possible that the Coalition may be able to demonstrate more significant increases in perception of safety as the years of Trauma Informed Care implementation and practice continues.

Results from this study are not indicative of long-term change to client perceptions of safety for agencies that may adopt a trauma informed approach to service delivery. Results from this study reflect outcomes after only one year of implementation. As such, these study results represent the beginning steps of implementation of Trauma Informed Care in an agency that started with high reports of client safety. As will be discussed in the section on future research, it would be important to look at implementation in other agencies in which clients may report feeling less safe prior to the

implementation of a trauma informed model. Moreover, it would be interesting to examine agencies that are further along in their adoption of TIC principles.

Colorado Coalition for the Homeless clients who reported that they were asked about trauma did report significantly increased perceptions of physical and emotional safety. This indicates a strong relationship between being asked about trauma and perceptions of safety, thus suggesting that it is important for service providers to ask clients about experiences trauma. Relative to this study, clients who were asked about the difficult experiences in their lives were more likely to feel physically and emotionally safe in the service environment.

LIMITATIONS

There were a number of limitations in this study which may have threatened internal and external validity. Such limitations are related to group participants, sampling, methodology, and uniformity of the intervention. Since the surveys in 2011 and 2012 were comprised of consumers who received services during the survey period of each year, it is probable that the groups were not equal. Though the group sizes for each year were large enough to most likely account for variations, the same people who received services during the first two weeks in August 2011 may not have been the same people who received services during the first two weeks in August 2012. This made the groups unequal for the 2011 and 2012 surveys.

The convenient and voluntary nature of the survey may have skewed the results in favor of participants who were willing to participate in the survey. It is possible that those who chose not to participate may have reported significant differences in their experience of safety at CCH, and those experiences may have affected their willingness to participate in the study. This has repercussions for internal and external validity such that we cannot ensure that we were truly testing client perceptions of safety if the clients who were feeling unsafe may have been uncomfortable participating in the survey, thus skewing the results in favor of safety reports. If this was the case, then we also would not be able to generalize the results to the entire adult homeless population. In this study, it was also probable that multiple participants were asked to complete more than one survey due to participating in more than one program. The anonymous and voluntary nature of the completion of surveys in this study made it difficult to know how many participants completed multiple surveys. It was also possible that CCH participants may have chosen

to only complete surveys for only some the programs from which they received services. This affects the sample equality for the survey years, further affecting the validity of the survey and the ability to generalize to the greater homeless population.

The methodology of survey collection was an issue for the CCH CSats. For example, surveys were collected by program leading to a myriad of collections procedures. Some programs, which only see their clients a few times a year, mailed surveys to clients. This meant that the self -selection of participation was different for those programs since the nature of in-person surveys and mail-in surveys is different. Moreover, while some programs had clients complete surveys in the office while waiting for services, other programs met the clients in their homes to complete surveys. This lack of uniformity in survey collection may have unintentionally skewed the population of participants in various ways which affects both internal and external validity. This study aimed to measure the safety perceptions of those receiving services at The Colorado Coalition for the Homeless in hopes of being able to extrapolate that information out the greater homeless population. However, if respondents are self-selecting due to collection procedures or comfort level, then it cannot be assumed that the study is capturing perception of safety for all clients nor for the general homeless population.

Finally, Trauma Informed Care is not an evidence based practice but, rather a philosophy of service. As such, no fidelity scale exists for TIC. Since there is not a fidelity scale for TIC, there is no way to tell if individual programs are implementing TIC uniformly. It, thus, becomes difficult to ensure validity of the study and uniformity of study results if one is not clear how the intervention is being implemented form program

to program. Additional research on TIC may help in the future creation of a fidelity scale for this model of service.

CLINICAL IMPLICATIONS

This study found that clients at the Colorado Coalition for the Homeless generally reported high levels of physical and emotional safety. This implies that the services provided at CCH were provided in a way that promotes feelings of safety, which reflects positively on the practices carried out at CCH. As the practice of trauma informed services continues at CCH, future client surveys will examine whether CCH consumers' experiences of safety may improve. This will be especially important for the 2013 and 2014 CCH CSats, since the use of a universal screening tool is being introduced in the pilot programs now and was only part of certain programs at the time of the 2012 survey. The results of the programs that did introduce the trauma screen prior to the 2012 survey could then be compared to the results of the programs that did not introduce the trauma screen. This comparison could shed light on the importance of the trauma screen to consumers' perception of safety.

Most importantly, this study suggested that asking clients about difficult experiences (i.e. traumatic experiences) in their lives was related to client's perceptions of physical and emotional safety. Knowing that asking questions about clients' trauma history makes them more likely to feel safe may provide clinicians and other services providers a clear method by which to promote feelings of safety among their clients. Trauma Theory postulates that increasing the levels of safety for clients promotes healing from trauma (Bloom, 1999). If increasing safety for clients promotes healing from trauma, and asking about trauma promotes safety, then asking about trauma may also promote healing from trauma. This is of particular significance for social work practice with groups who are prone to trauma, such as the homeless population.

Relative to social work programming for homeless persons, understanding what elements of the organizational practice encourage feelings of safety will be imperative to success. If the ability to recover from traumatic experiences is affected by clients' perceptions of safety, then Trauma Informed Care may be instrumental to clinicians and agencies in providing an atmosphere in which clients can heal from trauma.

FUTURE RESEARCH

Future research regarding Trauma Informed Care at the Colorado Coalition for the Homeless might consider examining differences between CCH programs to test whether programs that went through training first (and had more time to implement TIC) had improved reports of safety than programs that were trained later in the process. This might help to identify how quickly the initiation of TIC in an organization may have an effect on consumers. Moreover, administering satisfaction surveys at different stages of implementation (i.e. after the administration commits, after staff are trained, and after hiring practices change) *or* changing the order of implementation steps with periodic surveying may help to identify which steps of implementation are the most effective. This type of comparison between programs matched with observations of how each program is working to implement the ideologies of Trauma Informed Care would assist in the creation of a fidelity measure for TIC, which is lacking due to the early stages of this theory of practice.

Additional research regarding the effects of asking about trauma with other client groups would also continue to inform practice. Varying the clientele with whom this research is conducted would explore whether or not this is a phenomena unique to the homeless population or not. It would also be interesting to examine, through a randomized sample, whether asking about trauma history has on safety perceptions of the general population. This would determine is the effect is unique to groups with increased risk of trauma.

Finally, since Trauma Informed Care is essentially a change of culture for an organization, further inspection of how organizational culture affects consumers'

experiences would be another area for future research. Research on organizational culture and its effect on clients would help to inform social work practice on an administration and management level. Such research may also have implications for companies and organizations who seek to improve customer service, as well as hospitals and other services providers who strive to improve patient outcomes. This research would provide an opportunity for cooperation and cross-disciplinary study between social workers and other community groups, such as business owners and health care providers.

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