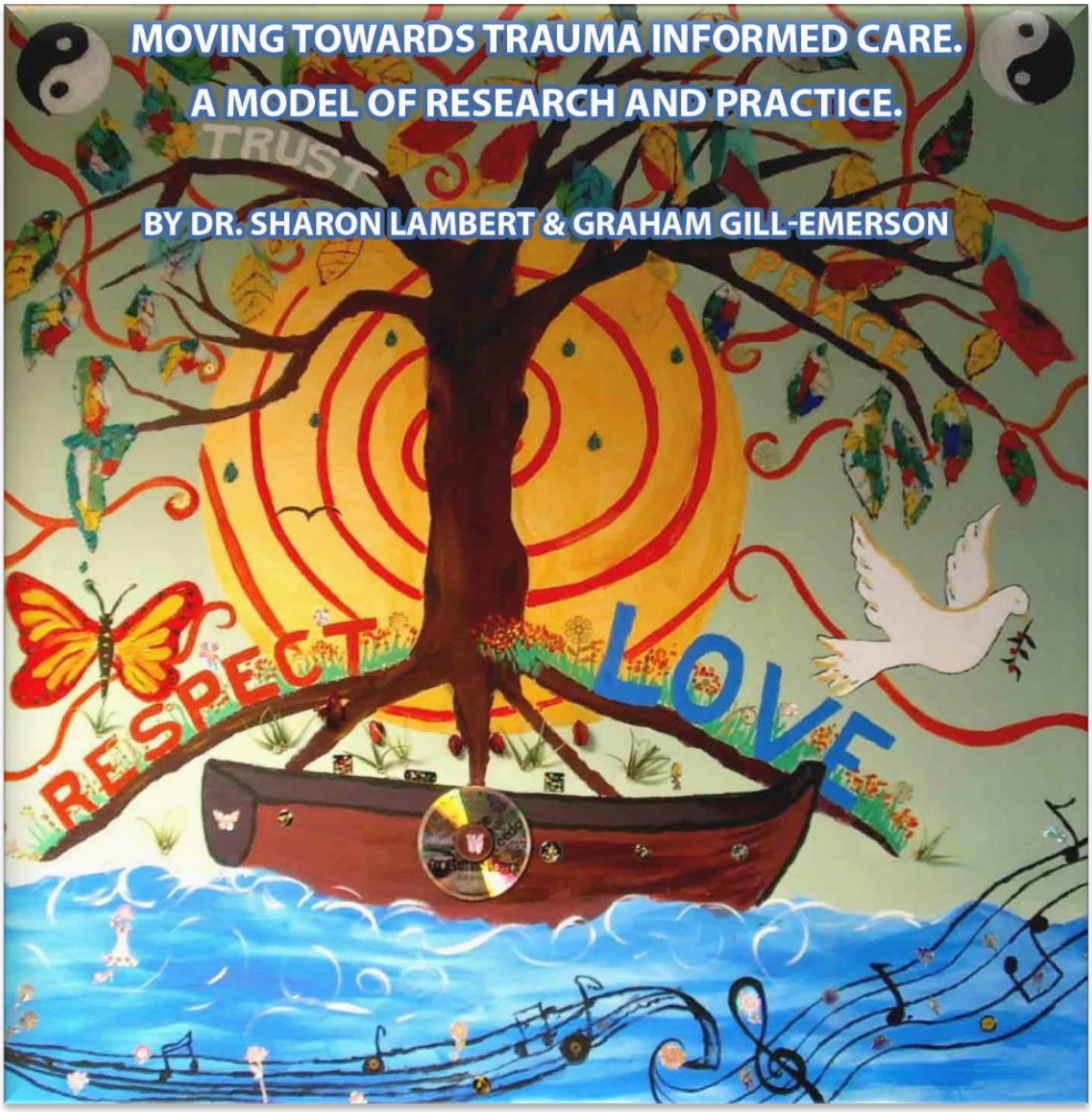
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CORK SIMON COMMUNITY



Research Team: Aidan Horan, Graham Gill-Emerson,
Annamarie Naughton, Sharon Lambert

Cork Simon
Believe in People

SCHOOL OF
APPLIED PSYCHOLOGY
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The Authors

Dr Sharon Lambert is a lecturer and researcher based in the School of Applied Psychology University College Cork. Since joining the staff team in UCC over two and half years ago Sharon's research interests have revolved primarily around inclusion health in the areas of mental health, substance dependence, homelessness and trauma and consequent impacts on service design and delivery. Sharon regularly delivers training to professionals working with young people on the impact of child and adolescent trauma and consequent issues. Sharon also presents at psychology conferences and has delivered training seminars in Investigative Psychology to the Metropolitan Police in the U.K. and to the National Bureau of Criminal Investigation in Ireland. In addition, Sharon worked as a lecturer on induction and training courses within An Garda Síochána. She has held a management role in an adolescent substance misuse service where her interests in the relationship between trauma and health behaviour and trauma informed care was initiated. Sharon has also acted as a special advisor to Garda Working Groups, the EU and the UK Home Office. In 2016 Sharon co-authored an EU white paper on trauma informed practices for children returning from Syria/Iraq, this paper has been presented to Commissioners in Brussels and adopted as a best practice document for the reintegration of children returning from Iraq and Syria.

Graham Gill-Emerson began his career supporting young people and adults in their recovery from problematic and dependent substance misuse in and around Dublin's North East Inner City. Graham holds qualifications in the areas of counselling & psychotherapy, addiction counselling and education from DCU, PCI College, UCD and Galway-Mayo IT. He currently works as an Addiction Counsellor with Cork Simon Community where he is a member of the HSE's Adult Homeless Integrated Team. He also teaches Community Reinforcement Approach, an evidence based addiction treatment model, in a private capacity to various drug & alcohol task forces and community organisations nationwide as well as lecturing in counselling part time with PCI college. He is a regular presenter at conferences and in 2015 published an article titled 'The Trauma Contagion' in Eisteach. He holds a special interest in the interplay between trauma and addiction and in the creation of evidence based service delivery approaches to meet this complex dynamic. He is trained in both Seeking Safety and Eye Movement Desensitisation & Re-processing.

Sharon Lambert

July 2017

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A very special thank you is due to all of the staff who participated in the ProQOL research project. Sincere thanks to all the staff in the various centres who facilitated and participated in the agency trauma self-assessment and to over 120 staff and volunteers who participated whole heartily in the trauma awareness training, your compassion and commitment was palpable and inspiring.

Finally, a special acknowledgment and heartfelt thanks to the Service Users who put themselves forward for an examination of their early life traumas in the hopes of creating greater service delivery for themselves and their peers.

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Executive Summary

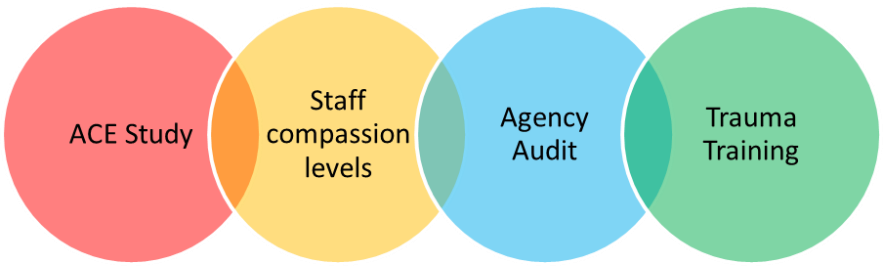
Context: Cork Simon Community offers care, accommodation and support for almost 1200 people annually. The current unprecedented housing crisis is pushing people into homelessness and preventing people from leaving homelessness. With increasing demands on resources those who are often the most vulnerable struggle to navigate systems and services and thus consideration of service design and delivery is required in order to maximise a service user's ability to engage effectively. There is a growing body of research that argues that trauma informed care (TIC) improves outputs for both staff and the people they serve.

Aims & Method: The aim of this project is threefold; (a) establish the prevalence of trauma within Cork Simon Community (b) assess Cork Simon Community's capacity for Trauma Informed Care (c) ascertain the implications of the findings for clinical and non-clinical interventions within homeless settings. This aim was addressed by completing three research studies. Trauma awareness training was also delivered to 120+ staff and data regarding capacity for TIC was collected at 6 training dates.

1. Establish service users' levels of early childhood trauma (ACE's)
2. Establish staff/volunteers levels of vicarious trauma (ProQOL)
3. Complete agency trauma informed assessment

The model (Fig. 1.0) offered an integrated exploration of the experiences of service users, and staff in parallel with the organisation they operating within. The information gained from these micro and macro perspectives informed the content of the trauma training as a means of amplifying existing strengths while shoring up skills and service deficits.

Fig 1.0 Model of TIC Implementation



Findings & Conclusions: The results of the ACE study revealed that there are significant levels of childhood trauma in the Service Users who participated in the research and that SU's were experiencing a range of negative health related behaviours as a result of substance misuse, homelessness and associated behaviours.

The results of the staff audit for secondary trauma revealed that there is considerable satisfaction with the work among staff but that there is a trauma contagion effect and that one quarter of the staff surveyed reported signs of secondary traumatic stress with 12% reporting indicators of burn out. The implementation of TIC and a re-evaluation of staff supervision and self-care processes can mitigate this.

An agency self- assessment for capacity for TIC revealed that in the main many of the organisations existing policies and procedures are operating from a place that provides for working with deeply traumatised people. There were some areas for improvement and these were mostly constrained by resource issues. There were a number of issues identified that are beyond the organisations control as they are dictated by national policies such as intake paperwork that is not strengths based and a policy of 'centre of interest'[1] that disregards a persons' choices which may well be dictated by an avoidance of memories of trauma situations. Organisations that work with people experiencing homelessness should advocate for greater resources and changes to national policies that conflict with strengths based trauma informed approaches. A number of recommendations have been provided.

[1] The 'centre of interest' policy is a policy designed to ensure that services and supports are provided for homeless people in the area that can be best considered their main centre of interest. It is designed to prevent the concentration of homeless people and homeless services in the country's main cities and it restricts homeless people from access to housing in areas that are not deemed to be their main centre of interest.

Introduction & Rationale

Context:

Cork Simon Community is the second largest Simon Community in Ireland, founded in 1971 Cork Simon offers care, accommodation and support for 1200 people annually. On average, on any given night Cork Simon provides supports 53 people in emergency accommodation, 56 people in five high-support houses and 39 people in flats or apartments managed by Cork Simon. Cork Simon also supports many others living in private rented accommodation, local authority housing and housing provided by various other voluntary housing associations; supporting people to keep their tenancies and to begin leaving homelessness behind them. Cork Simon hosts and works in close partnership with the HSE Adult Integrated Health Team. The organisation also offers Employment and Training Servcies, an Activities Programme and a Youth Homeless Drug Prevention project and other addiction related services including aftercare housing. The current unprecedented housing crisis is pushing people into homelessness and preventing people from leaving homelessness (www.corksimon.ie). With increasing demands on resources those who are often the most vulnerable struggle to navigate systems and services and thus consideration of service design and delivery is required in order to maximise a service user's ability to engage with increasingly fast paced and output driven funding environments.

Trauma:

Psychological trauma is the unique individual experience of an event or enduring conditions, in which; the individual's ability to integrate his/her emotional experience is overwhelmed or the individual experiences (subjectively) a threat to life, bodily integrity, or sanity (Pearlman & Saakvitne, 1995, p. 60). The impact of trauma can be viewed through a biopsychosocial lens where exposure to adversity particularly during critical developmental periods lends itself to structural changes in the brain (Bremner, 2006) and increases an individual's risk for poor quality of life in domains such as health (Felletti et al, 1998), education (Bethell et al., 2014), housing and employment (Topitzes et al., 2016).

The Adverse Childhood Experiences (ACEs) study (Fellitti et al, 1998) was the first study conducted on a national scale to show the wide ranging impact of childhood trauma on healthy development and later life negative health related outcomes. This study has been replicated a number of times and results consistently indicate that exposure to toxic stress or trauma as a child is significantly correlated with deleterious adult health and social behaviours (Taylor et al., 2008). The seminal ACE study with over 17,000 participants prompted a substantial interest in the ACE scale. This ten item scale posits questions related to an individual's exposure (before the age of 18) to physical, emotional and sexual abuse, and other household dysfunction such as a parent with substance misuse issues or an incarcerated relative (Feletti et al, 1998). The original study revealed that more than half of the respondents had reported at least one ACE therefore determining that exposure to early life trauma was relatively common. However analysis revealed that respondents with a score of

4 or more were at dramatically increased risk for negative health outcomes, and a dose response between the ACE score and risk for poor health experiences was noted (Feletti et al, 1998, Murogy et al 2013). Where there is a 4+ score, the likelihood of chronic pulmonary lung disease increases 390%; hepatitis, 240%; depression 460%; suicide, 1,220%. A study with a comparable number of recipients was conducted in Australia and similar results were found (Taylor et al., 2008).

In parallel to the recognition that exposure to maltreatment affected later health outcomes, the last decade has witnessed developments in brain imaging techniques that allows researchers to understand better than ever the impact of exposure to trauma on the developing brain (Riem at al., 2015). It is now recognised that the frontal and limbic structures of the brain are particularly vulnerable to the influence of child maltreatment (Hart & Rubia, 2012; Jedd et al., 2015). The first 1000 days of a child's life has been identified as a critical period for growth and development, it is during this time that major new neural pathways and connections are building, however exposure to abuse, neglect and/or household dysfunction during this time cause brain cell death right at the time that new neural pathways should be establishing (Riem et al., 2015). This results in impairment in the ability to regulate an integrate emotions and consequently difficulties emerge, such as an inability to establish effective interpersonal relationships, regulate emotions, and learn from own and others' experiences (Schore, 2003). The ability to recognize the signs and symptoms of trauma is essential in correctly interpreting the behaviour of the trauma survivors. For example individuals who have experienced complex, on-going trauma are at risk of excessive cortisol arousal, causing cell death in the hippocampus. (Riem et al., 2015) The associated consequences include difficulty reading facial and social cues, heightened startle responses, avoidance, memory problems, poor decision making skills and aggression. The aforementioned responses must be understood as 'normal' trauma responses but importantly these are factors that prevent individuals from appropriately engaging with mainstream services. Individuals who have been exposed to adversity have impaired decision making and are at increased risk of self-harm and substance abuse and present with challenging behaviour (Lynch & Lambert, 2016). A client blameworthy perspective can exist (McHale & Fenton, 2010) however development in research in this area tells us that these behaviours are adaptive responses to a perceived threat that no longer exists (Schore, 2003). An understanding of the impact of trauma on the brain facilitates a recognition of challenging behaviours as 'survival strategies' and thus enhances a services ability to engage with an individual in a more empathetic manner (Huckshorn, & LeBel, 2013). Practitioners and clinicians are supported in restructuring views such as 'reluctance to engage' to 'struggling to engage' using trauma informed practice.

Trauma & Homelessness

Homelessness is in essence traumatic. People experiencing homelessness have lost the protection of home and community, they are marginalized and isolated within society. People exposed to this experience are highly vulnerable to violence and victimization (SAMHSA).
A study exploring the pervasiveness of trauma experiences within a homeless community in Sydney found that 98% of participants had experienced at least one trauma and 93% had experienced two or more. The average number of traumas in the sample (n=53) was 6 with the first trauma experience having occurred by the age of 12. 79% of the sample had a lifetime prevalence of post-traumatic stress. In 59% of cases, the onset of post-traumatic stress disorder (the clinical manifestation of trauma) preceded the age of the first reported homeless episode leading the authors to state that Homelessness can be seen both as a consequence and a predictor of trauma (Taylor & Sharpe, 2008). A similar study conducted in Dublin Simon Community showed related findings with 95% of the sample (N=45) having experienced one or more traumatic events, 46% met the criteria for PTSD (Hallinan, 2015). Where the Sydney study showed a relationship between the level of trauma and addictive behaviour with participants disclosing addiction issues with alcohol 63%, substances 88% and gambling 66%, the Irish study showed a correlation between emotional regulation difficulties and sedative abuse (benzo, alcohol and opiates).

Trauma & Addiction:

Addiction and trauma holding a dual diagnosis position is not in any way ground-breaking. Back et al., (2008) found that two thirds of people seeking treatment for substance use disorders report one or more traumatic life events while Jacobsen et al., (2001) found that up to 75% of clients presenting with addiction have comorbid histories of trauma.

Najavitz (2002) found that of the clients sampled in substance abuse treatment 12 – 34% have current post traumatic stress disorder; looking at women alone these rates increased to between 33 – 59%. With rates of trauma this high in those attending substance abuse treatment one can only imagine the levels for trauma in the broader substance abuse community, particularly those that fall through gaps and do not manage to access treatment.

The research seems unambiguous on the co-morbid nature of addiction and trauma with a number of authors suggesting a functional relationship between both disorders, which is largely supported by empirical evidence (Van Dam et al., 2012; Lambert, Wall & Horan, 2017). Such empirical evidence points to a crossover in the dysregulation of hormonal systems found in those that suffer from both conditions, e.g. reduction in dopamine required for motivation. As a consequence SU's are viewed as unwilling to engage when in fact hormonal disruption means they have deleted hormonal levels to support their motivation and are unable to engage.

Modulation theory (Ogden, Minton & Pain, 2006) posits that we all have a window of tolerance (See Fig 1.0), this window is wider for some and narrower for others and that this window signifies the amount of emotional arousal (happy, sad, mad, glad, etc) that we are able to experience comfortably at any given time while the periphery of this window marks the transition of where we will move into states of either hyper (fight/flight) or hypo-arousal (freeze/faint).

Trauma narrows this window resulting in less and less levels of arousal launching the person out of their tolerance zone. Addiction to substances or behaviours can be seen as a means of self-medication in order to regulate an individual's levels of arousal with the ultimate goal of re-entering their optimal arousal zone. This is accomplished by using substances or behaviours that sedate (heroin, sleeping tablets,) when one is hyper-aroused and using substances or behaviours that stimulate (gambling, sex, cocaine, speed) as a means of bringing individuals up into our window at times of lethargy and flatness (hypoarousal).

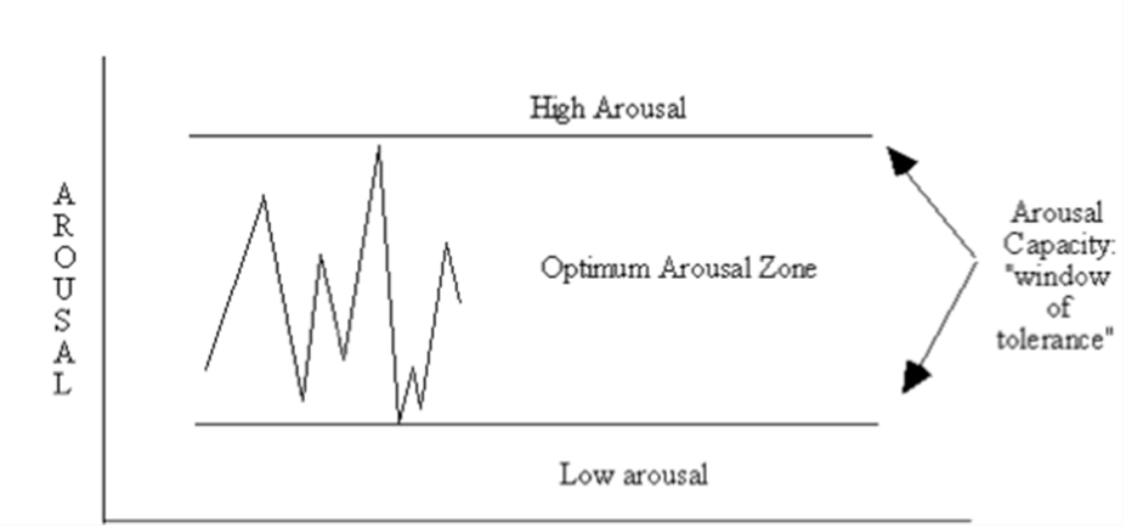


Figure 2.0 Window of Tolerance (Ogden, Minton & Pain, 2006)

The Contagion Effect:

Trauma can be conceptualised as infectious through both physically witnessing a victim's trauma or by learning about it. Despite this, much of our trauma literature has been compiled on the effects of trauma upon the primary survivor.

Emotional contagion refers to the individuals' tendencies to subconsciously mimic the emotional expressions of others (Feldman & Kaal, 2007 p.22.) This emotional contagion can be broken down into the two concepts of 'vicarious trauma' and 'secondary trauma'.

The term vicarious trauma was introduced by McCann & Pearlman and can be understood as related both to the graphic and painful material trauma clients often present and how it interacts with the [carers] unique world views (McCann & Pearlman, 1990).

Symptoms of stress can also be communicated to those close to the trauma survivor, who can become 'infected' with similar trauma symptoms (Goff et al, 2006 p.451). These Secondary Traumatic Stress Reactions (Figley, 1983) posit that at a foundational level, engaging in a caring relationship predisposes us to being emotionally vulnerable to the catastrophes which

impact those we work with. Thus, a ripple effect is generated where people connected to the victim also experience a trauma, mimicking the trauma survivor's symptoms.
Workers in a homeless setting are acutely aware of the difficulties trauma brings to the everyday lives of service users and are mindful of the delicate journeys that need to be negotiated in service users' individual recoveries. Such workers and the systems they operate within are not always as aware of the impact trauma proximity can have on themselves, often forgetting or failing to emphasise the use of self-care to stave off the onset of vicarious or secondary traumatisation that may potentially lead to burnout.

Trauma Informed Care (TIC):

A trauma informed service is one that understands the underlying psychological impact that trauma may have on an individual and incorporates their understanding and awareness into their practices and every aspect of the service delivery (SAMHSA, 2014). Two separate processes are required here, there is the process of becoming trauma informed and there is the process of trauma informed practice, both will be outlined further. A trauma informed service is cognisant that trauma is pervasive, complex and sometimes self-perpetuating. A trauma informed service seeks to do no harm and to avoid and reduce the potential for re-traumatisation for SU's and reduce vicarious trauma for staff. A trauma informed service does not necessarily provide trauma specific interventions but has trauma awareness as its focus. The Women, Co-Occurring Disorders, and Violence Study (McHugo et al., 2005) has provided evidence that trauma-informed approaches can enhance the effectiveness of mental health and substance abuse services.

Firstly, Harris & Fallot (2001) suggest there are 5 elements required to achieve trauma informed care.

1. Administrative commitment to becoming trauma informed; to effectively implement trauma informed services buy in is required at all levels of the service.
2. Universal Screening; a brief focused trauma screening tool to be applied consistently
3. Staff training; this refers to trauma awareness training for all staff at every level so that the research and theory of the impact of trauma is understood across the board. Many services invest in specialised training for clinical staff members but this does not penetrate the whole organisation and therefore does not facilitate an organisational wide trauma informed lens. Organisations should be cognisant that staff members who work on reception areas are the most likely to feel the most impact from a survivor as they are the first point of contact and equally the SU is impacted by this encounter. If it is not a trauma informed welcome then this impacts on the SU's experience and interactions with the service.
4. Hiring practices; Fallot & Harris (2001) recommend hiring staff who have a trauma awareness and to consider hiring a specific trauma champion who is responsible for overseeing policies and procedures to ensure that the service continues to be trauma informed in the long term.
5. Policies and Procedures; when an organisation has made a commitment to TIC and has undergone some training awareness training, management and staff should

carefully review existing policies through a trauma lens and identify any policy or procedure that does not take cognisance of trauma theory and research and amend as required.

There are a number of models reporting the principals of a trauma informed practice which range from 4 to 10 principles depending on whether the services include special populations such as children (e.g. Hopper et al., 2010, SAMHSA 2014).

1. Safety (physical and emotional); throughout the organisation, staff and the people they serve feel physically and psychologically safe.
2. Trust; Organisational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.
3. Peer support and mutual self-help; are integral to the service delivery approach and are understood as a key component for building trust, establishing safety, and empowerment.
4. Collaboration; There is a balance of power between staff and clients and among staff from clinical to non-clinical disciplines. The organisation recognises that everyone has a role to play in a trauma-informed approach.
5. Empowerment & Choice; throughout the organisation and among the clients served, individuals' strengths are recognised, built on, and validated and new skills developed as necessary. The organisation recognises that every person's experience is unique and requires a client driven individualised approach. This includes a belief in the ability of individuals, organisations, and communities to heal and promote recovery from trauma. This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.
6. Cultural Competence; The organisation actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography), offers gender responsive services, utilises the healing value of traditional cultural and/or religious connections, and recognises and addresses historical trauma. (SAMSHA, 2014, p.9-12)

Trauma awareness training should occur at all levels of the organisation from administration to practitioner, any individual who is likely to be in contact with a service user needs to be aware that trauma generates extreme sensitivity to sensory overload, manifested in behavioural and emotional responses and disengagement. Trauma responses are involuntary, the body reacts before thinking occurs, and a multitude of triggers can activate this response. It is impossible to create a checklist of possible triggers, this is entirely personalised to each individual's lived experience and the list of possible triggers is endless. The importance of awareness amongst every staff member in the organisation cannot be underestimated, for example, experiences at a reception desk or in a waiting room can trigger a trauma response and consequently impact on further engagement with the service (Lynch & Lambert, 2016).

Method

The aim of this project is threefold; (a) establish the prevalence of trauma within Cork Simon community (b) assess Cork Simon Community's capacity for Trauma Informed Care (c) ascertain the implications of the findings for clinical and non-clinical interventions within homeless settings. This aim was addressed by completing three research studies –

1. Establish service users' levels of early childhood trauma (ACE's)
2. Establish staff/volunteers levels of vicarious trauma (ProQOL)
3. Complete agency trauma informed assessment.

Ethics for data collection was granted by Director, Cork Simon Community and through the School of Applied Psychology Ethics Committee, University College Cork. Please see below for a concise ethical statement and Appendix 2 for information provided to participants.

Part 1:

The ACE survey (Appendix 1) was administered by members of the Adult Homelesss Integrated Team (AHIT) utilising purposive sampling of 50 service users (SU's) currently experiencing homelessness. 77.6% of the sample were male and 20.4% were female. The ratio of male to female represents the profile of the service, in 2016 Cork Simon Community states that 18% of those who they supported were female (www.corksimon.ie), this is representative of national figures where there is also a much higher proportion of men utilising homelessness services (www.cso.ie).

The 10-item self-report measure of Adverse Childhood Experiences (Dube et al., 2003; Felitti et al., 1998) was used to retrospectively assess the prevalence of abuse, neglect, and household dysfunction within the current sample. All questions about ACEs pertained to the participants' life before 18 years of age. The ACE categories included emotional, physical, and sexual abuse; emotional and physical neglect; witnessing violence against mother; abandonment, separation or divorce; and living with substance misusing, mentally ill, or criminal household members. For each of the 10 questions participants were coded 1 for a 'yes' response to a question about an ACE exposure and 0 for a 'no' response. The possible number of exposures ranged from 0 (unexposed) to 10 (exposed to all categories).

Participants were recruited through their involvement with the AHIT team and reported willingness to participate. Data was collected by professionals known to the SU's and where necessary relevant keyworkers were also notified that the service user had participated in a project addressing early childhood trauma. It has been documented that there is reluctance both in research and practice to ask questions relating to traumatic experiences as there is a concern for potential re-traumatisation (Draucker, 1999; DuMont & Stermac, 1996; Templeton, 1993). However others argue that acknowledging service users' past trauma

experiences in a safe environment is positive and empowering for a client (Walker et al., 1997, Griffin et al., 2003). Researchers have stated that benefits of participating in interviews as offering catharsis, self-acknowledgment, a sense of purpose, self-awareness, empowerment, healing, and providing a voice for the disenfranchised (Hutchinson Wilson & Wilson, 1994). The researchers also accepted that some kinds of trauma questions can cause minimal distress, and those participating in research recognise trauma questions as having greater importance and cost-benefit ratings when contrasted to other kinds of psychological research (Cromer et al, 2006). The research team in this instance inserted a Likert scale at the end of the ACE survey to determine if the process was distressing for the participants, with 1 not at all distressing and 10 very distressing. Assessors and SU's also had an opportunity to provide written feedback relating to the positive and negative aspects of using the measure. All data was entered into the Statistical Package for Social Sciences (SPSS) for analysis.

Part 2:

The contagion effect of working with trauma survivors was investigated using the Professional Quality of Life – ProQOL (Stamm, 2010). The ProQOL is a 30 item self-report measure to assess the dimensions compassion satisfaction, burn-out and compassion fatigue. The compassion satisfaction dimension (CS) measures pleasure derived from work where high scores represent a greater satisfaction related to your ability to be an effective caregiver. The burnout dimension (BO) in this scale is associated with feelings of hopelessness and difficulties in dealing with work. Higher scores are related to higher risk for burnout. The compassion fatigue dimension (CF) relates to work-related secondary exposure to extremely stressful events. High scores indicate that you are exposed to frightening experiences at work (Lauvrud, Nonstad & Palmstierna, 2009).

Staff and volunteers were recruited for voluntary participation following a presentation by a researcher at staff meetings. 53 ProQOLs were completed and returned, all data was entered into SPSS. Other variables recorded were length of employment and centre of employment. A Likert scale of 1 – 10 scoring a subjective emotional connection individual staff felt toward service users was also captured.

Part 3:

An agency self-assessment for Trauma Informed Care (Fallot & Harris, 2009) assesses an organisations readiness for implementing a trauma informed approach. The assessment is organised into five domains; *staff development, safe and supportive environment, assessment and care planning, consumer involvement and policies*. The agency self-assessment was completed by staff, management and a researcher, a total of 12 were completed across each point of care on the care & support continuum, (i.e. Day Centre, HESS, transitional housing, High support, housing support). A walk through assessment using the above tool was conducted by a researcher in the Day Service, the Emergency Shelter, Gateway, Victoria Road and housing

support. In this instance the researcher presented as a Service User and was walked through their journey.

A number of trauma awareness training days (x6) were delivered to staff and volunteers (120 approx.) across all levels of the organisation (e.g. maintenance, kitchen, keyworkers, management etc.). A component of this training was principles of trauma informed practice, these were presented and discussed and staff assembled their views on 'what worked well' and 'what would work better' in terms of their work. This data was also collated for analysis.

Ethical Statement:

Ethical approval was provided by Cork Simon Community Director and the School of Applied Psychology, UCC, Ethics Committee. All researchers were Garda vetted.

Inclusion criteria: Service users who are over aged 18 years, of a low threshold homelessness service who are or have in the past been connected with the HSE Adult Homeless Integrated Team.

Exclusion Criteria: Service users in a dissociative state or actively suffering from psychosis.

The following guidelines were adhered to:

Informed consent: Participants were asked to sign consent forms to participate in the study. It was made clear within the form and verbally that all participants had the right to withdraw their consent to participate at any point during the study up until June 2017 and that non participation or withdrawal had no consequence for the services they wished to receive.

Anonymity: Participants were assigned a coded reference by which they will be referred to within the study. In addition, all other names and defining details are omitted from the published study.

Safety: Recognising the potentially distressing nature related to the exploration of traumatic events each interview was conducted for 40 minutes with an additional 30 minutes post interview that could be utilised by the participant if they felt they need to speak about any distressing effects the interview process may have evoked in them. The data was collected by professionals from the AHIT who are known to the participants and data was collected on site. In addition where appropriate their appropriate case worker within Cork Simon Community was informed that the service user has participated in research.

Should a participant disclose issues relating to previous victimisation of a sexual nature, both Cork Simon Communities' policies and the professionals' own code of ethics were the guiding factor.

Trauma research interviews/questions have the potential to be distressing, however this does not necessarily mean that they will be experienced as such. In their study of participant reaction to trauma questions, Cromer et al. (2006), found that *"trauma questions caused relatively minimal distress"* and were seen by participants as having greater importance than other psychological research. This research may point to the idea that just because a story is difficult or distressing to tell does not mean that the person does not benefit from telling it.

Results

All data was analysed using SPSS version 2.0. ACE data from the sample of 50 service users, and ProQOL data from the sample of 55 staff was inputted into SPSS, screened and tested for violations of assumptions of normality prior to data analysis. All variables were approximately normally distributed with no items or variables markedly skewed.

1. Service Users' levels of early childhood trauma (ACE)

The 10-item self-report measure of Adverse Childhood Experiences (Dube et al., 2003; Felitti et al., 1998) was used to retrospectively assess the prevalence of abuse, neglect, and household dysfunction within the current sample of 50 service users engaging with AHIT in Cork Simon Community. Data was also collected from an edited version of the Cork-Kerry Initial Assessment for Homeless and addiction services. This was chosen due to its universality between services that may wish to expand on the study. Data from the Initial Assessment facilitated exploring relationships between early experiences and later life outcomes, such as age of onset of drug use, number of times hospitalised, self-harm history etc. Data was entered into SPSS and due to incomplete data one participant was removed from the analysis. Table 1 shows that over 77% of those who completed the ACE scored more than 4 out of 10, the original ACE study indicated that a score of ≥4 ACE exposures put an individual at an increased risk for behavioural and health risk factors (Felliti et al., 1998). Further research in this area has also differentiated between <4 and ≥4 ACE exposures (Murphy et al, 2013). The mean ACE score here was 5.15.

Table 1: Prevalence of ACE's

Number of Exposures	Frequency	Percent %
1	1	2
2	3	6.1
3	7	14.3
≥4	38	77.6
Total	49	100

The following mean scores were also calculated based on information provided by the participants in this study. The average duration of homelessness was 6 years, mean age left school was 15 years (min 10 years & max 19 years). The average age of first use for alcohol was 12 years old (Std. Dev. 2.456) and almost 20% had used alcohol before the age of 12. The results for cannabis use have more variability with average age of first use at 14, the range was aged 10 – 45 years with a standard deviation of 5.289, 62% had used cannabis by age 13. The average age of first heroin use was 23 years old while it was 26 years old for mean age at

first injected (min 13 years & max 44 years). The most common current drug of choice (i.e. primary issue) was heroin (68.2 %) while alcohol was at 9%. History of previous substance dependence treatment was recorded with 82% stating they had had a treatment experience and the average number of treatment attempts was 3 (Std. Dev 2.304) with a range of 0 -9. Some participants included reasons for treatment breakdown such as issues with ethos and demands of treatment, poor aftercare uptake and issues with other service users.

There were some interesting findings in relation to physical and mental health. The average number of visits to accident and emergency departments was 17 and the mean number of Intensive Care stays was 1.89. 47% reported suffering a serious head injury. 39% admitted to having shared a needle for IV drug use. 62% of participants reported they had overdosed in the past. Ninety percent of participants reported they had been seen by a psychiatrist or psychologist, and 90% stated they believed they had psychological problems but only 23.5% reported knowing of a diagnosis. The diagnosed disorders reported by the SU's were; depression, anxiety, psychosis, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Borderline Personality Disorder, Bipolar and schizophrenia. Thirty five of the participants reported being currently prescribed medication, these were mainly anti-psychotics, SSRIs, benzodiazepines, methadone and sleeping tablets.

Additional findings were that 17% reported gambling problems, 71.4 % had a history of suicidal thoughts, and 44.8 % had self-harmed in the past. Between them the cohort who participated in this study have 46 children in total across 50 SU's. 31% of those who answered the question 'have you ever been in care as a child' reported that they had and 20% currently have a child who is in care.

Table 2 shows the scores among the 49 Service Users for each individual ACE item and these have been compared with the scores reported in the original ACE study. The most common adverse childhood experiences reported were verbal abuse and a parent with a substance misuse issue with both present for more than 70% of the cohort. Physical abuse and emotional neglect are also high as almost 70% participants reported exposure to both of these. Across all ten items from the ACE scale Service Users in Cork Simon Community are scoring significantly higher for exposure to adverse childhood experiences when compared to the general population in the Felletti et al., (1998) original ACE study.

Table 2: Breakdown of ACE categories compared with Original ACE study

ACE Scale Item	Original ACE study % (N = 17,337)	Current study % (N = 49)
Verbal Abuse	10.6	75.5
Physical Abuse	28.3	67.3
Sexual Abuse	20.7	34.7
Emotional Neglect	14.8	67.3
Physical Neglect	9.9	26.5
Loss of Parent	23.3	49
Mother Victim of Domestic Violence	12.7	42.9
Substance Abuse in Family	26.9	71.4
Mental Illness in Family	19.4	59.2
Incarcerated Family Member	4.7	30.6

Participants were also asked to rate their experience of completing the ACE on a Likert scale ranging from 1-10 with 1 = no at all distressing and 10 = very distressing. The average self-reported level of distress was 4.08 (Std. Dev. 2.67), with a range of 1-9, the most frequently picked was 1 out of 10 and 82% rated their level of distress at 6 or under.

Qualitative data was also recorded post ACE completion:

- *Client noted that in doing the ACE Questionnaire he noted just how much things have improved in his family of origin since he turned 18 years old.*
- *Client was very interested in the study. He completed the questionnaire himself. Client took a look through ACE literature after filling in the questionnaire & spoke about how it made sense to his experiences in life & with his addiction & educational progress.*
- *Good to ask these questions. 'I always wonder, was I born an addict, or was it because my family put me into care?'*
- *I have been questioned about it so often that it doesn't affect me to answer questions about it.*
- *If you spend your life getting abused/ let down by people, you lose trust in people and how can you then be expected to walk into an NA meeting full of people?'*
- *It depends if you feel comfortable talking to the person. When you know you are not getting judged. There is not enough support. You are just another number. The problem is just getting passed on.*

The qualitative responses are generally favourable, two participants reported that completing the ACE made them feel uncomfortable and could only answer them because they had an established relationship with the assessor. One SU left the office during the ACE as he felt uncomfortable.

Analysis shows significant levels of exposure to childhood trauma among the adult service users currently experiencing homelessness.

2. Staff/volunteers levels of vicarious trauma (ProQOL)

The Professional Quality of Life survey, ProQOL (Stamm, 2010) a self-report measure to assess the compassion satisfaction, burn-out and compassion fatigue was administered. This was a purposive sample of 55 members of staff/volunteers of Cork Simon Community. Of the 55 sampled, 2 were removed due to incomplete data, 33 individuals reported their length of employment with Cork Simon, which ranged between 4 weeks and 15 years, 66.7% (N=22) have been employed for under 5 years while over one third (N=11) were employed 5 or more years.

Almost all (51/55) participants reported a subjective rating of emotional connection with the service users, these scores ranged from 4 to 10 with a mean score of 6.75.

75.5% (N=40) interacted with the service users on a daily or regular direct basis. 24.5% (N=13) did not interact with the service users on a daily or regular basis. Breakdown of the sample by role in the service is included in Table 3.

Table 3 *Profile Sample – role breakdown of staff of Cork Simon Community*

Role	**N**	**%**
Key worker	14	25.5
Care Support Assistant	9	16.4
Maintenance	1	1.8
Volunteer	18	32.7
Housekeeping	1	1.8
Mental Health Professional	1	1.8
Admin	4	7.3
Other*	7	12.7

Table 4 ProQOL subscales - Severity Categories

	Compassion Satisfaction		Burnout		Secondary Traumatic Stress	
	N	%	N	%	N	%
Low	11	20.0	11	20.0	14	25.5
Average	31	56.4	34	61.8	27	49.1
High	13	23.6	7	12.7	14	25.5

Table 4 indicates that three quarters of staff score within the average or high severity categories for CF and burnout. Interestingly this number also roughly corresponds to those that have an average or high compassion satisfaction. This possibly speaks to the ethos and value system of staff that they can continue to feel rewarded through the work they do despite its erosive nature. *Some data was excluded due to incomplete sections on forms.

3. A*gency trauma informed self-assessment.*

The trauma informed organisational self-assessment is organised into five domains with each domain containing a number of written statements, assessors rate each statement on a scale ranging from 'strongly disagree' to strongly agree', there is also an option to respond 'don't know' or 'not applicable in my role'.

- **Supporting staff development** contains

(a) 17 items which primarily relate to whether staff have received training on listed topics most of which relate to trauma training for example, what is trauma, what is impact of trauma on development etc.

Analysis of responses indicate an average ranking of disagree for 15/17 questions in this section. It must be noted that these were completed prior to the staff completing the trauma awareness training. In a follow up study in 6 months' time, the self-assessment will be re-administered; one would expect that this will more accurately reflect the training that has been completed. Qualitative feedback from the staff was that in general there is a very high level of commitment from the organisation with respect to staff training and staff noted that they had participated in various forms of training they had found good quality and relevant such as suicide awareness, mental health etc. two items were ranked as agree, these related to training on professional boundaries and cultural sensitivity.

In relation to the trauma awareness training that was delivered post self-assessment, overall the training was rated very highly in terms of relevance and delivery. Here is a sample of feedback received;

- *The training provided me with insight to appropriately work with clients who have experience trauma*
- *I found the training very useful and very applicable to my role*
- *I will be more aware of language and space when working with people*
- *I really enjoyed the training*
- *The trainer explained the theory of trauma very well; it was easy to understand*
- *The training gave me an understanding of the significance of the impact of early childhood trauma*
- *Very applicable to my job – will improve my relationship with service users*
- *The training will help how we help others and ourselves in being trauma aware*
- *I gained a great amount of learning that will benefit my future work*
- *Excellent training, very relevant to my job*
- *This has been an excellent training and has allowed me to re-evaluate my practice*
- *Showed me many areas we're excelling and has also motivated me and given me ideas for improvement*

(b) 12 items relating to staff supervision, support and self-care

Four items in this section were rated as either agree or strongly agree; staff members have regular team meetings, agency helps staff members debrief, supervision time is used to help staff reflect on their stress reactions and how this impacts on SU's. The remaining items were on average (with little deviation noted) rated as disagree. These include trauma is discussed in team meetings, self-care is discussed in team meetings, supervisors are trauma trained, agency has formal system for reviewing staff performance, agency provides for staff evaluation of programme.

Data collated at the staff trauma awareness training indicated that some staff were not clear on the difference between line management and supervision. Also as demands increase and outweigh resources staff reported that they prioritised the needs of the SU's over their own and would reflect more on the needs of clients than any issues that they may have. Some staff stated they had no staff room and that spaces that had originally been designed for staff were being used to support SU's. Not all centres have appropriate and separate rooms for staff or for staff supervision. Staff additionally reported that they wanted more focus and training on self-care and that while staff have personal responsibility in this area that it should be mandatory and driven by senior management. The current supervision form should be reversed so that supervision sessions begin and end with self-care and should be a mandatory and supported process. Access to additional outside supports should be promoted and a culture of help seeking among staff should be endorsed.

- **Safe and supportive environment** contains

(a) 9 items relating to a safe physical environment

Items here were ranked at either agree or strongly agree, statements related to physical spaces being well lit, monitored and SUs having the right to make suggestions on ways to improve physical spaces. Only one item was rated as disagree, '*staff members ask SU's for their definition of physical safety',* while the average response was disagree there were two staff who ticked agree. Feedback from staff at the trauma awareness training raised some areas for improvement, for example, single room occupancy for all residents should be explored,

(b) 24 items relate to establishing a supportive environment and these fall under categorisations labelled information sharing, cultural competence, privacy and confidentiality, safety and crisis prevention planning, open and respectful communication, consistency and predictability.

Information Sharing was rated as agree on 3/4 items; SU's have regularly reviewed rules and rights, are regularly informed and know how the organisations responds to crisis such as harm to self or others. Only one item was rated as disagree; 'materials are posted about traumatic stress'. It was noted by the researcher on the walk through of the organisation that each centre has its own list of rules, these were sometimes repetitive, not strengths focused, lengthy and provided with a lot of other information.

Cultural Competency was rated as agree on 4/5 items where both staff and SU's can speak native languages, prepare ethnic food, there is respect for religious and cultural practices. It was reported in both the self-assessment and the training days that programme material is not available in different languages (only Polish).

All 6 items on Privacy and Confidentiality were rated as agree or strongly agree. Staff do not discuss SU's with other clients, staff do not discuss SU's outside of the agency, there are private spaces to talk. It was noted that the private spaces were limited and somewhat visually over looked.

Open and Respectful Communication contains four items, 3/4 were rated strongly agree. These relate to people first language, non-stigmatising language and use of motivational interviewing techniques. One item was rated as disagree; 'staff ask SU's for their definition of emotional safety'. Both the walkthrough and discussion on trauma informed practices at the awareness training revealed some aspects to buildings that may cause an SU to feel

emotionally unsafe and thus trigger trauma reactions. For example, due to limited space some offices also contain beds for 'sleep over' staff, thus may be a trauma trigger for an SU who has been the victim of sexual violence. Staff noted that following on from trauma awareness training the need for more positive messaging in the buildings was required as information posters primarily focused on risk. The States' national policy of 'centre of interest' which dictates that a person experiencing homelessness should utilise services in the place of origin may disregard any trauma that is associated with the place of origin and it may not be appropriate or helpful for the SU to return to their birth place.

Three items relating to Consistency & Predictability were rated as strongly agree, staff reported that the programme is flexible and needs driven and there is opportunity to review and change schedules and procedures. Staff reported also that having a harm reduction policy had increased trust between SU's and staff. The options provided by employment and training for SU's were noted by staff as excellent. However staff also noted that 'bed rotation' for emergency accommodation (i.e. where a limited number of beds are rationed to a larger number of rough sleepers on a 'one night only' basis) was not providing opportunities for stabilisation.

- **Assessment and care planning** contains 5 sub-categories

(a) 12 items relate to Intake Assessment Questions. Three of these items are not applicable to the organisation as they relate to the care of children and Cork Simon Community is primarily an over 18s service. The remaining items were rated as agree (history of head injury, cultural background, current risks etc.). The history of head injury was added to the edited version of the national form and was just used in the ACE study. It was noted that the initial assessment form which is a national template is not strengths based, this was raised both on the self-assessment and training days.

(b) 5 items regarding the Intake Assessment Process were all rated as strongly agree. Items include private spaces for intake, detail on information sharing, observations of SU during intake. It was noted in the walk through and the training that SU's are required by the State to first register with the relevant statutory agencies. These appeared to the researcher to be complex State systems that were not cognisant of the trauma of the SU's or how their presenting crisis can impede their ability to engage with the statutory services including social welfare and housing. The service supported SU's in navigating these systems however the risk of these services triggering trauma reactions was noted by the researcher to be high. It was also noted they lacked flexibility. While Cork Simon Community rated highly for this aspect the external agencies who are also linked to the process of intake did not.

(c) 3 items for Intake Assessment Follow Up also rated on average as 'strongly agree'; based on intake there is onward referral if required, re-assessments are on-going and

consistent, the organisation updates consent forms when it is necessary to speak with a new provider.

(d) 3 items also rated on average as 'strongly agree' for Developing Goals and Plans; staff collaborate with SU's on goals, reviewed and updated regularly, exit plan is created.

(e) 2 out of 3 items relating to Offering Other Services & Trauma Specific Interventions were rated as strongly agree; service provides care available outside of the organisation for additional needs, the service has access to a trauma trained specialist. These were also strongly endorsed by the researcher walk through and by staff at the training dates. However one item was rated as disagree; the service educates SU's about trauma stress and triggers. Following discussion at training dates the access to counselling was raised a number of times, due to resources it was reported that there is a waiting list for counselling and SU's who fail to attend their scheduled sessions have to forgo their place to provide for the next on the list and in doing so they must start the process again.

- **Consumer Involvement**

(a) 3 statements are presented with regard to involving current and former service users. There was strong agreement in relation to the involvement of current SU's in providing feedback or suggestions on the service. However staff also reported low attendance at scheduled meetings for residents. In the main it was reported by staff that former SU's appear to be less involved (i.e. former SU's serve in an advisory capacity and are involved to share their ideas and experiences).

- **Policies**

(a) 6 items for Creating Written Policies were on average rated as 'agree' for the following; policies for respect for cultural difference, risk policy for SU and staff, policy on responding to SU/Staff crisis (i.e. self-harm, aggression) and policy on professional code of conduct for staff. An average rating of disagree was recorded for *policy on trauma informed care and all policies based on understanding of trauma*. This is to be expected for a service who has just started the trauma informed process.

(b) 3 items relating to reviewing policies is included in the agency self- assessment. There was inconsistency in the responses supplied thus may be due to not all staff being familiar with the creation of policies as it mostly occurs at management and administration level. Policies are reviewed to identify if they are responsive to trauma survivors was rated as 'disagree'. Staff are involved in policy review was rated as agree and SU's are involved in policy review was rated as 'disagree'.

The agency self-assessment was completed by staff, management and a researcher, a total of 12 forms were completed across all of the points of care on the continuum. This process was

supported by a researcher walk through of the service and input was provided by 120+ staff at trauma awareness training. Overall the agency operates its service in mostly a trauma sensitive manner. There are minor issues identified which are not difficult to rectify such as addressing beds in offices, reviewing policies with a trauma informed lens. There was a very clear and positive response from all staff in relation to trauma informed care and post training there were immediate responses to issues they had identified during training, such as improving physical spaces, reviewing paper work requirements for SU's. There are however systems (city, county & national) external to the agency that have a direct impact on the SU and their ability to access and engage effectively Cork Simon Community's services. These are governmental systems and services that are not yet trauma informed and have the potential to generate trauma triggers and impede a SU's potential for a successful outcome. These will be referred to again in the discussion and recommendations.

Limitations: All of the tools utilised (e.g. ACE, ProQOL, & agency self-assessment) are self-report tools and carry with them the risk for responder bias, over-reporting and under-reporting. Larger sample sizes can assist in increasing the generalizability of findings.

The original ACE study was conducted with a 'middle class' American population and may not be representative of the range of experiences for groups with a greater diversity in socio-economic and ethnic factors.

Conclusions

This project was completed by a research team involving 7 individuals (3 internal and 4 external) over a period of 18 months. It began with an exploration of childhood trauma levels (ACE) in Service Users as a means of proving the existence of a trauma loaded environment before investing further in practices of trauma informed care. As the data emerged the research group deemed it would be appropriate to extend the trauma impact assessment to staff working in this trauma laden environment and then to screen the environment itself from the perspective of physical environment, policies and practices. Trauma training was then offered to all staff with the content informed from the outcome of the three assessments (service users, staff and service). The training also facilitated the collection of data as over 120 staff participated in the training and each staff member had an opportunity to reflect on their work and centre and provided detail of what works well and what would work better when moving towards a trauma informed service.

The results of the ACE study revealed that there are significant levels of childhood trauma in the Service Users who participated in the research and that SU's were experiencing a range of negative health related behaviours as a result of substance misuse, homelessness and associated behaviours. This is in line with findings from other jurisdictions (e.g. Hopper et al., 2010; Taylor & Sharpe, 2008; Hallinan, 2015).

The results of the staff audit for secondary trauma revealed that there is considerable satisfaction with their work among staff but that there is a trauma contagion effect and that 25% of staff surveyed reported signs of secondary traumatic stress and 12% reported signs of burn out. A re-evaluation of staff supervision and self-care processes can mitigate this.

An agency self- assessment for capacity for trauma informed care revealed that in the main many of the organisations existing policies and procedures are operating from a place that provides for working with deeply traumatised people. There were some areas for improvement and these were mostly constrained by resources issues such as single occupancy rooms, lack of staff rooms, waiting list for counselling service, a day service that is now too small for demand. There were a number of issues identified that are beyond the organisations control as they are dictated by national policies such as intake paperwork that is not strengths based and a policy of 'centre of interest' that disregards a persons' choices which may well be dictated by an avoidance of memories of trauma situations as a means of creating safety.

Recommendations

Short term follow up:

- Formalise a trauma change team (should include former Service User) that will drive the implementation of TIC and allocate responsibility for the roll out of Trauma Informed Care requirements e.g. all policies, procedure and paperwork reviewed to ensure they incorporate TIC principles
- Identify and Introduce an appropriate universal trauma screening tool (that is fir for purpose inclusive of child and adult experiences) and include with the Initial Assessment. This should be evaluated as a pilot over 12 months. This can be supported by the existing research team as part of their follow up.
- Engage with external agencies to modify intake paperwork to include trauma screening and include strengths based approaches. This includes asking Service Users for their definitions of both physical and emotional safety.
- Repeat ProQOL and Agency Self-assessment at 12 months -18 months.
- Provide programme details in more languages
- Email the report to all staff post trauma awareness training for feedback on their views of areas that need updating to improve organisations capacity for Trauma Informed Care
- Address staff self-care by providing self-care training, formal staff rooms, reorganising structure of supervision and regularly remind staff to use internal and external resources.
- Address trauma and trauma contagion at all team meetings by including trauma on each agenda and provide sufficient time for staff to address any trauma related issues they have observed in SU's, any policy and/or procedure that appears to not be in line with TIC and discuss secondary trauma impacts.
- Review current paperwork for Service Users such as rules, rights and agreements. Reduce paperwork and make it more universal between centres with an emphasis on positives and strengths.
- Review current bed rotation system for alternatives that can provide for more stability.
- Source and provide informational material on stress and trauma for Service Users and increase access to interventions such as mindfulness training.
- Review waiting list systems within the service and identity ways of making these align with trauma informed principles.
- Promote increased attendance at resident's meetings.
- Review current capacity and operations within the Day Service as it has become increasingly busy and may not be able to facilitate all of the activities that operate from there.

Long term follow up:

- Advocate for additional resources to address building issues such as beds in offices and larger site for Day Service
- Assess and source resources required to provide single room occupancy and/or communal housing first sites for those who can utilise them.
- Advocate for SU's on a national basis to ensure that national policies that impact on homeless people (such as the 'centre of interest' policy can be trauma informed

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Appendix 1 Adverse Childhood Experiences Scale (ACE)

Before your 18th birthday, did a parent or other adult in the household often or very often…

1. Swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?

2. Push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?

3. Before your 18th birthday, did an adult or person at least five years older than you ever… touch or fondle you or have you touch their body in a sexual way? Or attempt or actually have oral, anal, or vaginal intercourse with you?

4. Before your eighteenth birthday, did you often or very often feel that…no one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?

5. You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

6. Was a biological parent ever lost to you through divorce, abandonment, or other reason?

7. Was your mother or stepmother: often or very often pushed, grabbed, slapped, or had something thrown at her? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

10. Did a household member go to prison?

ACE Score:

On a scale of 1 -10 how was it for you to complete this

1 – Not At all distressing 10 - Very Distressing

Appendix 2 Information for Participants

Plain Language Statement

To whom it may concern,

We are currently seeking participants for a research study titled *"Exploring the Effects of Adverse Childhood Experiences upon Those Using Homeless Services"*. This study is being carried out through University College Cork's School of Applied Psychology and Cork Simon by Dr Sharon Lambert, Dr Aidan Horan, Dr Anna Marie Naughton and Graham Gill- Emerson.

We are specifically seeking patients of The HSE Adult Homeless Integrated team who are utilising homeless services in Cork Simon.

Service users will be asked to participate in a one-to-one interview for a period of 40 - 50 minutes in which the participant will be asked a number of interview questions related to difficult childhood and adult incidents.

As in any re-telling of a traumatic incident there is a risk of the participant becoming distressed, however, there are also benefits such as the opportunity for the participant to tell their own personal story of the how they experienced their partners traumatic incident and how it affected them.

All data obtained from the interviews will be kept and stored securely on a password protected computer, while paperwork and results will be securely locked away. Within the published study identifiable features of participant's identities, including their names and story will be excluded or changed wherever possible and feasible, however, confidentiality of participants and information provided will be subject to legal limitations.

This is a voluntary study and any participant may withdraw from the research at any point up until June 2017.

By further researching and publicising the service users' experience, this study intends:

1. Examine the prevalence and severity of trauma within the homeless community in Cork.
2. Identify a relationship between childhood (ACE) trauma and that of homeless and other adult life events
3. Consider the implications this info can have for clinical and non-clinical interventions within the homeless setting?

People that wish to participate in the study are asked to contact any member of the AIHT team in person or through a homeless service worker.

INFORMED CONSENT FORM

This research study is titled *"Exploring the Effects of Adverse Childhood Experiences upon Those Using Homeless Services"*.

This study is being carried out through University College Cork's School of Applied Psychology, HSE South Addiction Services and Cork Simon by Dr Sharon Lambert, Dr Aidan Horan, Dr Anna Marie Naughton and Graham Gill-Emerson.

This study is interested in the lived childhood and adult experiences of the homeless service user's life.

The participants will be asked to answer some questions with reference to:

- Difficult childhood experiences
- Difficult adult experiences
- General health
- Homelessness

The information is solely taken from the Cork Kerry Initial Assessment Form which you have previously completed and a short survey on early experiences. The information will anonymised and given to a researcher in Applied Psychology, UCC. This information will contain no identifying information.

Participant – please complete the following (Circle Yes or No for each question)

I have read the Plain Language Statement (or had it read to me) *Yes/No*

I understand the information provided *Yes/No*

I have had an opportunity to ask questions and discuss this study *Yes/No*

I have received satisfactory answers to all my questions *Yes/No*

I am aware that my interview will be audiotaped *Yes/No*

I understand that this is a voluntary research study and that I may withdraw from the research study at any point up until June 2016.

I am aware that my confidentiality will be protected whenever possible or feasible and that confidentiality of information provided is subject to legal limitations.

I have read and understood the information in this form. My questions and concerns have been answered by the researchers, and I have a copy of this consent form. Therefore, I consent to take part in this research project.

Participants Signature: _____

Name in Block Capitals: _____

Witness: _____

Date: _____

The participant

To whom it may concern,

We are currently recruiting participants for a research study titled *"Exploring the Effects of Adverse Childhood Experiences upon Those Using Homeless Services"*.

This study is being carried out through University College Cork's School of Applied Psychology and Cork Simon by Dr Sharon Lambert, Dr Aidan Horan, Dr Anna Marie Naughton and Graham Gill-Emerson.

We are specifically seeking users of the Adult Homeless Integrated Team/Cork Simon to answer questions around adverse childhood and adult experiences. These experiences will include areas such as abuse (physical, sexual and neglect), homelessness and general health.

In a 30-60 minute one-to-one interview, participants will be asked to assist the researcher in **the Cork Kerry Initial Assessment Form which you have previously completed and a short survey on early experiences.**

As in any re-telling of a traumatic incident there is a risk of the participant becoming distressed, however, there are also benefits such as the opportunity for the participant to tell their own personal story of the how they experienced their partners traumatic incident and how it affected them.

All data obtained from the interviews will be kept and stored securely on password protected computers, while transcripts and notes will be securely locked away. Within the published study identifiable features of participant's identities, including their names and story will be excluded or changed wherever possible and feasible.

This is a voluntary study that will be completed by June 2017.

I thank you for your time and your openness to reading this letter. If you are interested in being a participant in this research, please contact a member of the homeless medical team directly or through a member of staff in the homeless agency.

Please find attached an informed consent form.

Yours truly,

The Research Team

Sharon Lambert, Aidan Horan, Graham Gill-Emerson, Anna Maria Naughton

Appendix 3: Professional Quality of Life Scale (ProQOL) Version 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

1. I am happy.

2. I am preoccupied with more than one person I [help].

3. I get satisfaction from being able to [help] people.

4. I feel connected to others.

5. I jump or am startled by unexpected sounds.

6. I feel invigorated after working with those I [help].

7. I find it difficult to separate my personal life from my life as a [helper].

8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].

9. I think that I might have been affected by the traumatic stress of those I [help].

10. I feel trapped by my job as a [helper].

11. Because of my [helping], I have felt "on edge" about various things.

12. I like my work as a [helper].

13. I feel depressed because of the traumatic experiences of the people I [help].

14. I feel as though I am experiencing the trauma of someone I have [helped].

15. I have beliefs that sustain me.

16. I am pleased with how I am able to keep up with [helping] techniques and protocols.

17. I am the person I always wanted to be.

18. My work makes me feel satisfied.

19. I feel worn out because of my work as a [helper].

20. I have happy thoughts and feelings about those I [help] and how I could help them.

21. I feel overwhelmed because my case [work] load seems endless.

22. I believe I can make a difference through my work.

23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].

24. I am proud of what I can do to [help].

25. As a result of my [helping], I have intrusive, frightening thoughts.

26. I feel "bogged down" by the system.

27. I have thoughts that I am a "success" as a [helper].

28. I can't recall important parts of my work with trauma victims.

29. I am a very caring person.

30. I am happy that I chose to do this work.

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