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Client Experiences of Trauma-Informed Care in Social Service Agencies

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Abstract

This paper describes a qualitative study of individual client interviews (n=26) from four social service agencies to understand how clients experience trauma-informed care services and implementation challenges. We used the Fallot & Harris (2009) framework to explore client experiences of the five core concepts of trauma-informed care (safety, trustworthiness, choice, collaboration, and empowerment) using semi-structured interview questions with each client. The four agencies consisted of: refugees (n=4), substance abuse (n=8), older adults (n=12), and maternal/child health (n=2), and the agencies varied in size, service goals, and clientele. The results of the study suggest that clients' experience of these concepts was shaped by the actions of other clients, and these experiences were either mitigated or hindered by actions of the agency employees. Agency policies either supported or enhanced their experiences as well. The results also suggest that it was challenging for agencies to provide for all of the trauma-informed care (TIC) concepts at the same time. We discuss the implications of these findings for social service delivery in a range of agency types. Future research should examine the effects of trauma-informed policies on client experiences of each TIC domain.

Introduction

Trauma-Informed Care (TIC) is an organizational approach to care that takes the stance that all clients may have histories of potentially traumatic experiences (Wolf, Green, Nochajski, Mendel, & Kusmaul, 2014). These are not necessarily organizations that treat trauma. In fact, their services may not address trauma at all. However, an organization need not provide trauma-specific care in order to provide TIC. A trauma-informed approach can help survivors ''develop their capacities for managing distress and for engaging in more effective daily functioning'' (Gold, 2001, p. 60). In this perspective, the practitioner and the organization are sensitive to this possibility and to the ways in which the client's current problems can be understood in the context of past victimization and experiences (Knight, 2015). In changing from a traditional model of care to a trauma-informed model, agencies must examine their policies and practices for elements that may inadvertently exacerbate trauma symptoms in clients (Wolf et al., 2014). In general, these would be any practices that decrease safety, lack trustworthiness, remove choice, fail to allow collaboration with clients, or disempower clients from making decisions about their own lives (Fallot & Harris, 2009).

The implementation of TIC has been slow, and there is virtually no research that has examined clients' experience of TIC. This qualitative, descriptive study explores the service delivery experiences of clients who were actively receiving services at several different types of human service agencies. This provides information on the implementation of TIC in real world agency environments, including the perceptions of clients, and challenges and successes.

Background and Framework

Trauma-informed care values/principles

Fallot and Harris (2009) define the five values/principles of TIC as safety, trustworthiness, choice, collaboration, and empowerment. The Substance Abuse and Mental Health Services Administration (SAMHSA) adds the exploration of culture, historical and gender issues, defined as "The organization actively moves past cultural stereotypes and biases, considers language and cultural considerations in providing support, offers gender-responsive services, leverages the healing value of traditional cultural and peer connections, and recognizes and addresses historical trauma" (SAMHSA, 2016, n.p.).   The broadness of the definitions make it applicable to many different settings, but less clear as to what it should look like in those settings.

Previous literature on TIC implementation describes several different yet uniquely specific settings. The most well-known work is Sandra Bloom's *Creating Sanctuary* (2013), in which she described the implementation of her Sanctuary Model, a manualized TIC model, in an inpatient psychiatric setting.   The Sanctuary Model is based on four components: Trauma Theory, organizational commitments (Sanctuary commitments), SELF, and the Sanctuary toolkit (Bloom, 2013). One essential component of the Sanctuary Model is the therapeutic milieu, in which potential trauma in all individuals associated with the setting is recognized. While the Sanctuary Model is a manualized approach, TIC principles are broader, but experts agree that TIC involves the whole system. System approaches, such as improving working conditions, have been advocated to promote patient safety cultures (Stone, et al., 2007). However, the independent effects of many working condition factors on client safety outcomes is still not known (Stone, et al., 2007).

Client Experience of Organizational Culture

How individuals experience a system is often related to their role within the system. If the TIC values/principles are safety, trustworthiness, choice, collaboration, and empowerment (Fallot & Harris, 2009), clearly some roles and positions in agencies lend themselves to more choice and control. Even in agencies who believe they have implemented these values/principles, direct care staff may not feel, for example, safe or like they have choices, which in turn affects the patient experience (Wolf et al., 2014; Kusmaul, Wilson, & Nochajski, 2015). The whole premise of TIC emerged from the idea that clients lack control which adversely affects those who have experienced traumatic events, which typically involve overwhelming events beyond the individual's control. Yet by needing services, or requiring the assistance of others, an individual may need to put trust that they do not have in a system to meet those needs.

Trauma Risks in The Study Settings

Recipients of health and social services exhibit higher rates of exposure to potentially traumatic events than non-service seekers (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005), which makes that assumption of potential trauma exposure a safe one and highlights the importance of using a TIC approach. In the general population, Benjet et al (2016) found that the incidence of exposure to life-threatening trauma was about 70%, with 30% of respondents reporting being exposed to four or more events. More than half of the trauma exposures involved witnessing death or serious injury, the unexpected death of a loved one, being mugged, being in a life-threatening automobile accident, and experiencing a life-threatening illness or injury (Benjet et al., 2016). The experiences of trauma rarely occurred in isolation, rather people with a history of trauma exposure were more likely to have experienced to multiple traumatic events (Benjet et al., 2016; Gelaye et al, 2017). While the identity of the specific agencies in

this study are masked to protect the subjects, we discuss the types of problems served by these

agencies to highlight specific trauma risks in each setting. These agencies serve older adults,

substance abuse clients, refugees, and pregnant women.

Older Adults

In a community sample of 1,792 older adults, about 70% of older men and 41% of older

women reported lifetime exposure to trauma (Creamer & Parslow, 2008). Older adults can

experience distress resulting from their early-life traumatic experiences, particularly due to

coping resources and abilities being compromised by age-related changes and declines in health

(Anderson, Fields, & Dobb, 2011; Peters & Kaye, 2003). Greater lifetime trauma exposure is

related to poorer self-rated health, more chronic health problems, more functional difficulties,

lower psychosocial functioning and higher rates of mental health problems in older adults (Durai

et al., 2011; Krause, Shaw, & Cairney, 2004; Pietrzak, Goldstein, Southwick, & Grant, 2012).

Pregnant Women

Pregnant women are at risk for both experiencing trauma and re-experiencing past

trauma during the prenatal, delivery, and postpartum periods with long and short term

implications for both mother and child (Gelaye et al, 2017; Wosu, Gelaye, & Williams, 2015).

Mothers who experience physical violence during pregnancy are at significant risk for co-

occurring substance abuse and depression (Horrigan, Schroeder, & Schaffer, 2000). Women

with histories of childhood sexual abuse are much more likely to experience pregnancy

challenges such as physical discomfort, depressive symptomology and dissociation (Leeners,

Richter-Appelt, Imthurn, & Rath, 2006), and adverse pregnancy outcomes such as preterm

contractions, cervical insufficiency, and premature birth (Leeners, Stiller, Block, Görres, & Rath,

2010). Women also may experience trauma related memories during labor, due to pain, loss of

control, and musculature that may be associated with previous sexual abuse (Leeners, et al., 2006). Premature birth creates a sequelae of risks for long term physical impacts in children. But there can be long term, intergenerational psychological impacts as well, with a mother's history of childhood trauma impacting the behaviors of their school age children (Babcock Fenerci, Chu, & DePrince, 2016). In mothers, trauma intensity scores are strongly correlated with postpartum depression or depressive symptoms (Gelaye et al, 2017; Wosu et al, 2015). Together, these illustrate the importance of considering trauma in prenatal settings.

People who Use Substances

Clients with substance abuse disorders have particularly high rates of trauma exposure (Giordano, et al., 2016; Sanford, Donahue, & Cosden, 2014). Giordano et al. (2016) surveyed 121 clients in treatment for substance abuse and found that about 85% of the sample reported experiencing at least one traumatic event in their lives. In a study of 51 men and 102 women in drug treatment court, Sanford, Donahue, and Cosden (2014) found that participants experienced an average of four traumatic events during childhood. In addition, higher levels of substance use are found in people with severe mental illness who also have a history of trauma as compared to those with no trauma history (Mauritz, Goossens, Draijer, & Achterberg, 2013). Therefore, it is imperative to integrate trauma-informed services in substance abuse treatment centers.

Refugees

Refugees display a complex mix of trauma-related problems, including PTSD, depression and anxiety, psychotic disorders, and somatic symptoms (Lindencrona, Ekblad, & Hauff, 2008; Lolk, Byberg, Carlsson, & Norredam, 2016; Silove, Ventevogel, & Rees, 2017). Often, pre-migration experiences with interpersonal trauma, such as physical and sexual violence intersect with resettlement stressors such racial and ethnic discrimination (Tummala-Narra, 2014). Severe

trauma can also alter an individual's worldview and their capacity to handle stressful situations (Lindencrona, et al., 2008). Recent studies have proposed an ecological model which posits that refugee mental distress stems not only from prior war exposure, but also from a host of ongoing stressors in their social ecology including displacement-related stressors (Miller & Rasmussen, 2017). Similarly, Lindencrona, Ekblad, and Hauff (2008), in their meta-analysis, found that resettlement stressors are important contributors to the persistence and increase in mental distress in refugee populations. Daily stressors include living in unsafe environments; challenges in meeting basic survival needs; inability to pursue income-generating activities; and isolation from family and traditional social supports (Miller & Rasmussen, 2017). Interventions should emphasize creating supportive social environments to reduce ongoing stress rather than specific trauma treatment (Miller & Rasmussen, 2017), and such an environment would be a natural part of TIC.

While many different populations of people (such as refugees, clients with substance abuse issues, elderly, pregnant women, etc.) have differing experiences of trauma, the commonality is that they have experienced trauma. Some populations have compounded trauma issues due to the very issue for which they are seeking social services (such as refugees, who are fleeing due to the circumstances in the country they were residing in.) Since trauma affects anywhere from 54% to 75% of the population (Atwoli, Stein, Koenen, & McLaughlin, 2015; Mills et al., 2011), it is a ubiquitous issue that social service agencies must take into account when providing services, no matter what the actual service is. Trauma-informed systems create a way for agencies to work with clients in ways that are not only not re-traumatizing, but also comforting and healing (Machtinger, Cuca, Khanna, Rose, & Kimberg, 2015).

Methodology

This was an exploratory, descriptive study that was approved by the Institutional Review Board of a university in the northeastern United States. The goal of this study was to examine the lived experience of TIC in individuals receiving social services at different types of social service agencies. Using a list of agencies with which the University social work program had partnerships, a member of the research team contacted each agency's administrator by phone or email. If they agreed to participate, the agency posted recruitment flyers in their common areas/waiting rooms. Clients called the researchers to state their interest in participating in the study, and a researcher met with client participants individually at their agency.

Sample

Twenty-six in depth, semi-structured interviews were conducted with adults who were receiving agency-based social services at the time of the study. These interviews were anonymous, and client demographics were not collected to protect the identity of the clients.   Participants received a $5 gift card after the interview. Agency types included refugees (n=4), substance abuse (n=8), older adults (n=12), and maternal/child health (n=2). The semi-structured interview guide asked participants about their experiences of safety, trustworthiness, choice, collaboration, and empowerment at the target agency.

Analysis

Interviews were recorded and transcribed verbatim. Guided by phenomenology, interviews were analyzed using a multi-step content analysis method (Elo & Kyngäs, 2008) to create definitions of TIC that encompassed participants' lived experience of receiving social services in their particular setting. The goal of this method is to "describe the phenomenon in a conceptual form" (Elo & Kyngäs, 2008, pp 107). First the transcripts were read in their entirety to "become immersed in the data" (Elo & Kyngäs, 2008, pp 109). Then the transcripts were re-

read and codes were created from the data. The codes were then grouped into themes or

categories. Quotations from the interviews were used to illustrate the themes. Themes were

clustered into the five TIC categories from the interview guide and into two overall themes.

Results

Safety

Clients were asked to describe their experiences of both physical and emotional safety as

experienced within the agency. Overall, physical safety was enhanced by specific actions, while

emotional safety was enhanced by attitudes and approaches. Staff response to incidents helped to

enhance feelings of safety.

In the area of physical safety, the set-up of the agency created feelings of enhanced

safety. One client at an agency that served refugees that was situated in an unfamiliar city

neighborhood described how she sometimes felt unsafe due to her history, but "*But inside here*

we are all safe. This place, we safe. (Client in Refugee Setting)*.*" Another client in an inpatient

substance abuse setting echoed her thoughts about safety as it related to locked doors:

"*Physically, I feel safe because, um...the build is locked 24 hours a day…* (Client in Substance

Abuse Setting)."

In another inpatient setting clients offered two different perspectives on night time room

checks but both perceived them as enhancing safety. One client perceived it as intrusive but

understood how it improved safety in light of a recent suicide:

> *Q: Anything else about safety? Are the doors locked enough?*
> *A: Yeah, I wish we had locks in our rooms.*
> *Q: Other than staff, do people just barge in?*
> *A: At night they do. And sometimes in the morning too, when they are coming to wake*
> *you up. A girl just killed herself about 2 months ago. Ever since that happened they have*
> *been on top of stuff, which I can understand cause you never know when it can happen.*
> (Client in Substance Abuse Setting)

The other client felt that the night checks allowed her to sleep "like a baby" knowing that staff

knew she was safe.

> *Overnight staff just to make sure, check on us, y'know, every so...every fifteen minutes or something they look in on all of us. y'know, each room. So, y'know that's pretty secure. To make sure everyone's comfortable, sleeping, or no one's missing or anything. Check the doors, the windows. 'Cause I...we don't got locks on our doors, but I could sleep like a baby.* (Client in Substance Abuse Setting)

Other examples of agency practices that enhanced feelings of safety including a sign in/sign out

book, arranging transportation for appointments, and locks for personal items.

> *Specific staff responses to incidents enhanced client feelings of physical safety.*
> *I know that, um, there are usually emergencies with older people and the staff is really very obliging. They make sure that, you know, that people aren't around. And I like the way they do handle things, the staff.* (Client in Aging Services Setting)

> *When I started going with her, a fellow she used to see occasionally, I never seen her with anybody, so I started dating her. This fellow confronted me, he said she was his girlfriend for seven years and he threatened me. They took care of him, in the office up there. I think [social worker] was involved in it too. He threatened me with bodily harm. He said I was taking his girlfriend.* (Client in Aging Services Setting).

In the second case, the couple who was interviewed had felt physically unsafe due to the actions

of this other client and the staff protected them (took care of it). The perpetrator was banned

from the center.

Emotional safety was characterized by caring attitudes of staff members and genuine

interest in the needs of clients. One said, "*Emotionally I feel safe because my counselor and the*

rest of the staff are very attentive to my emotional needs… And my mental needs as well. (Client

in Substance Abuse Setting).*" A similar example:

> There's just - *they got the genuine caring attitude...you know, if you need something when you first get here they're checking up on you and...if you, if you are, if you don't know something - if you have a question you're not going to feel stupid if you ask it* (Client in Substance Abuse Setting)

Trustworthiness

Elements of trustworthiness included delivery of services as promised, openness, and

follow through. Examples of times when programs or staff were trustworthy include:

> *I'm from [location], and I don't want to go back to [location], I want to stay here, but I am on drug court. My counselor is trying to help me. Every time she sends Drug Court something in [location], she shows me what she sends. So yeah, she keeps it real.* (Client in Substance Abuse Setting)

> *Plenty of notice for activities- We have plenty of time - like we had spring cleaning last week and we knew for like a month ahead of time. Like - "hey next Friday - Friday and Saturday late in April, we're gonna be cleaning the rooms and the rest of the house...so don't plan anything."* (Client in Substance Abuse Setting)

When services were not delivered as promised, this was seen as less trustworthy. One client in a

substance abuse program identified a problem with groups getting cancelled and clients not

being told why as a lack of trustworthiness. He went on to say that the agency had recently

changed their program and it has gotten better, and thus more trustworthy (Client in Substance

Abuse Setting).

One client in a refugee program expressed difficulty with trust related to past

experiences. He expresses an overall belief that you cannot trust everybody. He is comfortable

with some people at the agency but not others. "*But some people, a few people, really, really few*

people, I just don't trust them. When I don't feel comfortable, I don't trust (Client in Refugee

Setting).*"* He went on to say that he does not like when people have too much of an interest in

him. When someone has too much of an interest and he can't figure out why he has trouble

trusting. He believes this has to do with being gay in a country where it is not safe to be gay. He

trusts people who do not ask questions. He also feels like straight women are more trustworthy

than straight men. He blames his past history. He copes with this by choosing who he will tell

his life to people and who he will not. If he believes they will keep it private he will share but if

he does not know he will not share. He said, "*Being gay is illegal in [country of origin] and you*

will be jailed (Client in Refugee Setting)*."* This example is less about the services than other

examples, but it demonstrates how this client's history impacts his perceptions and experience of

the services.

Choice

Choice was characterized by programs offered and ability to choose which programs to

attend. Naturally, some settings offered more choice than others. However, too much choice was

seen as a challenge.

In the substance abuse treatment setting, choice was framed as ability to choose activities

and shape one's recovery plan to the individual's specific needs.

> *They give you...I would say they give you guidelines. You know, like this is what you*
> *should be doing. You know. And, I mean it's a broad spectrum. And, 'cause I mean each*
> *person individually, you know, has their own way of recovery and you know, what might*
> *fit me might not fit this guy. So, I mean, it's nice because, you know, they tell you, you*
> *should be at least one meeting a day and you know, so.* (Client in Substance Abuse
> Setting)

Within these guidelines, clients were free to choose which meeting to go to. Beyond meetings,

clients were also free to choose activities, and felt that the agency helped them access the

activities they chose.

> *That guy just came back from the library, you know...um...you get stuff for, um, like the*
> *library. There's different places for...say you want to volunteer, um...you can get*
> *memberships for the college, for the gym, and the pool and all that stuff. And you get*
> *pamphlets on all the meetings whether it's NA, AA. All the time, whenever they*
> *meet...They give you tokens so that you can get to the meetings and, you know, stuff like*
> *that. You know, if you need some help.* (Client in Substance Abuse Setting)

Several clients in this setting identified that the choices they had were an indication that the

choices reflected a belief in the clients to do what they were supposed to do, with support. One

said, *"[Y]ou're a grown up and they expect you to do what you're supposed to do* (Client in

Substance Abuse Setting)*."* Another said:

It's almost all my choice. I mean, they- they're there to guide you or kind of help you out along the way but, um like, during the day and stuff like that, I mean...Whenever I want to do, whatever I need to do to get where I want to be, I mean, that's up to me.. You know, they don't force anything on me and you know, if I go to them and say "hey, I'm having a problem with this or that" they're there, but to kind of help me - but still in the end it's my choice. (Client in Substance Abuse Setting)

In another setting, clients recognized that the agency offered them many choices but they felt the agency was offering more choices to draw in more clients rather than serving those that were there.

I don't feel particularly restricted. I know that I....it's hard for me to answer that. I, I don't know. I don't... I feel that I'm able to use common sense and whatever I want to and I don't feel unduly restricted. I just don't like the, you know...I... don't like the idea of having so many classes. I just feel, you know, they just want to bring in more people, and more people and... (Client in Aging Services Setting)

Collaboration

Client definitions of collaboration included both opportunities to work with staff on specific goals and to suggest future services. One client defined collaboration as voice and choice: "*I have a voice and I have choices in setting goals on my treatment plan. That is set up with my individual counselor* (Client in Substance Abuse Setting).*" Collaboration was further operationalized as those times when staff provided necessary resources for reaching one's goals, as shown in these two examples in two different agency types.

They help me a lot with that. They know I have my court date soon; they are trying to make me comfortable, they give me some time. Sometimes I need some time alone, in a room, read my materials, so they provide that for me. Like now, I need a printer, so they provide it for me. (Client in Refugee Setting)

[W]e set our own goals here and they're - they don't really tell you "hey this is what we want from you." It's whatever you want to do. And "we'll help you to get there." like with the school thing I mentioned. If I didn't want to go back to school, they're not gonna say "hey you have to go back to school." But since I wanted to do that, they're there, they supportive and they're there to help me out with it. (Client in Substance Abuse Setting)

Empowerment

Empowerment included recognizing strengths and skills and offering opportunities for

education and self-direction.

> *I think the biggest help I have ever seen everybody needed to speak English. They create classes, this is the biggest. If you need, if you want to feel stupid, when you speak the same language then the other person and you begin to understand then you feel the power, some power. The power of communication and they provide this, this power, they are teaching us this, to speak English.* (Client in Refugee Setting)

> *[T]he counselors...and [name] himself, which is the director. I gotta give [name] a lot of props because...and the staff and all the staff because they recognize our strengths. And um, they encourage us to empower ourselves. Greatly. One hundred and ten percent. And the[y] recognize our skills and our strengths.* (Client in Substance Abuse Setting)

Another client felt empowered when he was given the opportunity to research something that

would benefit the agency, because he was included in the process.

> *I haven't said much about, like, the actually services part of it. But if there's like, downstairs we have the little rec area and there's no ping pong table...so, I asked the director, I said "is there any way we can get ping pong tables?" He said "Yeah, you know, we had them before, but if you want to get some quotes for us. If you want do that you can, and..." Um you know, she didn't just blow it off. She said, so you know, I like that kind of they. If you do a little research and, we'll see what we can do for you.* (Client in Substance Abuse Setting)

Theme 1: Differences in Experiences with Staff and Other Clients

Clients across settings experienced differences between how staff treated them and how

they were treated by other clients. One respondent said another client cheated during recreational

activities, so while staff was trauma-informed, he had to "look out" for other clients. There were

other examples as well.

> *The organization doesn't have control over everything that happens at the center. He cited the actions of other members who don't clean up spills, move furniture, etc. He cites getting injured when another member moved a chair and rammed his leg. He is concerned because the agency "want to have it as a senior center" but that the people who come do some dumb things, "bells missing in their belfries" and the staff doesn't/cannot control it.* (Client in Aging Services Setting)

Another client experienced discrimination from other clients at his agency. He felt, "*Staff people can only do so much, they cannot change people's mind and is about people's mind* (Client in Refugee Setting)." Further,

> *The people who live here with me is people from different countries, different cultures and most of them they are not so much different than the people in my country. That is why I feel like I am not in United States of America. That is why I am not open, gay open. I don't tell people I am gay because it is not safe for me. Even not telling some people, they are not stupid and they figure out I am. Even they not be sure they try to discriminate me. So that is why I say people, the staffing is really nice. They supporting and respectful. The problem is not staff, it is the other people is different backgrounds, is different cultures, different countries, so here is not like I am in America.* (Client in Refugee Setting)

In another example, the client felt like the staff had done as much as they could do about the situation and it was just up to the client to avoid the other clients who caused problems.

> *I can manage and unless there have been a couple of people here who have been very nasty - a couple of the...and who've really, really gotten me quite angry. And so of course I have come and complained to [social worker] vociferously. But...I just keep my distance. But there are some people who tend to be pretty nasty...most people are rather pleasant and...Whatever so you know, my dealings with people I know. I know who they are and how to handle them, so...* (Client in Aging Services Setting)

Theme 2: Conflicts between Constructs

Although research suggests that TIC is a single construct (Hales, Kusmaul, & Nochajski, 2017), simultaneously implementing all sub-constructs was a challenge for agencies. Participants felt that policies that addressed one construct may challenge another. In one case, a policy intended to increase safety, curfew in a facility in a dangerous neighborhood, was perceived by clients as decreasing choice. "*Everybody knows about the people that lives here*" (Client in Refugee Setting).

Yet at the same time, it does appear like a single construct because it was difficult for clients to parse out which construct an example fell into. For example, in one of the quotes above related to choice, "*Whenever I want to do, whatever I need to do to get where I want to be,*

I mean, that's up to me," this client's description also contains elements of empowerment, in that the agency allowed him to decide where he wanted to be and the steps he needed to take to get there.

Discussion

It is clear that for the clients that were interviewed at these agencies, the concepts of TIC had different meanings for them, and experiences of these concepts were different as well. For instance, for two clients in the same agency, whereas one client felt safe because the staff checked on them every fifteen minutes during sleeping hours, those safety checks made another client feel unsafe. In this way, a policy in the agency that is designed with the clients' safety in mind can accomplish its goal (as it did with one of the clients), or can accomplish the opposite of the goal (as it did with another client). There are several ways an agency can handle such a policy. First, the agency can obtain informed consent to the night-time checks, before the client establishes residency in an inpatient setting. This would empower the client to say yes or no, and would give them choice in the matter. Second, the agency could try to work with each client individually, by asking them if they feel comfortable with night-time checks. If the client feels uncomfortable, perhaps the agency could work out a different arrangement. For instance, we live in the age of technology, and perhaps there is technology (such as baby monitors) that could serve the same purpose but less intrusively. Most importantly, the client needs to be given the opportunity to collaborate with the agency towards their shared goal of safety. If the client feels physically safe, but emotionally safe, then their healing trajectory might be compromised or lengthened. This speaks to the idea that TIC being one construct—not that all 5 values need to be used in every interaction/policy; but if safety is compromised for one client, how can we use the other values to increase being trauma-informed (i.e. letting them know the purpose of the safety

check and when/by whom it will happen – trustworthiness; or collaborating with them to see

what would help them feel more safe during safety checks; or giving them alternatives if it is

possible – choice).

Another issue that arose for some of the clients interviewed was conflict between

themselves and other clients. This can happen in any setting, but certainly in an emotionally

charged situation, such as inpatient residency or refugee services, there is a higher likelihood of

client disagreements happening (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola,

2013). On a positive note, it appears that the clients felt emotionally safe enough to trust the staff

by telling them that these issues were happening. This also shows that the staff were utilizing

another TIC principle of trustworthiness. At the same time, the clients felt that the staff 'could

only do so much', which meant that the problem was still there. Perhaps in these types of

situations, the TIC principle to focus on would be empowerment, in that the staff can help to

empower the clients to do what they need to do to feel safe (such as allowing clients to leave the

room when they need to, continuing their open-door policy of listening to client issues, doing

role-plays with clients to empower them to work out their differences with other clients, etc.)

The interconnected nature of TIC constructs can create implementation challenges

(Bloom, 2010). As the second theme showed, clients in multiple settings reported that the TIC

environment was challenged by other agency clients. While TIC can be thought of as a single

concept there are also sub-constructs within that concept, and just as no one person can be all

things to all people, no one agency can fulfill all constructs to all clients, and mental health

workers can struggle with how to provide services that are in line with TIC values (Muskett,

2014). However, agencies that operate from a true trauma-informed perspective can work

towards the majority of the staff and clients feeling safe and cared for by the agency (Bloom,

2010; 2014; Fallot & Harris, 2009). In addition, agencies need to address the ways and places

that clients interact with each other and establish ground rules that are clear, enforceable, and

trauma-informed (Hodgdon et al., 2013). All stakeholders should review agency policies to

ensure that they are trauma-informed (staff, client, management) (Hodgdon et al., 2013). Based

on what is known about the need for safety in trauma-informed environments, seeking help from

trained professionals that match client's cultures within a culture-specific environment (clinic or

center) is more likely to support this essential component of TIC (Jennings, 2004).

　　　　TIC is a broad practice model which allows it to be implemented in a range of different

types of agencies, and the results of this study show that there are similarities and differences

between the ways that clients experience the five domains of TIC at each agency. While the

domains are the same, the practices look different at each agency. These results also suggest that

clients have different expectations of the services provided by different types of agencies.

Organizational culture is an important piece of the experience of TIC, and some of that

experience of culture has to do with a sense of belonging or attachment to the organization

(Bloom, 2010). For instance, one client in the aging services setting was upset about the changes

that occurred over time in the agency's culture and climate, with attempts to be more open and

welcoming to new members making her feel more excluded. This should make agencies aware

of the risks of change. Transparency (trustworthiness) and including clients/staff in the process

of change (collaboration) is important. There is a need for a system approach of the five

values/principles. In her case she liked the agency the way it was, and now there are all these

changes, maybe for the better, but it is not her agency anymore. Perhaps if she had been engaged

in the change process this would not be the case. Change is hard, and leaders must clearly

communicate the rationale and benefits of the changes to both staff and clients (Menscher &

Maul, 2016).

A final point of discussion is that even though these agencies are not considered 'trauma-

specific' agencies, all agencies were using components of TIC without labeling it as such, which

is commonplace in many social service agencies (Wolf et al., 2014). However, since many social

service clients have trauma histories (Fallot & Harris, 2009), even places that are not trauma

specific can be addressing hidden trauma histories of their clients. An area of future research

would be to examine the effects on clients when trauma-informed agencies have policies that

acknowledge the hidden trauma histories of their clientele (such as by way of referral to trauma-

specific services). Of particular interest would be the outcomes and longevity of the clients at

these agencies.

This study had a few limitations. One such limitation is that there were only a handful of

clients interviewed in each type of agency setting. It is possible that having a few more of each

agency's clients might have yielded more results. However, since the researchers achieved

saturation of the results/themes with each agency, it is doubtful that more clients would have

changed the outcome of this study. An additional limitation was the variable nature of the agency

participants. While they provided information across a range of agency types, there were other

types of agencies that were not represented and thus provided a limited picture of agency

implementation.

In conclusion, this study gives voice to the clients who have been largely absent from the

literature on TIC at agencies. These results demonstrate that there are ways that clients

experience (or in this case, don't experience) TIC based on organizational culture, the

change/growth process of the agencies, and most of all, the behaviors and actions of other

clients, and by extension, staff members at the agencies. This study needs to be replicated with similar and different agencies to examine whether these results are homogenous across studies. However, these results are promising, in terms of understanding how to create policies around TIC at agencies such that clients can experience safety, collaboration, choice, trustworthiness, and empowerment. While other work has looked at the impact on staff, this study looked at client perceptions which have not been represented in previous research. In implementation, both client and staff perceptions need to be considered and neither in isolation.

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