Hull Homeless Mental Health Team:

Towards Emergent Models of Healing in Homelessness

AUTUMN 2022

Acknowledgements

Thanks and heartfelt gratitude go out to all the professionals, stakeholders, commissioners and service users who took part in or contributed to this report, generously giving their time, insights and energy. Without their voices this report would not have been possible.

Author

This report was produced by Arras Healing on behalf of Hull Health and Care Partnership (part of Humber and North Yorkshire NHS Integrated Care Board). Arras Healing brings together lived experience of trauma recovery with the latest thinking and research in trauma informed theory and leadership. Arras Healing is committed to supporting people, communities, organisations and systems to unlock the hidden healing powers of trauma. These are accessible to us when we learn to 'lean in' with love, forgiveness and curiosity to the parts of us (and our societies) that feel absent, stuck and numb. More info: https://arras-healing.co.uk/

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This report and its illustrations have been designed by Dave Bull, artist, illustrator, cartoonist and instructor: http://www.davebull.co.uk/

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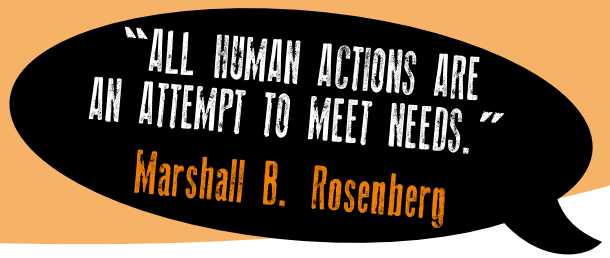
This Report At A Glance



An independent and holistic evaluation of the *Hull Homeless Mental Health Team* is presented in the report that follows. The journey of compiling this report has focused on gathering insights, good practice and the valuable knowledge of staff and frontline workers, while at the same time offering a platform for some of the most marginalised people in our communities.

The ultimate ambition of this report is to support and highlight the journey towards new models of healing in our societies and communities, across our health systems and our statutory services.

Hull's *Homeless Mental Health Team,* which at the time of writing is in its third year of NHS England funding, has adopted a pre-engagement and pre-treatment approach to healthcare that draws on trauma informed practice and the innate strengths of the individuals who are receiving its support. It holds a key spot in our understanding and imagining of future care, not just for the most marginalised and vulnerable communities amongst us, but for the wider population and systems we serve.

The Pre-Treatment Model, which is described and demonstrated throughout this report, arose out of a realisation amongst health and social care workers around the world that "there must be another way." Traditional approaches to healthcare and patient engagement were not working, were not lasting, or were not even getting off the ground at all. Something had to give.

In these times of intense pressures and expectations on health, care and statutory services, it may be an opportunity to look at where we can be radical and paradigm-shifting in our philosophies of what it means to bring healing and change to our communities – and moreover our world.

The *Homeless Mental Health Team* has been on its own journey of paradigm-shift from inception to implementation, and now establishment with the stakeholders and community it serves. Where it may once have been expected to deliver business-as-usual mental healthcare, it is carving a new path for itself, educating partner agencies on the impact of trauma and Adverse Childhood Experiences, and building strong foundations and a trustworthy relationship with the people it is here to work with.

Not only is the service patient-focused and progressive in its approach it also understands that its role as a leader is to model this new approach for fellow colleagues and frontline workers across the city. Though there is more work to do around this, the awareness of reflective practice and Psychologically Informed Environments (PIEs) is growing well as a result of the team's efforts, expertise and passion.

There are many strengths to the service and its approach, particularly in its joined-up, flexible and visible working philosophy which is well respected by its peers and partner agencies (as seen in Section 3: Mapping Outcomes). There are also areas where the service may benefit from more support and development, such as in the expansion of its mental health interventions, or in its movement away from traditional frameworks of psychology (as seen in Section 4: Learning, Challenges and Opportunities).

If there is a new medicine emerging and it is the right time for statutory organisations to recognise and embrace it, then the *Homeless Mental Health Team* along with its partner organisations have a key role to play in this.

People who are experiencing homelessness are some of the most vulnerable in our society, and without exception have been through the most traumatic experiences that a human being can go through. Relentlessly, society, systems and people who were supposed to love them have let them down and almost extinguished their light. But as we can see clearly in Section 2 of this report, their voices are powerful and here to be heard, and it is the right time that we embrace the strength and knowledge that live in the hearts of society's most outcast.

As Carl Jung said: *"the brighter the light, the darker the shadow."* If there is a new medicine to be discovered, then our most traumatised citizens are the ones to help us find it.

Gathering together a varied mixture of qualitative and quantitative evidence, this report aims to be creative and bold in its presentation of information, while remaining accessible to the everyday reader and stakeholder. Parts of this document fulfil the traditional style anticipated in reports of this kind (Sections 1, 3, 4) while other parts aim to be more thought-provoking and radical (Sections 2, 5, 6). It is this both/and approach that will support us onward in our journey from here.

Thank you for taking the time to read this report. It is hoped that it may offer some inspiration and ideas to a brave generation of trauma informed practitioners and trailblazers. It is also hoped that through telling the story of Hull's *Homeless Mental Health Team,* the passionate people behind systems change can be recognised, and an emergent model of healing move closer into our awareness.

The Journey So Far:

An in-depth look at the Hull Homeless Mental Health Team

> "SEE ALL HUMAN BEHAVIOUR AS ONE OF TWO THINGS: EITHER LOVE, OR A CALL FOR LOVE."
>
> Marianne Williamson

The *Hull Homeless Mental Health Team* was commissioned by Hull Health and Care Partnership (formerly NHS Hull Clinical Commissioning Group) in January 2020 using recurrent NHS England funding. The provider is Humber Teaching NHS Foundation Trust, one of the main mental health providers in the region.

Due to their existing integrated approach to holistic care for the homeless, Hull Health and Care Partnership was selected by NHS England to be one of 6 pilot sites to develop and deliver innovative mental healthcare to the homeless in the city. A prerequisite of the service was the delivery of fully accessible, barrier-less, psychologically- and trauma-informed care for the homeless.

At the time of commissioning, the service was known as the Assertive Engagement Team and this was later changed to Homeless Mental Health Team, with the team recognising that 'assertive engagement' does not feel like trauma informed language and does not describe what that they offer. The service is known across the city to beneficiaries and stakeholders as the Homeless Mental Health Team, and throughout this report "team" and "service" are used interchangeably to refer to their work. Some stakeholders have also known the team as the 'Rough Sleepers Outreach Service' but this name is no longer in common use.

Where the wider Hull system and homelessness services are being discussed in this report, this is made clear, with "services," "landscape" and "system" often used to discern between commentary. The Homeless Mental Health Team exists within an ecosystem and partnership of homelessness services across the city, closely interconnected with each other, and the compilation of this report has produced rich information and insights that go beyond the team's direct service alone.

This section offers a close-up view of the team's work, its context, and how it operates and provides care on a day-to-day basis.

The Homeless Community in Hull

The total homeless and unhoused population across Hull – including those staying at hostels, those sleeping rough on the streets, and those who are considered hidden homeless* – is not known with certainty.

Statistics provided by Hull City Council on the current known number of rough sleepers is between 20-30 people on the streets at any one time. A further 80-100 individuals return to and from the street on a frequent basis. Finally, there are approximately 350 people in hostel / short-term accommodation in Hull, including the Complex Needs setting at Russell Street, and the hostels at William Booth, Westbourne Avenue and Great Union Street (Service Specification, 2019). This would total an estimated number of known homeless individuals in Hull of 450-500 at any one time (excluding hidden homeless).

These numbers may fall or increase following the closure of William Booth hostel, currently run by the Salvation Army, and the largest hostel of its kind in Europe. At the time of writing a great deal of work is taking place behind-the-scenes as housing staff and social care move to rehome the 109 individuals who live there and an extended transition period is now in place until March 2023.

Numbers of people who are experiencing homelessness are expected to rise this winter owing to the increasing costs of living, the energy crisis, an anticipated economic recession, and the lack of affordable housing and renting options.

Homelessness and Mental Health

People who are experiencing homelessness have often had negative experiences of support services and mental health care is no exception. This can mean contact with mental health services for them is emotionally upsetting, causing high levels of distrust and distress, or resistance and total avoidance. Sometimes this may lead to expressions of emotion and actions by service users that health and care professionals interpret to be difficult, volatile and challenging. Outside of a trauma informed environment, this generally leads to relationship breakdown and the further marginalisation of this community.

A high percentage of people who are experiencing homelessness – between 60% to 80% – have experience of four or more Adverse Childhood Experiences (Service Specification, 2019). This places individuals at significantly higher risk of developing mental health difficulties and physical health issues than the rest of the population.

The mental health of the homeless community across England is strongly tied together with what is known in statutory services as **Severe and Multiple Disadvantage (SMD)**. This means an individual has a mixture of experiences of *substance use, homelessness, mental health* and possibly also *contact with the criminal justice system*.

Across England approximately 92% of people experiencing SMD had a self-reported mental health problem and 55% had an already diagnosed mental health condition. Suicide and accidental overdose is also more prevalent in this vulnerable population (Service Specification, 2019).

When speaking to staff and professional stakeholders as part of this report, it became evident that it is more likely that **all** individuals experiencing homelessness of any kind are also experiencing poor mental health. Taking this on board, it does not feel possible to separate out homelessness, its causes, and mental health.

Though it would make patients and services easier to understand and deliver if we knew whether 'the chicken or the egg came first' – whether that is homelessness, mental health, or substance use and addiction – arguably this is not the right question to be asking or focusing on.

The more helpful questions to ponder are the ones which the *Hull Homeless Mental Health Team* has been commissioned to build itself upon – what are the roles of trauma and Adverse Childhood Experiences (ACEs) in a person's route into homelessness, addiction and mental ill health – and how can they inform the way we **develop, deliver, evaluate** and **evolve** our healing and support services?

**Hidden homelessness incorporates those citizens not known to services, or at least not known as being at risk of homelessness. This includes but is not limited to: people who are experiencing domestic abuse; people who are experiencing modern slavery or forced labour; people who are exchanging sex in return for housing or are working as sex workers (most often women) to keep a roof over their heads; people who are sometimes referred to as 'sofa-surfers' meaning they are reliant on moving from house-to-house with friends, family and associates; or people who are sleeping in their cars or other forms of unsafe / unreliable accommodation e.g. squats and shipping containers.*

Overview of the Service

Hull's *Homeless Mental Health Team* is relatively modest in size, made up of a team of 7 staff based at Miranda House on Gladstone Street (1 Clinical Lead, 1 Clinical Psychologist, 2 Mental Health Social Workers, 1 Peer Support Worker, 2 Health Care Assistants). The Peer Support Worker is funded separately by Hull and East Yorkshire Mind but is a member of the same team.

All staff have their own caseload of patients from the homeless and rough sleeping community in Hull, sharing the care of some patients in the service or taking the lead for other patients.

The **aims of the service**, as defined in the original service specification, are to:

- provide specialist mental health care and support for the homeless population in the city, which recognises, understands and supports the complexities of trauma and mental health;
- be values-based, kind, compassionate and accessible in its approach;
- use a trauma informed approach and ensure the individual is at the centre of their own care;
- work to transform mental health outcomes for one of the most vulnerable and deprived groups in our society.

The **objectives of the service**, also defined in the service specification, are to:

- improve access to appropriate health and social care services for people experiencing homelessness;
- provide proactive and personalised mental health care to homeless people;
- improve the experience of mental health and social care service for individuals who are homeless;
- support registration with GP Practices, where required;
- support access to Primary Care and also substance misuse support;

- work in an integrated way with the Homeless Hub to deliver joint health and social care assessments and interventions for individuals who are homeless, ensuring seamless transition and co-ordination of care between primary care, social services, housing-related support, substance misuse and the voluntary and community sector;
- support sustained mental health improvement of individuals who are homeless through the provision of an ongoing care plan once discharged from the team;
- work in conjunction with Hull City Council's Housing Options Team to support people into appropriate housing, to live independently and to prevent repeated homelessness which perpetuates poor mental health;
- provide support to establish and maintain networks to prevent isolation;
- support access to appropriate organisations in relation to welfare and benefits advice;
- be a key contributor to the continual development of the homelessness and mental health offer in the city.

The service specification goes further to define its **key outcomes** which offer more insight into the commissioned roles and responsibilities of the service and how it may measure its successes and impact now and in the future.

The **Key Outcomes** of the *Hull Homeless Mental Health Team* are to be observed and measured as having achieved:

- the provision of trauma informed care;
- a no-barriers approach to accessing mental health care;
- a taking account of Adverse Childhood Experiences (ACEs) in care planning;
- bespoke care that puts the individual at the centre of their unique care package, promoting participation in their own recovery;
- individuals able to make choices which improve their health and quality of life;
- improvements in an individual's self-reported wellbeing;
- a supporting of the treatment and improvement of health in those who are homeless;
- increased stability and quality of lives of individuals;
- a responsive and timely service;
- a positive experience of care delivered by service users;
- an integrated approach: that has ensured joint working with other agencies i.e. substance misuse, housing, physical health services;
- a leading role in development of Psychologically Informed Environments (PIEs);
- registration of patients with their local General Practitioners;
- increased contact between the most vulnerable homeless people, appropriate mental health services, general practice care and other support agencies;
- care coordination and continuity of care from appropriate services upon discharge from the team;
- a positive experience of care and support;
- fewer people experiencing stigma and discrimination.

The provision of complex trauma informed care in a fully accessible, barrier-less service which leads on creating psychologically informed environments (PIEs) is a main focus of the team. Before this service came into existence, there was no specialist or dedicated support for homeless people's mental health in the city. People who were experiencing homelessness had to go through the same mainstream channels as the wider public, such as the Crisis Team or Community Mental Health Teams (CMHT). Neither of these are considered to offer appropriate care to the patients involved, owing to the unique needs of this patient cohort, such as addiction and dual diagnosis. Patients would often be discharged in response to what is seen as their failure to engage with support or due to their active substance usage, the latter which can lead to fluctuating mental capacity concerns.

The Homeless Mental Health Team recognises that all people who are experiencing homelessness, particularly rough sleepers, have experienced trauma and that the experience of homelessness itself can be retraumatising. To be truly barrier-less means that the *Homeless Mental Health Team* does not discharge patients if they miss multiple appointments or temporarily refuse to engage, are still actively using drugs and alcohol, or have other ongoing addiction difficulties. It also makes provision for the expression of anger that is directed at NHS and statutory services, which generally comes from a place of deep pain caused by previous contact with services. The team meets individuals exactly where they are at their current experience of life and seeks to provide trauma informed and trauma-sensitive interventions in a non-judgemental and radically compassionate way.

The Aims and Objectives are built upon by the service's own internal **Standard Operating Procedure (SOP)**** to widen and clarify the remit of the team and the services they offer. Please note that the SOP is currently in draft version at the time of writing and may be subject to changes.

The SOP is transparent about the issues that statutory services face in providing care for this under-reached and often under-served population: *"The team recognise that individuals in this group may not be ready to contemplate change or to engage with mental health services and a Pre-Treatment Approach is taken that focusses on building a relationship."*

More information on the Pre-Treatment Model is offered below.

The service aims to offer a full **Mental Health Assessment** to every patient referred, however in reality, the capturing of an assessment can take several weeks or months to obtain in full. This is for a multitude of reasons, such as capacity concerns, inability to locate or contact the patient, or a patient's preference for shorter meetings and contact.

Language barriers and high-quality translation services can also be a factor sometimes. As one stakeholder noted, it is one thing to make small talk in a different language, but it is another thing entirely to share your life story and your troubles.

All patients in the service with active, open cases are discussed and their files updated each week during the Multi-Disciplinary Team (MDT) meeting. The MDT gives the team opportunities to discuss new and existing referrals, allocate additional staff, offer peer advice and support, explore effective patient engagement techniques and strategies, share knowledge, and liaise with external colleagues in a psychologically safe setting.

**Please note that at the time of writing, the Standing Operating Procedure (SOP) was awaiting formal sign-off by the provider organisation, Humber Teaching NHS Foundation Trust, through the relevant governance and organisational channels. Its contents may therefore have changed or being amended since this report was published. It is felt with confidence that, at the time of writing, the draft SOP in its current form still accurately reflects the existing processes for service provision and referral, and where more detail is known from the gathering of insights for this report, this has also been provided.

A general patient referral through the Homeless Mental Health Team is shown in this flow chart

Referral Opened and/or Actioned
The Team discuss at its weekly MDT, including which care pathway the Service User may fall into and whether a psychological formulation is required. At other times a team member may respond immediately e.g. if the Service User's current location is known and the team has capacity to attend

Lead Worker Assignment
An individual caseworker is assigned to the referral. A new clinical note is opened on Lorenzo and the original referrer is updated on the progress of the case

Contact Made
The team member attempts to make contact with the Service User either via telephone or face-to-face

(if contact cannot be established and all options exhausted to locate the Service User, the referral is closed and they can be re-referred at any point)

Mental Health Assessment
This may take several weeks or months following the Pre-Treatment Model Approach (relationship and building trust becomes the main intervention focus)

Additional **Care Plans** or **Formulation(s)** are prepared as required; multi-agency meetings may take place to inform formulations and support effective partnership working

Interventions / Pre-treatment continues until the Service User becomes stabilised for transition to other services or discharge

Discharge / Transition
The Team supports the transition into other services e.g. CMHT, community groups, peer support etc; Patient is then discharged from the service.

The 'Pre-Treatment' Model

Sometimes called the pre-engagement approach, the **Pre-Treatment Model** has in recent years become one of the most cited methods and tools for engagement by health professionals working within homeless communities. It originated out of work conducted by clinical social worker Jay S. Levy, MSW throughout the 1990s and 2000s in the United States and championed further by the work of psychotherapist John Conolly (Westminster Homeless Health Service) in the United Kingdom. It is the model adopted by the *Homeless Mental Health Team* and actively informs their approach to engagement throughout the patient journey from the point of referral.

The pre-treatment approach is closely interlinked with development of Psychologically Informed Environments (PIEs). Pre-Treatment incorporates **5 Key Principles** (Levy, 2021) for successful outreach into homeless communities:

1) **Promote Safety –** apply crisis intervention and harm reduction strategies to reduce risk, increase safety, promote stability, and embrace the opportunity for positive change

2) **Relationship Formation** – engage with homeless people in a trust-, safety- and autonomy-promoting manner while developing goals (e.g. motivational interviewing techniques, person-centred listening skills) resulting in a person-centred relationship that is goal-driven

3) **Common Language Construction** – try to understand the homeless person's world by learning the meaning of their gestures, words and actions, thus promoting a mutual understanding, communication style and jointly-defined goals

4) **Facilitate and Support Change** – point out discrepancies, explore ambivalence, reinforce healthy behaviours, develop skills as well as identify needed support for positive change (e.g. using change models and or motivational interviewing techniques)

5) **Cultural and Ecological Considerations** – a 'person in environment' lens; prepare and support the homeless person for successful transitions and adaptation to new relationships, ideas, services, resources, treatment, accommodation, recovery etc.

The pre-treatment model is ***a relationship-based approach*** for frontline workers, tunnelling down to "the very 'nitty gritty,' the 'nuts and bolts,' of what it actually takes to connect with someone" (Conolly, 2021). It offers a model for empowering and authentically supporting service users, at the same time as meeting them where they are at in the present moment, at a pace and rhythm they can tolerate at that precise time – and without judgement or unrealistic expectations.

In *Pre-Treatment in Action* (2021), Levy provides the rationale behind this approach:

> "Pretreatment… is defined as "an approach that enhances safety while promoting transition to housing (e.g. housing first options), and/or treatment alternatives through client centred supportive interventions that develop goals and motivation to create positive change… An outreach counselling model based on a Pretreatment philosophy affords us the opportunity to become both interpreters and bridge builders... Potential resources and services are therefore re-interpreted and reframed so the client can more fully consider these options and their potential impacts. This is the first major step toward building a bridge to needed resources and services that include housing and treatment options. It is a bridge consisting of ***a safe and trusting relationship between worker and client***, as well as a common language that fosters communication. This aligns with our efforts to ***understand people's values and stories*** in a manner that imparts dignity, meaning, and purpose to their lives." [Report author's emphasis]

Pre-treatment meets homeless service users where they're at, explores what safety means to them and in their own language, develops a shared narrative and gets to know their likes and interests. It could be seen as ***a re-humanising process*** aimed at overcoming historical and systemic "othering" of hyper-marginalised peoples, at the same time as offering a model for engagement that will be less triggering and retraumatising for individuals so often at the edge of care and support services.

The conclusion of a pre-treatment process is generally the point at which a service user is transitioned into more mainstream care or mental health support.

Some quotes from different members of the Homeless Mental Health Team reflecting on their service's pre-treatment approach and philosophy:

"We are offering the beginnings of a relationship they might never have had"

"We're not clock-watching with clients"

"Relationship is everything"

"At the same time it's not about building dependency. It's not about being someone's mate. But I am validating them and I am having their corner"

"It's about seeing this as a worthwhile job for someone who is worthwhile"

"It's playing the long game with our service users"

"Playing pool with someone is seeing clients. Playing pool is the intervention"

"I have to be a consistent, secure base. My service user may only last 15 minutes before he storms off"

"For me it's about being properly person-centred. This is the way we should be working in mental health, it's a no-brainer"

"Someone might tell me to 'fuck off' 100 times, but we are a no-barriers service"

"It's recognising that I'm working with the most invisible people in society, and life hasn't been fair to them"

"Pre-treatment itself is a specialism. This relationship building in itself is the specialist service"

"We are supporting individuals to get to the level where they can engage with other services e.g. CMHT"

"The therapeutic intervention is the relationship-building. No matter what they present with we are non-judgemental and building trust all the time"

"I might support someone for 6-8 months and then they might feel stable at that point to see the Psychologist, so they do. That is the pre-treatment model"

"For a lot of people we see, they don't trust mental health services, so we work on that with them"

"It takes persistence, patience and flexibility with our service users to pre-treat them. We meet them for coffee, go for walks, guide them through tasks, take them to groups. There are definitely befriending elements to it"

"Often if service users come with something practical we can help them with, that opens them up and they want to see what else we can help them with. It builds trust. If you can help someone with something, even small, they're more likely to open up"

"We don't have to sit in a room with people and tick boxes. The flexibility we have to work with people, we don't have that in mainstream services. It provides us a lot of job fulfilment."

The Homeless Care Pathway and Overview of Provision

Following referral, two clinical pathways operate within the service:

- **High Functioning/Low Intensity pathway:** this refers to service users who are able to engage well, are willing to access support via drop-in services, 1:1 sessions or groups and are open to the prospect of undertaking therapeutic work.
- **Low Functioning/High Intensity pathway**: this refers to service users who are a) unable or refuse to engage, either due to high levels of distress, 'challenging behaviour' or lack of mental capacity, b) who require indirect support in terms of trauma informed consultation, psychological formulation, informal supervision and c) have high levels of attendance at Accident and Emergency (A&E) or contact with Crisis Teams.

The service adopts a personalised response depending on where it's felt the referred patient falls within these two categories:

1) If the patient is deemed to be *high functioning and low intensity*, the support provided will centre around drop-ins, one-to-one therapeutic work, befriending, groups and active advocacy. More practical support will also be offered. The focus is the establishment of trust, safety and a good relationship with the members of the team involved in their care i.e. the pre-treatment model;

2) If the patient is deemed to be *low functioning and high intensity*, then direct support is not offered. The support provided will be based on a complex trauma understanding which recognises the current disorganisation and distress that a service user is experiencing. In these instances the team offers more indirect 'wraparound' support in line with a trauma informed provision, such as supporting Patient Formulations and working with partner agencies to improve engagement outcomes.

The wraparound support process for partner agencies where a service user is low functioning and high intensity is described in more detail in the SOP:

> "The primary aim of this pathway is to develop a trauma-informed psychological understanding of the individual in order to link chaotic presentation to history of trauma. The formulation approach aims to provide a wraparound service that includes input from all services working with that individual (e.g. hostels, Hospital Discharge Pathways Discharge Team, Hull City Council, substance misuse services, etc.) The formulation supports the wider team to understand how the individual's chaotic presentation can be understood as a maladaptive way of eliciting care within the context of complex trauma and opportunities to intervene.
>
> - It is important to establish from the outset that the service is consultation-based, does not involve 1:1 support at this stage and is not a crisis service
> - Lorenzo and paper notes are reviewed to gather information about history, exposure to ACEs, and interaction with other services
> - Indirect assessment of history and presentation with information from a variety of sources (including review of notes and staff interactions), including brief introduction to the structure, theory and benefits of a psychological formulation
> - Team formulation sessions to synthesise all available information for the individual
> - Formulation to be shared with clear depiction of triggers and opportunities for intervention
> - Reflective practice to support staff with the impact of challenging work
> - Formulation approach to be followed up (e.g. after a month, three months) to review developments."

All provision is trauma informed and based on what are known as 'trauma stabilisation' models of relational and environmental safety, psychoeducation, and skills-building. A rotating, regular provision of **Mental Health Drop-in Clinics** (more info below) and tailored **one-to-one sessions** are offered within the High Functioning Pathway. Individuals can request to access services at any time. Drop-in Clinics are often the first point of access for new referrals into the service.

If patients struggle to engage, decline support or are discharged from the service at any point, re-referral is generally via the drop-in clinics again. In the future the team would like to explore group work and peer mentoring, and supporting patients to develop into volunteers for the service if they would like to.

Mental Health Drop-In Clinics

The numerous and regular 'drop-ins' take place across the city, utilising hostel spaces to offer these as well as Trafalgar House and the City Centre Hub. They are generally fortnightly or more often as needed. They are delivered as consistently as possible, by the same staff, usually the Mental Health Social Workers and the Health Care Assistants (these staff are the most well-known members of the team and most visible amongst stakeholders and service users in the city).

The main function of the drop-ins is to focus on the establishment of a good therapeutic relationship. The team are mindful of past experiences

of mental health services which were negative for the service user and instead focus on allowing attendees to gradually build up trust through the experience of safety and equality in the relationship.

At the time of writing (September-October 2022) the service is seeking to trial more regular weekly drop-ins at the hostels and Trafalgar House, such as allocating a member of the team to visit a location once per week and base themselves there for several hours, as opposed to the 1-2 hour drop-ins at present. No appointments would be necessary, as is already the case with drop-ins, and service users would hopefully become accustomed to knowing that a member of the team would be present on a particular day every week. It is hoped this will support further trust-building and removal of barriers in the city, thereby supporting people who are experiencing homelessness to be more confident and feeling able to accept and receive the care on offer.

Further guidance for staff deployed to Mental Health Drop-Ins (as detailed in the SOP) is summarised below:

- Whilst thorough mental health assessment and psychological understanding would be aimed for as a function of engagement with the Homeless Mental Health Team, at this stage formal assessment is not attempted due to possibility of re-traumatisation and a risk of disengagement;
- It is advised that staff (including hostel and outreach staff) explicitly state the function of the drop-in clinic with a statement that attendees should not explicitly describe adverse childhood experiences / attachment difficulties / other trauma experiences due to the possibility of destabilisation;
- There should be offered a focus on strengths and functional coping skills as well as discussion of present time difficulties;
- It is recognised that not all service users will move on to further interventions from the Homeless Mental Health Team following their initial attendance at drop-in clinics. If they do not engage on a regular basis moving forwards, the discharge criteria should be invoked;
- The focus at this stage is generally on engagement and the building of a trusting therapeutic relationship. Lorenzo referrals are opened but relevant assessment documentation are not attempted immediately and are progressed as relevant clinical information is gained over time. A clinical note should be completed at every drop-in attendance as per other clinical interactions, and a rationale should be given in the clinical note explaining why assessment documentation has not been completed;
- If significant risk is identified or becomes apparent via other sources then documentation can be updated and information shared in the appropriate manner;
- If an assessment or intervention plan for a service user is deemed complex and requires wider clinical discussion within the team (e.g. psychological consultation, occupational therapy etc), then the service user should be added to the next MDT discussion list.

One-to-One Therapeutic Work

The service works one-to-one with patients who are at the ‘contemplation stage’ (ready to explore their mental health more readily) by offering sessions with the Clinical Psychologist or another member of the team, such as the Clinical Lead or a Mental Health Social Worker. As the team expands, this may also include a nurse and a GP who can offer more clinically-based one-to-one work and prescribing.

Many of the patients seen to date have been identified as pre-contemplative and the Clinical Psychologist is working with 5 people at the time of writing (Oct 2022), with other patients felt to be not yet ready to work with a psychologist. This number may increase over time as more resource becomes available to the team to develop the psychology offer or the ways in which it might be adapted for people who are experiencing homelessness and complex trauma.

More commentary and feedback on the psychology model is provided in Section 4.

At a glance, the **one-to-one work** on offer from the service currently includes:

- An onus on engagement (building up attendance and attachment)
- Starting to build up an assessment / formulation of the service user

- Beginning to contract for more formal work together
- Beginning to understand the nature of difficulties from a complex trauma perspective (such as naming emotions, cognitions, relations, understanding patterns etc)
- Identifying triggers and foundational work e.g. grounding, slow building of emotional regulation skills, self-compassion, mindfulness, and 'scaffolding' skills to manage patterns and emotions
- Techniques for stabilisation e.g. working with flashbacks, dissociation, hearing voices
- Motivational interviewing elements
- Mentalisation Based Therapy (from late 2022 and early 2023)
- Normalisation of mental health experiences *e.g. "so patients know they are not mad / not going mad" (quote from the team)*

One-to-one work with the Clinical Psychologist is often delivered via home visits, as service users can struggle to travel to Miranda House or may find it triggering to bump into people they know on buses, such as former acquaintances or drug dealers (anecdotal information gathered through staff and stakeholder conversations).

The emphasis of one-to-one support is on ***foundational work***, and trauma therapy is not usually offered at this stage. It is felt that the majority of service users seen to date are not ready for deep trauma work and inquiry, and people will move onto mainstream services when they become ready for this. This will most likely mean discharging service users to the Community Mental Health Team (CMHT). The service has not yet come to a point with a patient where they need to explore this route, though 1-2 patients are stabilised to such a degree that they may cross this bridge soon. At that point, a greater understanding of what discharge to CMHT looks like will become possible. This will also help the team to assess the capacity, capabilities and flexibility CMHT has to provide accessible complex trauma recovery work with this patient group.

Further commentary on the provision of trauma therapy within the *Homeless Mental Health Team* is offered in Section 4.

A selection of insights from the team on one-to-one therapeutic interventions:

> ***"Once service users demonstrate self-regulation we will move them to CMHT. Actually sitting down and talking about trauma is years away, service users need lots and lots of grounding. Our role is repairing and restoring the trust and safety."***
>
> ***"We look at what our service users need in terms of container, attachment and meaning. We might be the only quality, boundaried relationship they have ever had."***
>
> ***"The therapeutic intervention is the relationship-building. We remain present and consistent. It's often not the right time to delve into childhood, history etc, they're not ready to get into it. So we model a consistent and positive relationship instead. We take stock of what is happening in their lives now."***
>
> ***"The mental health assessment is the intervention, it can take months to complete it."***

Other One-to-One Provision – Befriending and Holistic Support

Other one-to-one provision is provided by the Health Care Assistants, Peer Support Worker and Mental Health Social Workers in the team. This is generally a more holistic and practical offering, with elements of the above clinical work to support trust-building, stabilisation and general engagement.

This work forms the backbone of the **'Pre-Treatment Model'** described earlier in this report.

This support from the team can be ad hoc or more regular, is completely person-centred, and may include any of the following interventions and activities:

- Flexible outreach into hostels and supported living accommodation, either via the drop-ins or more informally when external agencies and professionals ask for it;
- Street outreach e.g. rough sleepers, or accompanying Emmaus or the Lighthouse Project in their outreach work;
- Befriending work, e.g. taking service users for a coffee, or a walk; driving service users to pharmacies to collect their prescriptions, or to their appointments; playing pool or board games or visiting clients at their new flat; supporting them to set up their utility bills and find their local shops; building trust and rapport; being a friendly and familiar face; being as visible as possible;
- Health-related tasks, such as registering clients with a GP; supporting the resolution of prescription issues or communication with pharmacists and GPs; booking appointments for clients e.g. physical health checks;
- Liaison work with other health professionals or support workers / agencies / rehabilitation and detox facilities; liaising with Crisis teams or CMHTs;
- Social isolation work, such as supporting service users to connect into local community groups, similar to a social prescribing role; accompanying them to new groups and activities if requested; supporting their confidence to find and attend local groups and outings such as fishing or gardening;
- Advocacy work, e.g. supporting assessments or welfare reviews; supporting benefits claims; supporting housing assessments and placements; liaising with police and secondary or acute (emergency) care; organising additional support and agency visits to service users; arranging additional caring interventions;
- Practical tasks, e.g. opening a bank account, reporting stolen bank cards; completing paperwork and forms; cooking and meal preparation; personal hygiene such as sourcing clean clothes or encouraging a shower / bathing.

Group Work

Group Work is not currently offered by the *Homeless Mental Health Team* but the team is ambitious for the development of this in future, be that peer support work or providing more holistic interventions in a group setting e.g. creative activities, cooking etc.

Pending additional staff training, Mentalisation Based Therapy may be offered in the future within a group container. This may begin in late 2022 or early 2023. The team is also interested in developing some process-focused groups such as working with anger.

Further commentary is provided in Section 4 to highlight areas of potential repetition or duplication in the city's holistic offerings for the homeless community, and how greater integration of services may be achieved to mitigate this, such as through a shared Directory of Services.

'Psychology in Hostels' Model

The Service Specification (2019-20) highlights a 'psychology in hostels' model as commissioned to form the basis of therapeutic and trust-building work within the city's hostels and supported accommodation environments.

'Psychology in Hostels' as a model has been particularly effective in other parts of England and it is thought that many service users would benefit from this opportunity. There is no exclusion criteria in terms of the psychology provision. A psycho-therapeutic approach to complex care and social exclusion is fundamental and a core part of the service delivery and development. The psychologist works with a caseload in collaboration with and support from the wider Homeless Mental Health Team (Service Specification, 2019).

This report could not find examples of the 'psychology in hostels' model in action as part of the current service offer, however it may be part of ongoing service development and evolution in the future. At the time of writing the team were reflecting on how they may improve engagement within hostels, such as offering more frequent (even weekly) low key floating support and outreach.

Further commentary on the role of psychology in this service is offered at Section 4, which may help to inform future provision of psycho-therapeutic work.

Patient / Service User Formulation and Supporting Partner Agencies

It has already been mentioned that the service, via the leadership of the Clinical Psychologist, offers consultation to wider services through bespoke **patient formulations**. This is particularly in the instance of a homeless person who is felt to be low functioning and high intensity, and unable to engage in the support that is on offer.

Formulation or re-formulation (i.e. if workers are still struggling to engage with or build trust with a service user) is also offered within the team of the service itself and may be flagged for follow-up during MDT meetings.

Formulations are provided by the Clinical Psychologist within the team. They are pulled together based on existing case notes and records from partner agencies involved in the care and support of the individual in question. Further information is provided via email or face-to-face from frontline workers such as anecdotal information or observations of things that may have helped in the past, or which had not helped, in terms of engagement with the individual.

It is important to note that formulations are offered without the input of the service user and the Clinical Psychologist hasn't met the service user before providing the formulation. This is flagged here as several key stakeholders made this observation, and it was felt to be a weakness in the process.

Overall, whilst at first some partner agencies felt they did not understand the role of formulation, awareness has grown and patient formulations are now well-received and felt to be useful on the whole. Some formulations have supported greater engagement with a service user by offering insights into their behaviours and backgrounds, such as their attachment difficulties and how these may direct or condition their trauma responses to play out in their lives.

Partner agencies are felt to be increasingly cognisant of the role of attachment and ACEs when working with people who are experiencing homelessness, and are now actively seeking the input and expertise of the service on a regular basis. This is felt to be a positive marker of partnership working.

Further reflections and feedback on patient formulations is offered in Sections 3 and 4.

> ***"I can ring the team whenever I need to for advice."***
>
> ***"To change the world for one person might just be a regular shower."***
>
> ***"At first I didn't like the formulations but now I understand their value."***
>
> ***"It took me a while to understand it doesn't happen overnight. People take years to heal, not a matter of months. It might take a long time."***

Psychologically Informed Environments (PIEs)

Work is ongoing across the city of Hull and the wider Changing Futures Programme to identify and nurture **Psychologically Informed Environments (PIEs).** The Changing Futures Programme and other city-wide projects such as the Rough Sleepers Initiative (RSI) and Making Every Adult Matter (MEAM) are interdependent with the *Homeless Mental Health Team* and vice versa.

A Psychologically Informed Environment (PIE) is one that "takes into account the psychological make-up – the thinking, emotions, personalities and past experience – of its participants in the way that it operates." (Department of Communities and Local Government, 2012).

PIEs are a key part of creating trauma informed settings, services, care pathways and organisations. They are a key component in ensuring successful trauma informed systems change, not just for the benefit of service users and patients, but also for the benefit of staff and frontline workers.

There are 5 pillars present in the creating and sustaining of a PIE:

- Relationships
- Staff Support and Training
- Physical Environment and Social Spaces

- A Psychological Framework
- Evidence Generating Practice / Evaluation

Further specific information about PIEs is beyond the scope of this report, but information can be found at the No One Left Out website, which is operated by consultant Claire Ritchie, a leader in the field of PIEs and homelessness.

A key outcome for the *Homeless Mental Health Team* is **to lead on the development of PIEs** across the city's homelessness services. The team view the development of PIE settings as key for lived experience to play a bigger role in co-production of services, as well as crucial in the delivery of positive patient outcomes and good staff retention and resilience. PIE is growing in awareness as a concept amongst hostels and frontline workers in the city, as demonstrated through the stakeholder conversations that contributed to this report, and the service has played a large role in this education.

Despite the growing awareness of PIEs and what this means for services in the city, implementation of PIEs ***still feels limited in practice*** and stakeholder feedback indicates that there is still a way to go before PIEs become business-as-usual.

In terms of physical environment, the team have noted that their previous base of St Andrews (before moving to Miranda House) had offered a setting more in-keeping with the principles of PIEs, such as kitchen facilities, showers, and a more welcoming atmosphere. They feel this has affected their ability to invite service users to Miranda House, which is more well-known for housing inpatient facilities and the Crisis Team, both of which service users are likely to have had negative experiences of in the past.

The change in a secure and stable base also caused some upheaval for the team at short notice, though they now feel they have mostly integrated and reconciled these changes. The team would be open to a move back to St Andrews if it became available, or to another setting aligned with PIE principles. The impact of the team's move is an example of how important *'secure bases'* are for staff as well as for service users.

The Clinical Psychologist and other members of the team are playing a key role in offering bespoke training and workshops around PIE to partner agencies and organisations, in particular VCSE organisations and hostels.

The delivery of **Reflective Practice** also forms a key and visible part of the service's PIE offer.

Reflective Practice for Professionals and Partner Agencies

Through the Clinical Psychologist, and sometimes student psychologists undertaking placements with the team, regular **Reflective Practice** has been offered to partner agencies and organisations across the city. This has included hostels, VCSE organisations such as ReNew, and housing / social care teams such as those working within the Rough Sleepers Initiative or part of Making Every Adult Matter. This is generally delivered as 1 hour per month per each organisation / team.

The reflective practice offering from the Homeless Mental Health Team is well-received by organisations and stakeholders across the city and one of its most well-known functions.

The team enjoys being able to offer this and finds deep value and job fulfilment in being able to offer it. Though it is known that additional resource is coming on board from the MEAM and Changing Futures programmes to lead on both PIEs and Reflective Practice across the city going forwards, it would be worthwhile to enable some of these two strands to remain with the team, in order to take account of their experience to date in delivering this work and maximise the learning that has already taken place in this arena through the *Homeless Mental Health Team*. This could be reduced from the current volume of work undertaken in this area in order to free up additional capacity for therapeutic work inside hostels, within group settings and one-to-one with service users.

Further commentary on PIEs and Reflective Practice across the city is provided at Section 3.

Voices of Hull's Homeless Citizens

"COMPASSION IS NOT A RELATIONSHIP BETWEEN THE HEALER AND THE WOUNDED. IT IS A RELATIONSHIP BETWEEN EQUALS. ONLY WHEN WE KNOW OUR DARKNESS WELL CAN WE BE PRESENT WITH THE DARKNESS OF OTHERS. COMPASSION BECOMES REAL WHEN WE RECOGNISE OUR SHARED HUMANITY."

Pema Chödrön

This section tells the stories of Bobby, Greg, Daniel, Matilda, Michael and Trevor.*

All six are currently or formerly experiencing homelessness in Hull. They have all had contact with the Homeless Mental Health Team, either briefly in passing or more frequently as a long term client.

Throughout their lives they have experienced deep suffering through forms of abandonment, neglect, violence, abuse, poverty and deprivation – usually from a very young age. As service users they are generally seen as complex or as having complex needs, and difficult to engage or keep engaged. Here their voices are strong and powerful, their needs straightforward and easily relatable, and they have much to teach us and share with the world.

All six have kindly and generously shared their stories for this report, offering a window into their lives, and their deepest thoughts and feelings.

It is hoped by writing their stories down that their voices gain a larger platform and audience, as well as the love, respect, and attention that they deserve.

Ultimately it is hoped their stories can inspire the trauma informed revolution of service provision for homelessness, mental health and addiction in the city.

All names have been changed to protect the privacy of individuals.

Illustrations throughout this report are an artistic interpretation of the stories that have been shared by the people we have spoken to. The illustrations are not intended to identify the real people behind these stories and careful consideration has gone into protecting their anonymity throughout this report.

It is anticipated that owing to close integration between services in Hull that some professionals reading this report might feel able to identify their services users from these stories, due to their working knowledge of the homelessness community. This is felt to be unavoidable and discretion / sensitivity is encouraged.

Bobby's Story

Bobby is 33 years old and lives at the Crossings Hostel. He has been homeless for about 6 months.

Bobby has been alcohol dependent for some years, and this has led to a diagnosis of stage 3 liver cirrhosis. He is not currently receiving treatment for this but is aware of how it may affect his health in the future.

Health professionals have asked Bobby to continue drinking in smaller amounts to help manage his liver condition, and Bobby has succeeded in cutting down to 5 cans a day. In recent months since coming to live at the hostel, Bobby has also lost nearly 5 stone in weight, having – in his own words – been a much bigger lad before.

Bobby is a highly skilled labourer. He has had former jobs in painting and decorating, butchering, and fitting bathrooms. Due to his high skill-set, Bobby is clear that he would like to get back to working at some point in the future:

"I don't want to be on PIP the rest of my life."

Bobby has recently had an assessment for residential detox and rehab and has been approved. He is looking forward to getting away from Hull and seeing a fresh environment. He feels motivated to stop drinking and get his health back to a stable state, especially so that he can be there for his children, who he sees at weekends and loves to spend time with.

"I know I did this to myself," says Bobby, "it's my own fault, but it was my coping mechanism. The only one that's gonna make it better is me, isn't it?

"I'd rather be normal than pissed up all the time."

Bobby is keen to get away onto the residential detox sooner rather than later, and feels that in the last few months, with the help of the Homeless Mental Health Team and other agencies, things have rapidly started to fall into place for his recovery:

"I can't wait to get away. It's helped having my own space here too [at the hostel]."

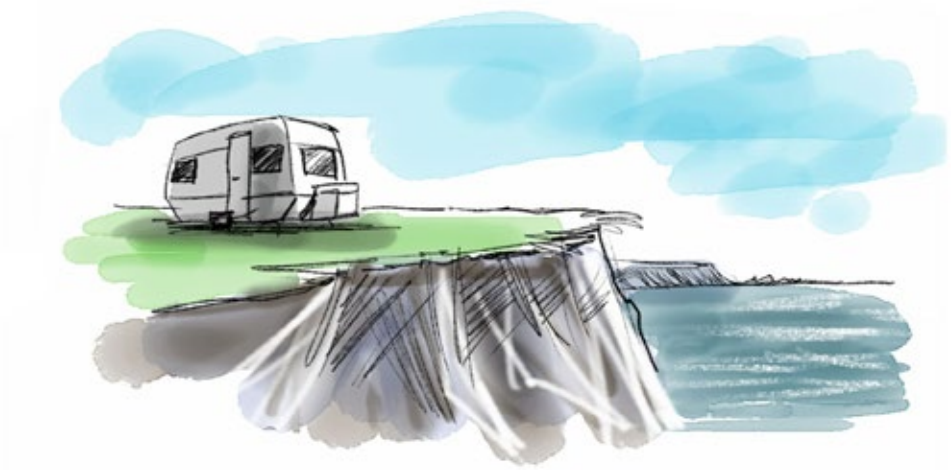
Sleeping has been an issue for Bobby recently, because it's just too hot in his room, and the fans are only blowing hot air around.

Bobby's head just won't switch off too – he struggles with a busy mind and intrusive thoughts. He used to feel suicidal, and has tried to hang himself before, but is feeling better in the last two weeks and no longer feels that way.

"Life's too short," he says.

Bobby is extremely self-aware and knows what he would like his life to look like. He recognises how far he's come and celebrates his small achievements, such as cutting down to 5 cans a day.

Longer term goals for Bobby look like going through detox and rehab, getting his money sorted when he comes back to Hull, and buying a caravan so that he can get back out on the road:



"I want to buy a caravan, so there's no one to answer to. Get back out on the road, park it where there's no neighbours. Maybe near the coast so I can see the cliffs. Have as many dogs as I want."

Bobby is close to his family and sees them quite often:

"I went for a few drinks with my dad recently. Later on I saw my mum and she said he'd enjoyed my company.

"That's the first time he's ever said that."

Greg's Story

Greg is in his early 60s and visits the Breakfast Club at Trafalgar House as much as 3-5 times per week, describing it as “a lifeline.” He has been offered a clean change of clothes today, freshly laundered and which fit him perfectly.

Greg is rough-sleeping across Hull at the moment, preferring this to the hostels which he dislikes due to the quantity of drugs around. He also says that he finds it difficult being around the poor hygiene of other hostel residents:

“A lot of people are quite ill, and don’t know how to keep themselves clean.”

He explains this is because they were never taught how to as children.

When asked what would make Hull a better place to live and support more people to move off the streets into more permanent housing, Greg is clear that more places for him and others to go during the daytime would be helpful. He often spends hours in museums to pass the time, due to his love of history.

“We’ve nothing much to do all day except drink ourselves to oblivion.

“I might go round the museums to pass a few hours. My favourite time in history is the Bronze Age, really old stuff like that. I love history and it was my favourite subject at school. I like the World Wars and all that stuff too. I wrote an essay at school about the French Foreign Legion, I had to do all the research, I loved it.”

Greg would happily try metal detecting and anything related to history.

He also loves animals and used to have a dog, which he rehomed with a friend when he came to live on the streets:

"I love animals, but not rats. I see some really big rats and they frighten me."

Working with his hands and tinkering with old motorbikes and cars is something else which Greg would like the opportunities to do. He would also happily volunteer to go into schools and tell his story to students and teenagers:

"We've got to catch them early, while they're still at school. If they've already had a taste [for drugs] then they've a taste for life and it's too late. I'd gladly go round schools and tell them what might happen to them.

"If I can only save one bairn's life, I'll have done my job."

Greg would like to get off drugs but finds the support difficult to navigate and accept sometimes. He has been out of prison for 3 years but continues to make shop thefts of clothes and other items to pay for the drugs he uses.

"I have an addictive personality. I still remember the first time I smoked crack. My brother gave me some to try, because I didn't believe him it could be that good, or everyone would be doing it.

"It was a euphoric feeling. I remember I felt warm and loved, for the first time ever.

"If I could have one miracle it would be to give up all the drugs with no withdrawal."

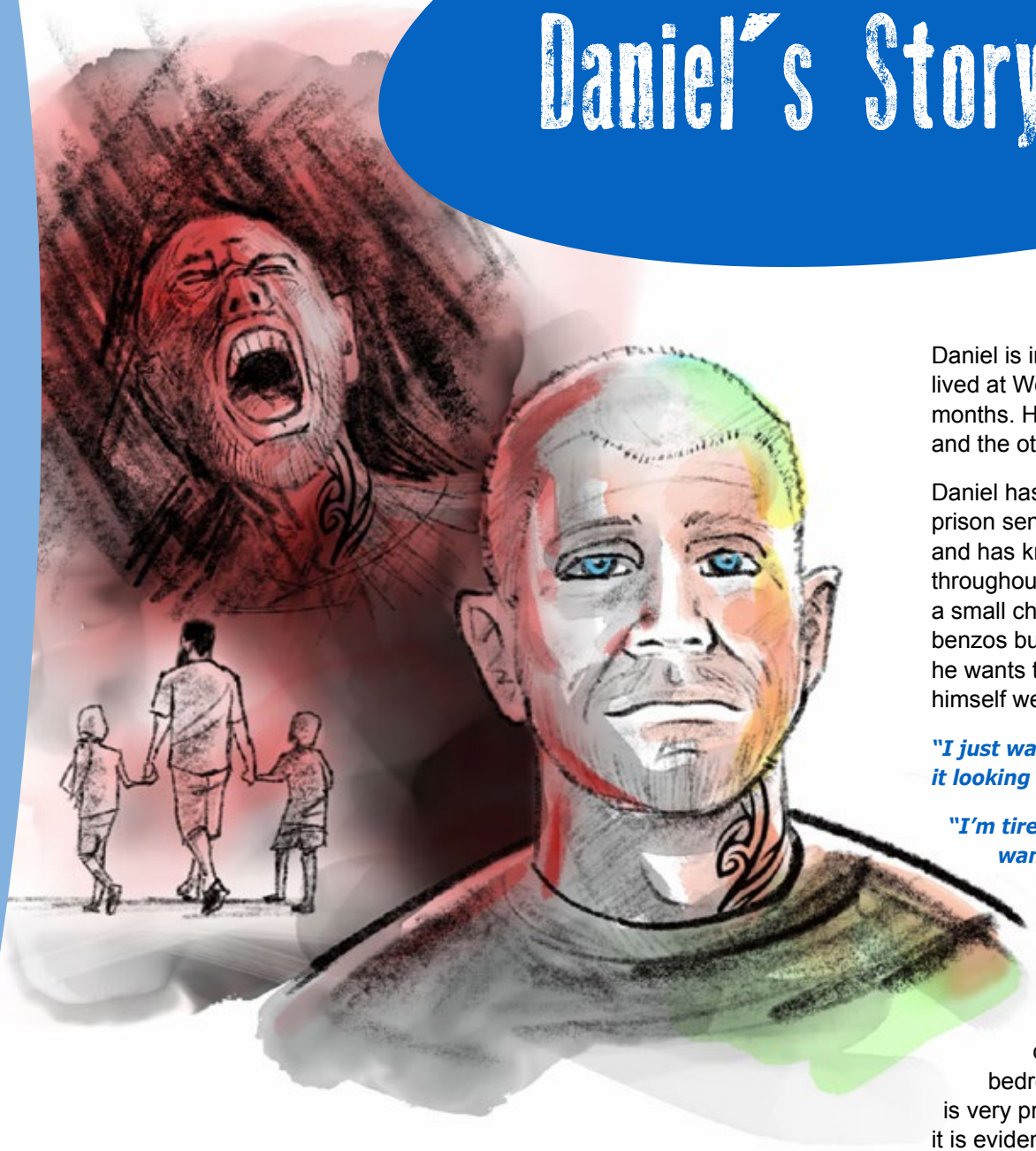
During his visit to the breakfast club that day, Greg is updated on the potential offer of a flat which has become available in the city. The support workers confirm an appointment time with him for the following day so that they can talk about this further. During the conversation they emphatically remind him how worthy he is of this support.

Greg says: ***"People here have never given up on me. I don't know why sometimes."***

Having lost his father during the Covid pandemic, and not getting the chance to see him because the hospitals were closed to visitors, Greg feels that when he gets a flat he will finally be able to spend time properly grieving:

"I didn't get the chance to say I'm sorry to my Dad, for all the things I done. If I can get my own flat, to be honest I just want to sit and grieve."

Daniel's Story



Daniel is in his mid-40s and has lived at Westbourne House for 8 months. He gets on well with staff and the other residents.

Daniel has served numerous prison sentences over the years and has known much violence throughout his life, since being a small child. He currently uses benzos but he is very clear that he wants to get off tablets and get himself well:

"I just want to get a nice flat, get it looking nice, that's all I want.

"I'm tired. As I get older I just want to see my kids one last time."

Daniel hasn't seen his children for 9 years. He has framed photos of them hanging in his bedroom at the hostel. He is very proud of his children and it is evident how upsetting it is for him that he isn't able to see them. He describes an encounter earlier in the week when he saw another man with his children and how emotional this made him, stirring up strong pain and distress.

Daniel is frustrated at how the outside world views him. He is open and transparent about his difficulties in life and the intensity of the anger which he feels:

"I've got all this hate in me. But I don't know what would help me, I need locking up to stop me. It was easier in prison as they provided everything for us.

"I have mad thoughts and I don't want to act on them."

Daniel is desperate for real help that will support him to improve his life, release his anger, and for the world to change its view of him. He has a good understanding of the abuse he experienced in his childhood, the way he was parented, and the experiences that shaped him growing up into a young man.

In particular Daniel tells a moving story of the way he is treated at the local Job Centre when he goes in for help to complete his paperwork. Daniel can't read or write and he is supported with his paperwork in the back room, rather than in the main room with the other staff and members of the public.

He feels this is because they want to hide him away and because they see him as like an animal.

There is even a plastic screen between him and the support worker. Daniel finds this really triggering and it reinforces his belief in how the world views him:

"I'm not an animal, you don't need to talk to me from behind a screen."

After breaking down in tears on one of his visits, the Job Centre is now taking steps to see Daniel without the screen in place.

Daniel enjoys films, music and television. He lights up when talking about his favourite scene in Peaky Blinders. He loves animals, particularly dogs, and interacting with them. He tells a funny anecdote about his time once visiting a farm.

Daniel is interested in weight training and boxing, though he is raw and open about why he wants to do this – so that he can be stronger than other men, especially those who would hurt him or have hurt him in the past. Daniel wants to act upon his angry thoughts but at the same time he desperately asks for help with them.

Although there are strong elements of anger in his story, this should be met without fear. Anger could be a key part of Daniel's healing. Having had no safe adults in his life nor safe male role models, Daniel was curious about the idea of men's groups or some sort of mentoring from resourced men.

Daniel doesn't feel like there is the right level of support from services for his mental health at the moment, with staff only spending limited time with him:

"We might only get half an hour and then the worker leaves, what good will that do? It just sets things off."

He also isn't sure that talking about what's happened to him throughout his life is the right approach: "Why do they want to open me up at 45? Open up boxes and memories?"

Daniel expresses remorse for things he has done in the past but also disbelief at the way he has been treated throughout his life:

"I didn't ask to come here, to this planet. All I've had is shit."

Matilda´s Story

Matilda is in her early 30s and lives at the William Booth hostel, which is run by Salvation Army. She has a history of homelessness and domestic violence, having fled her abusive partner.

Matilda currently uses alcohol but she is no longer using what she calls harder drugs. The Homeless Mental Health Team is supporting her to obtain housing and explore her traumatic past, offering support and low level psycho-education around PTSD.

With excellent money management skills, Matilda is looking forward to regaining some of her independence by getting her own flat, and is excited about the small things such as organising her own grocery shopping and doing her own cooking again.

In terms of recovering her mental health, she is really keen to understand anxiety and how panic attacks are affecting her in everyday life:

"I'd like to understand why I'm like this, why when I'm walking down the street anxiety just comes out of nowhere. I'd like to learn how to calm myself down.

"I've had CBT before but found it a bit boring and my therapist told me I wasn't ready and so she just discharged me.

"I just want help. Take my drug use out of it. I felt so deflated when the therapist sent me away."

Matilda would feel more comfortable accessing 1-to-1 mental health support as opposed to a group setting. She would consider the detox groups based at Trafalgar House and ReNew, but struggles to access them alone. If Matilda could have support to get to and from the groups, she would feel able to attend. She's also interested in women's groups for things like building confidence.

The Homeless Mental Health Team has been working with Matilda for several months and come to have a good relationship with her, to the extent that she knows they are always there at the end of the phone.

The next steps are finding Matilda more permanent housing and supporting her to achieve her goals. She would like some help to identify her likes and hobbies, as she has felt deflated for a long time:

"I'm 34, something has got to give.

"I'm great at giving advice but not at taking my own. I've lost interest in my old hobbies and not sure what they are anymore."

Matilda reminisces on how much she enjoyed visiting the Body Shop when she was younger and smelling all of the soaps and scents. There used to a kind of soap there which was similar to play-doh and could be worked into different shapes and objects. She loved going there to do this.

While talking about this, Matilda reveals that she is a qualified hairdresser and used to have girlie nights in with her teenage daughter. She is looking forward to getting her own flat so that she can invite her daughter over for these girlie nights again.

In her youth, Matilda was very active and creative. She took part in drama school and theatre classes, with dancing, acting and singing. She was nearly cast in a popular movie as a small child. She loves music and drama, and would love the opportunity to do this again, with costumes and even on stage.

When Matilda talks about her acting days at drama school, she lights up.

Michael's Story

Michael has a long experience of homelessness, drug-induced psychosis, and an acquired brain injury.

Michael was known to the Homeless Mental Health Team for a while until he began working with them. He was referred in 2020 and re-referred numerous times in 2021 while staying at William Booth hostel. During this time, Michael was very unwell and support services struggled to provide the help they so wanted to give him.

This culminated in the Homeless Mental Health Team leading a 'patient formulation' meeting, which brought many services together to support a shared understanding of Michael and to develop a plan for engagement. This would hopefully make services more accessible for Michael and be person-centred and patient-led. Ultimately, this would begin to build a trauma informed understanding of Michael and his life experiences.

Later in 2021, Michael made an attempt on his life and experienced several visits to A&E

with suicidal thoughts. During his time in hospital, mental health staff were able to forge a good relationship with him, setting the scene for additional contact with the Homeless Mental Health Team in 2022.

During this time in Michael's life, services all agreed that he faced a high risk of accidental death as a result of his substance use. Services also felt Michael was aggressive to other people and staff when under the influence. Unfortunately there was no hospital discharge plan in place for Michael except for discharge to the street, and eventually this is exactly what happened.

His 1-to-1 engagement with the Homeless Mental Health Team began therefore from a shop doorway on Newland Avenue, where he was found rough sleeping.

Throughout this period Michael remained at severe risk of accidental death and continued to experience regular hospital admissions. Services continued to aim for a multi-agency response, involving the Homeless Mental Health Team, ReNew, Probation, Hospital Pathways, Frequent Attenders, the Rough Sleepers Initiative team, Emmaus, and the police all working together to try and support him.

Eventually a plan was put in place and Michael was discharged from Castle Hill Hospital into an emergency bed at William Booth hostel. This bed was available for Michael from 8pm to 8am daily. It was anticipated that it would take 6 weeks for Hull City Council to obtain more permanent accommodation for Michael in the form of his own flat.

Michael finds hostels to be a very distressing environment and so to support him during these 6 weeks, a plan was made for daily contact.

This daily contact would be with one of the teams supporting him, to meet for a coffee, warmth, offer emotional support and to help Michael to remain substance free. The Homeless Mental Health Team were involved in this support, providing soup, clean clothes and showers for Michael at their base at the time at St Andrews.

Hull City Council obtained a cinema pass for Michael so that he had somewhere warm to go during the daytime, until he could return to the hostel at 8pm. Michael successfully managed this period with the support of the partner agencies until he got the keys to his new property.

The Homeless Mental Health Team continued to support Michael practically and emotionally once in his flat. He is so grateful for this support that he would like to volunteer in some manner for the team in future if this is possible.

Michael continues to be doing really well and is working with the team's Peer Support Worker to look at activities and moving on with his life. He has also been able to maintain his sobriety.

The team is really proud of Michael.

In Michael's own words:

"***Emma has asked me to write a quick story of how I've managed to sort myself out and more importantly how I've found a happier version of myself so here we go: I'll start with when I was in hospital for a bleed on the brain which I have no recollection of. I'm sure I probably got into a fight and got hit with something hard.***

"Anyway just before this my drinking had escalated massively, I had recently lost my dad and some close friends. I was in and out of hostels. The Crossings, Willy Booth, Westbourne, I've been in them all. I had been kicked out of the Crossings for a violent incident (I was assaulted and retaliated) and because I retaliated I was told you have 20 mins to pack your stuff and get gone. Wow. This was a massive trigger for me. Homeless, skint, cold. I was losing the will to live and did not want to wake up in the morning.

"I was shoplifting from 8am to 11pm, mainly alcohol and to fund my addictions to crack and heroin.

"I really was at the gates of hell.

"I think losing my father had a massive effect on me although I hadn't really grieved properly. Because of Covid I couldn't visit my dad in hospital. I was numb, emotionally and physically, and when I think back I realised I didn't have long left to live. My support workers tell me I was on their radar because I was at risk of death.

"During my stay at hospital I started seeing my key workers and they said here is a light at the end of the tunnel – but I just couldn't see it personally. How wrong I was!

"I had to go into the emergency hostel beds at Willy Booth for four weeks before I got a flat and it nearly killed me. I genuinely didn't want to wake up in the morning. Anyway I got a visit date to view the flat and it was perfect! Quiet, good neighbours, all brand new stuff. Oven, fridge, sofa and telly. Even loads of DVDs.

"On Christmas Day, I stopped everything bad. Drugs, drink, tablets – everything finished!

"Even though I was getting so much help from the teams I was doing my own bit as well.

"I was so determined.

"I've got to say Emma and Jane helped me massively when I was in Booth hostel. They let me get a bath and fed me up on soup meatballs! Everything! Emma and Jane deserve rewarding for what they do. I can't say enough how they affected my life and Chris as well – basically the whole team from start to finish. It felt fantastic for a change.

"I started believing in myself and my confidence and leaving all the shit behind (because that's what life is).

"Anyway now I'm about 90% of what I want to be and it feels so good. Thank you so much."

Trevor´s Story

Trevor is in his late 40s, Hull born-and-bred, and has been using the Homeless Mental Health Team for about a year.

He is a former drug addict and lost his leg to ulcers in 2015. Since then, Trevor has had an artificial leg and he speaks frankly and openly about his experience of this trauma. In time the Homeless Mental Health Team hopes to work with Trevor to offer more targeted support, because he is hearing voices. Trevor has been hearing voices for many years but he has never sought help for this before. In mainstream mental health services, hearing voices can still be very stigmatised and misunderstood.

Having recently moved into his own flat, Trevor is no longer rough sleeping or having to rely on hostels, and he has regained a lot of his independence and confidence.

He enjoys cooking homemade meals at his flat, such as lasagne, and entertaining friends and family members. The Homeless Mental Health Team are still present in his life, supporting him to appointments and to pick up his methadone prescriptions. The pharmacy is quite far for him to walk and his leg gives him aches and pains.

Trevor also gets on well with the peer support workers and staff at Trafalgar House, striking up strong friendships which support his confidence and recovery.

Trevor has found that maintenance work such as clearing leaves and tree debris at Trafalgar House helps to keep his mind focused. He is thinking of turning his efforts to the garden next to his new flat next:

"My mental health is not bad now, but I'd like to be a bit more busy.

"It would be good to get a paid job. I'd like to help others, and I can put my mind to anything."

Trevor speaks highly of the Homeless Mental Health Team as well as other homelessness services around the city and the services speak highly of him. In particular several of the support workers feel he could be a champion and spokesperson for amputees, such has been his recovery and adaptation to his disability.

Trevor had to learn to walk again following his operation and he recognises that he could be a positive role model for other amputees:

"I could help others who've struggled with narcotics. I've lost a limb, I could share my story.

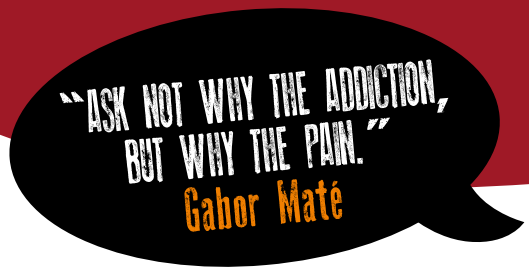
"Others aren't as good walking as me, I see them coming here in their wheelchairs."

Trevor enjoys Rugby League, weight training, boxing, and singing. He's a fan of Elvis, Buddy Holly and country music, normally choosing to sing these genres on the karaoke. He is also creative and enjoys drawing.

If Trevor could say something to his younger self it would be:

"You've done so well to get where you are, keep going."

Mapping Outcomes, Impact and Good Practice



In this section we take an early look at outcomes, impact and good practice across the *Homeless Mental Health Team,* before moving onto a view of learning and opportunities.

It will be helpful to recap the outcomes of the *Homeless Mental Health Team*. These are:

- the provision of trauma-informed care;
- a no-barriers approach to accessing mental health care;
- a taking account of Adverse Childhood Experiences (ACEs) in care planning;
- bespoke care that puts the individual at the centre of their unique care package, promoting participation in their own recovery;
- individuals able to make choices which improve their health and quality of life;
- improvements in an individual's self-reported wellbeing;
- a supporting of the treatment and improvement of health in those who are homeless;
- increased stability and quality of lives of individuals;
- a responsive and timely service;
- a positive experience of care delivered by service users;
- an integrated approach: that ensures joint working with other agencies i.e. substance misuse, housing, physical health services;
- a leading role in development of Psychologically Informed Environments (PIEs);
- registration of patients with their local General Practitioners;
- increased contact between the most vulnerable homeless people, appropriate mental health services, general practice care and other support agencies;
- care coordination and continuity of care from appropriate services upon discharge from the team;
- a positive experience of care and support;
- fewer people experiencing stigma and discrimination.

At the time of writing, the service is just under three years into its initial 5-year funding lifecycle.

As this report covers the service part-way through its first funding term, it may be useful to carry out a follow-up evaluation or report in late 2024 in order to observe any changes and map further impact.

Approach to Outcomes Data

In order to offer an *early view of impact and outcomes*, this report has employed the following method of data collection:

- **Quantitative data collection and analysis** e.g. Key Performance Indicators (KPIs), service milestones, service outputs, patient monitoring data, quarterly returns etc where these exist;
- **Qualitative data collection and analysis** – service user case studies and conversations; informal and ad hoc engagement with people who are experiencing homelessness at hostels and outreach clubs in order to capture their views, voices and

insights (as opposed to more formal methods of collection such as surveys and questionnaires); stakeholder and service staff conversations and insights-gathering, through informal interviews, meetings and in-person shadowing of the team; Stakeholder/Frontline Workers Online Survey.

The emphasis throughout the compilation of this report has been on the gathering of rich qualitative data, from staff, stakeholders and service users, as opposed to the more commonly-employed focus upon service outputs and KPIs. By emphasising human voices and experiences throughout this report, it is possible to offer a more holistic and creative (emergent) view of the service and its impact on people who are experiencing homelessness and mental ill health.

There are also practical reasons for employing this methodology: the unique needs and life experiences of the service beneficiaries are such that more formal data monitoring and capture (such as patient form-filling, feedback questionnaires and attention to KPIs) is inappropriate, stressful at times (for both staff and service users) and largely unhelpful. Reliance on old, repetitive patterns and traditional forms of data collection and monitoring could be seen as a non-emergent process, which is discussed in more detail at Section 5. It is hoped that through the holistic approach of this report that new forms of trauma-conscious evaluation for the aims of transformation and radical healing may emerge.

Current Limitations in the Outcomes Data

Incomplete quantitative data has been provided for the period January 2020 – end June 2022. Service capacity and resource, as well as the Covid-19 pandemic, has limited some parts of data collection or restricted it to more basic monitoring of patient demographics and numbers of referrals per month.

Where service capacity has been limited, this has been due to low or incomplete staffing and was a particular issue for the service in the period October 2021 – March 2022. During this period the team made the difficult decision to close for new referrals and focused on existing referrals and open cases until additional staff could be recruited. This has had a direct impact on availability of outcomes data.

It has also been noted earlier in this report that the completion of Mental Health Assessments with patients can take several months to complete, whereas for other patient cohorts this may be completed within the first appointment or consultation. The service also utilises the Pre-Treatment Model, prioritising relationship and trust-building, which can limit the availability of outcomes data and collection of monitoring evidence, simply as it is often inappropriate to ask for and collect this information during the pre-treatment process as it may dysregulate and disrupt the relationship.

In the supporting of service users, the completion of the Mental Health Assessment over a period of weeks or months is itself the clinical and professional intervention, particularly where patients have been traumatised by past contact with NHS and statutory services.

The prioritisation of relationship over [clinical or service] outcome is significant and radical because services and organisations “cannot be trauma-informed without recognising relationships as the basis for a sustained transformation from systems that can be trauma inducing to those that heal trauma” (Loomis et al., 2019). The service could thus be seen as working towards new models of outcomes capture and emergent evaluation practice, which work for (not against) the patient cohort.

To that end this report relies more heavily on qualitative data and insights, aiming to capture the ‘living wisdom’ of service users, staff and stakeholders who contribute to the *Homeless Mental Health Team,* something which cannot be achieved through quantitative data analysis alone.

The Hard Data – Referrals and Statistics (Outputs)

The charts below capture the known hard data for the service as it stands, between January 2020 – end June 2022.

Please note that it has not been possible to de-duplicate referral figures, and it is not known at the time of writing whether or not referral numbers include the re-referral of service users who have previously passed through or had contact with the service (and perhaps declined support or felt unable to engage at that particular moment in time). It is estimated that a proportion of the figures below will include multiple referrals for the same individual. This may be an area of refinement for future reporting and outcomes capture. It may help to understand if re-referral of individuals is a particularly common occurrence, to what extent this is happening, and what, if any, learning this might reveal.

No patient identifiable quantitative data was shared at any point during the compilation of this report, in order to maintain strict confidentiality and ethical standards:

Statistics	To Date (Jan 2020 – Jun 22)
Total No. of Referrals*	533
Male	75.7%
Female	24.5%
Other**	N/A
History of Mental Health	67%
Current Physical Health Issues***	16%
Current Substance Misuse (alcohol or drugs)	78%
Current Domestic Violence****	4.3%
Declined Support	9.7%
Mental Health Assessments*****	116

**it is anticipated that this figure includes duplicate counting / multiple referrals the same individual*

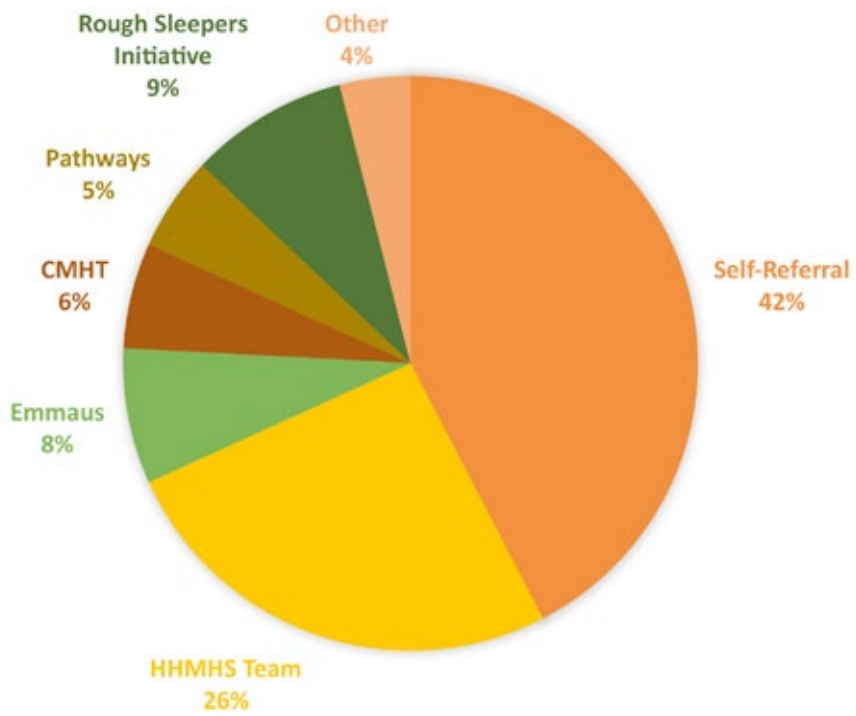
***further demographic breakdown unknown*

****no known data for 2020; estimated to be higher*

*****no known data for 2020*

******data only available for the period Mar-21 to end Feb-22; anticipated to be higher*

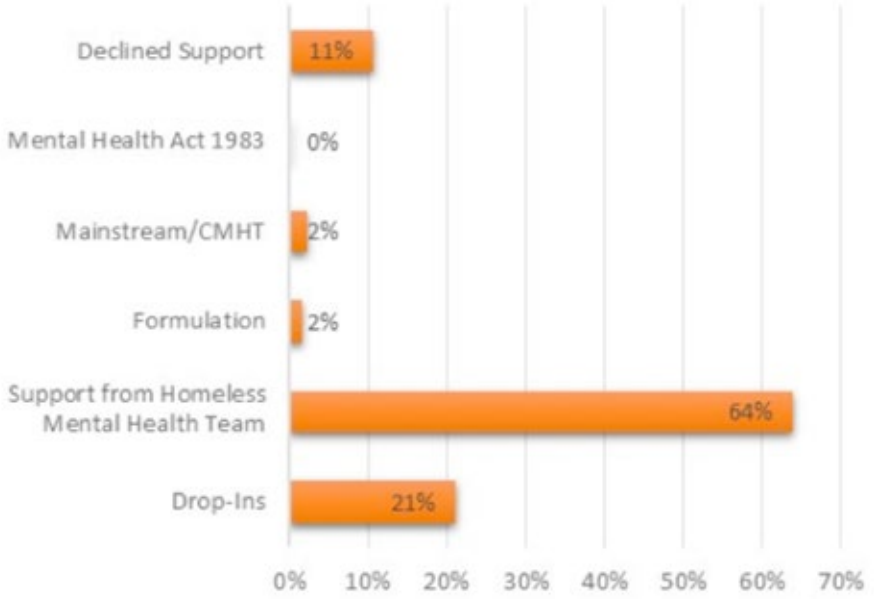
Referral Sources:



**In the chart above, HHMHS stands for Hull Homeless Mental Health Team.*

The majority of service users self-refer (42%). This is via the mental health drop-ins, outreach groups e.g. Breakfast Clubs or via their hostel support workers. One-quarter (26%) of referrals are via the Homeless Mental Health Team themselves, and these referrals may come about organically such as via drop-ins, time spent at hostels, supported living and on street outreach, and spontaneous contact at outreach groups e.g. Breakfast Clubs.

Referral Outcome:



Over half (64%) of referrals go on to receive one-to-one support from the *Homeless Mental Health Team* and join the caseload of the team, the process of which is described in Section 1.

Just under one-quarter continue to attend the mental health drop-ins (and may go onto receive one-to-one support or may already be doing so at the same time).

Service users who decline support for whatever reason or circumstance is around 9% - 11% at the time of writing, based on available data.

Stakeholders and Frontline Workers Online Survey

As part of the data- and insights-gathering process, an Online Survey was carried out with frontline workers and professionals who have had contact with the *Homeless Mental Health Team* across Hull.

This survey consisted of 10 Questions, predominantly open-ended, and was aimed at the capture and baselining of high level stakeholder feedback. A copy of the full survey has been included in the **Appendices** to this report.

A brief look at the most useful data from the survey is summarised below.

Altogether, **19 complete responses** were received to the survey from stakeholders and frontline workers either involved with, connected to, or aware of the service:

- **Professional awareness of the service** – the majority of respondents (17) were aware of the *Homeless Mental Health Team* and the team's work; of the 2 respondents unaware one of these was a worker from Job Centre Plus.

- **Making referrals into the service** – the majority of respondents answered positively, noting the service is easy to access and contact. Issues were noted around getting service users to engage with the Mental Health team and that multiple drop-ins were sometimes required. The direct telephone contact number and access was noted as particularly helpful.

- **Number of referrals made to the service** – this varied by respondent but is shown in the chart below:

- **Satisfaction with contact and communication** – 18 out of 19 respondents were satisfied with their contact and communication with the service. The only answer in the negative came from the stakeholder at Job Centre Plus who was unaware of the service.

- **Short-term improvements to the service** – a range of suggestions were provided, some key ones shown below. Increased staffing levels appeared most frequently:

"More staff!"

"Increased mitigation regarding rough sleepers who are unlikely to engage in drop-ins as the client base struggle to attend appointments. For example, more informal sessions; professionals going to them rather than them going to professionals. Additionally, increased sharing of information regarding the service-user's mental health. It seems difficult to ascertain a client's mental health based on a few meetings (in regards to successfully getting a referral), information could be attained through liaising with hostel workers more and going through past incidents in relation to their mental health at the hostel."

"I feel having the team working remotely each day at the city centre hub would benefit, instead of only part week. However I appreciate by doing this provision this would probably remove provision from another area within the Changing Futures workload."

"Due to current demand, more trained staff with a passion for working with homeless people."

"I do not think there is anything that needs to be improved in the short term, there is always someone available to talk to and ask for advice."

"This team would benefit from having more extensive staffing available. The large client base and need to maintain a flexible approach to engagement mean the service can be restricted in their opportunities to outreach if not fully staffed."

"I feel the team need to have more influence within Humber to gain access to specific services for individuals where in their clinical view it best supports the client. It may be that this has improved significantly since 2020."

"More staff members to cover more locations, some services are limited to due to lack of staff. More OT, peer support work."

"To be more consistent. Service users need consistency to engage. The drop-ins are changed a lot."

"As the partnership agencies have grown with funding, staffing and resources, it has made a greater demand upon the Rough Sleepers Service for referrals in or for consultation. The team have struggled to be as reactive as partner agencies may request or like. The team would benefit from an overview of what the team was set out to do with the initial funding compared to what the team accomplish now and consideration for an increase in funding/staffing. The team are looking at providing something more substantial to 16 year old's which is another area to staff and resource. The team would benefit from a resource close to the city centre where we can offer an informal drop in/coffee morning for those in hostels so that the team can work smarter and in a pre-treatment approach. We already contribute to those offered by Renew. Emmaus and City Centre Hub, however there are barriers to people attending each of these areas, such as dislike of the agency hosting , or police presence as in the city centre hub." [Comments from team member]

"Offering volunteer or peer support activities for our client base who have moved into properties and who struggle with isolation, and the change of being in a property." [Comments from team member]

"It may be helpful for the drop-in services to be fine-tuned, as sometimes they are not being used to the best of their ability."

- **Meeting the needs of the homeless community across Hull** – the chart below demonstrates that the majority of stakeholders feel the service is either somewhat meeting the needs or meeting the needs. 5 respondents answered 'other' and their rationale for this may be covered in the following question:

- **Ideas for long-term improvements to mental health services for the homeless in Hull** – please note this question was deliberately phrased to mean *all mental health services* and not only the Homeless Mental Health Team, in the hope of drawing out wider knowledge and insights to support future development e.g. public education campaigns. Again, increased staffing was a popular choice:

> ***"A bigger team would be advantageous as it would allow for more people to be seen on a more regular basis."***
>
> ***"Increased planning surrounding a procedure for suicidal rough sleepers. Currently, the system in place is an endless cycle of waiting on hold for hours for crisis team, being referred to calling an ambulance, being referred to crisis team, told to contact GP or call an ambulance. There's no system in place for immediate suicide prevention, help is only sent when someone has already self-harmed or tried to commit suicide. There also appears to be a lack of engagement from external professionals, that do not regularly deal with rough sleepers, when mental health issues are induced by substance abuse. I think there should be plans to increase their awareness of drug induced mental health issues as these people are still suffering at the end of the day."***
>
> ***"I am unsure of the provision already in place but do feel having a mental health professional based within each HRA could be really beneficial."***
>
> ***"A community pod where clients know they can access the service daily, with walk in available."***
>
> ***"A campaign to let people know the best way to help the homeless when they come across them."***
>
> ***"Greater professional education around the risks associated with mental health, the focus of the pre-treatment model, and Psychologically-Informed Environments."***
>
> ***"More staff, more funding, more provisions for clinics for clients to attend - central of the city, safe environment and clinical."***
>
> ***"Increase staff numbers and provide a more accessible base for client group to access the service more flexibly outside of the hostels."***
>
> ***"Anything that will close the time-gap between clients consenting to access the service and seeing a professional would be welcomed, as above more frontline workers, daily presence in safety hub etc."***
>
> ***"Access to trauma therapy as and when the individual is ready to access it and for this to be available for as long as the person needs it. Access to dual diagnosis specialists as a standard offer."***
>
> ***"More in-depth training around trauma for hostels, services like Renew and Hull City Council housing officers."***
>
> ***"Increasing training and provision for women who are rough sleeping or at risk of homelessness, and understanding how best to engage with this population."***
>
> ***"More funding/staffing provision to cover 16-18 year olds."***

- **Areas of Best Practice –** respondents were asked to comment on any areas of best practice that they were aware of and able to share. Several examples were provided:

> ***"Apart from great mental health social work, no! I believe that the team, as is, offers a fantastic, different, way of working with people who are homeless or at-risk of being."***
>
> ***"I think lately there has been slightly more interaction between external mental health professionals that deal specifically with rough sleepers and I think that is showing to be beneficial for the service-users."***
>
> ***"There has been numerous occasions were we have seen best practice here is just a couple to share. Paula [redacted] and Emma [redacted] went to see a gentleman that is sleeping on the streets, he was very difficult to engage with and would not really open up to us and was only saying he was fine and to leave him alone. Paula and Emma visited and introduced themselves and they managed to have a conversation with him. The gentleman even agreed to speak again and also would stand up and talk with them as he felt rude laying down and speaking. This was a huge achievement and we would like to thank them for speaking with him as he is a long term rough sleeper and hopefully with continued interaction from them he will eventually agree to come indoors."***
>
> ***"Another example of where best practice was witnessed by ourselves was Paula [redacted] and Chris [redacted] was very quickly involved with a gentleman that presented at Miranda***

House, he presented at night and they asked if we knew of him. We did and they agreed to speak with him and he was struggling massively with his mental health. The gentleman is looking at going back to Poland to live with family but said that he feels that he could not fly due to his mental health. Both Paula and Chris have had a chat with him through an interpreter and are going to carry on supporting him until his flight home. I was very grateful that they came to see him and he also felt at ease that someone was there to help and offer some support surrounding his mental health."

"Joint working with services, working collaboratively to ensure best patient care."

"Have known this team work very effectively in engaging vulnerable, hard to engage patients in hostels and hospital, as well as following up patients into independent housing. Demonstrated a dedicated and flexible approach using a broad range of disciplines and experience."

"Timescales for contacts!"

"Psychologists formulations to support services to work to meet the needs specific to that individual - this has been vital in keeping individuals with significant mental health problems in accommodation."

"The pre-treatment approach and stabilisation work is something we work well at as a team." [Comments from team member]

"Stabilisation work, relationship building, gentle approach."

"The low engagement, high intensity approach has been successful. When a person cannot or will not engage with mental health, however there is a clear need and a great demand on other services. We work with professionals and agencies to develop a plan and formulation, rather than simply discharge." [Comments from team member]

"The only thing to mention is that everyone within the homeless mental health team are doing a great job, I know they will be under extreme pressure to provide mental health support to those that are homeless, we are grateful that they are around to speak with if we have got any concerns."

"Not all rough sleepers stay in the city centre so would be nice to be able to have a contact number given to all officers so that appointments can be arranged for those harder to reach rough sleepers."

"This is an effective and valuable team for the homeless population of Hull which benefits from an experienced, hardworking and passionate team, but which is limited by the resources available to them."

"I really enjoy working with the team."

"Communication between services needs to improve."

"The team recognise that when a person does not have the basic necessities such as shelter, warmth, food, money etc alongside the other factors that contribute to homelessness such as trauma, substance use, etc, that they may present with mental health difficulties, however their mental health is not the aspect that the person prioritises as a need at that time. We have recognised that the pre treatment approach is most beneficial and that builds to a better relationship when they have met their basic needs. The team make themselves visible but not assertively so at Breakfast clubs and other activities, venues, hostels, across the city." [Comments from team member]

- **Other Comments / Miscellaneous –** respondents were offered the opportunity to share any final thoughts or anything not covered in the above questions. Several stakeholders shared additional comments:

RAG Rating of the Service Outcomes

Based on the above information as well as the qualitative data showcased throughout this report e.g. in Section 2, it is possible to establish a current **RAG (Red Amber Green) Rating** baseline for the service's outcomes, at this midway point through the initial 5-year funding term.

This is provided in the table below alongside brief commentary:

Outcome	Current RAG Rating	Notes
1) the provision of trauma-informed care	GREEN	All members of the team actively consider trauma and ACEs across their work with service users, and promote awareness of this across the city e.g. via PIEs, reflective practice, formulations, influence. This is clearly recognised by stakeholders.
2) a no-barriers approach to accessing mental health care	GREEN	The service operates a no-barriers and highly flexible approach in its work with service users which is recognised by partner agencies.
3) a taking account of Adverse Childhood Experiences (ACEs) in care planning	GREEN	ACEs are considered in care planning, Mental Health Assessments and formulations. They are promoted as part of the PIEs development. Stakeholders and partner agencies are interested in additional support around this.
4) bespoke care that puts the individual at the centre of their unique care package, promoting participation in their own recovery	GREEN	The service actively aims to provide person-centred care and support, deploying a strengths- and assets-based approach and championing this with stakeholders and frontline workers. Qualitative evidence suggests service users recognise this.
5) individuals able to make choices which improve their health and quality of life	GREEN	Qualitative evidence suggests that service users feel able to express their choices and work towards improved quality of life. This is supported through the Pre-Treatment Model approach.
6) improvements in an individual's self-reported wellbeing	AMBER	This has been marked Amber due to lack of additional quantitative outcomes data e.g. Recovery Star or ReQoL. However this is likely to become Green with a refinement of the service specification and increased / clarified focus on outcomes capture (and perhaps additional staff training to enable). Qualitative data indicates improvements and further potential for improvements.
7) a supporting of the treatment and improvement of health in those who are homeless	GREEN	This is confirmed by stakeholders and frontline workers but requires additional measuring or refinement.
8) increased stability and quality of lives of individuals	AMBER	See notes against Outcome 6.
9) a responsive and timely service	GREEN	Feedback from stakeholders and frontline workers is strong against this outcome.
10) a positive experience of care delivered [reported] by service users	GREEN	Qualitative evidence e.g. case studies and service user feedback indicate this is positive. Further measurement tools could be employed to build upon this picture.
11) an integrated approach: that ensures joint working with other agencies i.e. substance misuse, housing, physical health services	GREEN	Frontline workers and stakeholders have consistently confirmed this is happening. Main feedback for improvement is around more regular updates from the team on the status of referrals and what is happening to support service users. Patient Formulations are a good indicator of strong partnership working and these are appreciated by partner agencies.
12) a leading role in development of Psychologically Informed Environments (PIEs)	GREEN	The team is actively taking a leading role in awareness and creation of PIEs and is passionate about this work.
13) registration of patients with their local General Practitioners	GREEN	The team actively supports primary care management on behalf of service users. Main feedback from stakeholders is that the team don't necessarily need to fulfil this function as Hostel Support Workers should already be doing this.

14) increased contact between the most vulnerable homeless people, appropriate mental health services, general practice care and other support agencies	GREEN	The service and its team are very visible, flexible and active, working in joined-up ways with other homelessness services, physical healthcare, primary care, social care and housing. They perform advocacy work and accompany service users to appointments. The service has a key linkage role in the city but could benefit from a clarification of its identity amongst existing services in a changing funding and provider landscape. See Section 6.
15) care coordination and continuity of care from appropriate services upon discharge from the team	AMBER	No service users have been discharged at the time of writing following long-term 1-to-1 support, e.g. into mainstream or CMHT provision. Existing discharges have come through patient declining support or engagement difficulties for the team where no further action is taken by the team unless in the event of re-referral.
16) a positive experience of care and support	GREEN	Qualitative data and feedback from frontlines workers and a modest number of service users indicate this is positive.
17) fewer people experiencing stigma and discrimination	AMBER	No measurement tool is currently in place for this. This outcome could be tracked as wider impact in a later report.

This is a large number of outcomes and it is recommended that as part of the refinement and 'take-stock' exercise (see Section 6), that these outcomes are condensed and agreed upon to a smaller, more-focused set.

This could be used as an opportunity for lived experience input and the emergence of new (perhaps radical) models of healing and intervention for this patient cohort. See Section 5 for more commentary on this.

Recovery Star and future Outcomes Capture

The team is looking to implement the 'Recovery Star' and staff training was planned at the time of writing. The Recovery Star is a tool used for supporting and measuring change when working with adults who experience mental ill health.

The Recovering Quality of Life (ReQoL) survey was originally planned for use and is mentioned in formal commissioner reporting, but no data is available to date. ReQoL was developed specifically for the NHS by the University of Sheffield. It has two versions: a brief 10-item measure (ReQoL-10) and a 20-item measure (ReQoL-20). The surveys aim to assess the quality of life for people experiencing mental ill health.

The Clinical Lead has noted that the service still uses ReQoL where possible, but as per the Pre-Treatment Model the service is not assessment-focused. Originally the team had plans to complete ReQoL assessment after 3 sessions with a service user, and then repeat periodically. Realistically this tends not to be feasible because support to service users will not be at that point after 3 sessions.

Service Impact

Impact and outcomes within programmes can often be confused or overlapped, and it is worth making the quick and hopefully helpful distinction for the benefit of readers:

> ***Outcomes*** are shorter-term and intermediate changes that occur in service users / clients / beneficiaries, staff and stakeholders as a direct (or sometimes indirect) result of the programme's activities, inputs and outputs. These outcomes can be long-lasting but come about within the lifetime of the programme and are ideally measurable.
>
> A good example of a service outcome might be: *"increased quality of life for service users"* or *"improved confidence in accessing services in the future."*
>
> ***Impact*** is about the broader (often systemic) and long-term changes that occur within organisations, communities, populations and society as a result of the programme's outcomes. Impact may not come about until several months or years after the end of a programme.
>
> A good example of a service's impact might be: *"there is less repetition and duplication of services"* or *"there is less stigma towards homelessness in the general public and a greater appetite for change going forwards."*

It is difficult to plan for impact during the conception of a service or programme, as the theory of change does not always accurately identify what the future impact may be. Impact is often determined and measured later, during the evaluation of a programme or a reflection period.

Looking at the impact of the *Homeless Mental Health Team* needs more time. This report has focused on the capturing of its rich data to date and will support in the realisation of impact at a later stage. It is recommended that the service begins to think about impact, legacy and sustainability around the 4-year mark, so this would be circa January 2024.

When the times comes the following areas of work may benefit from impact analysis:

- The introduction and delivery of the Pre-Treatment Model;
- The introduction and adoption of Patient Formulations across the service;
- Psychologically Informed Environments (PIEs);
- Reflective Practice across the service and the city;
- The movement towards trauma informed care and trauma informed transformation in Hull;
- Perceptions of people who are experiencing homelessness, addiction and mental ill health;
- Perceptions of mental ill health including personality disorders, psychosis and schizophrenia;
- Understanding of Adverse Childhood Experiences (ACEs) and their effects on later life across the city including understanding within the criminal justice system, police etc;
- Understanding of and perceptions of neurodiversity (including Autism, ADHD, ADD, Dyslexia) and its links to trauma, homelessness and addiction;
- Burnout, compassion fatigue and vicarious trauma across Frontline Workers in homelessness, addiction and mental health services; also staff morale;
- Psychological frameworks and mental health interventions for the treatment of Complex Trauma or Complex Post-Traumatic Stress Disorder (CPTSD) including innovations.

Good Practice

There are several areas of emergent good practice identified during the compilation of this report, as reported or commented upon by stakeholders, service users and staff. These might be revisited in future reporting and analysis:

- **The Pre-Treatment Model –** the focus on trust-building and relationship-building has been key in successful service user outcomes. It is worth continuing to expand this model and bring any broader learning or innovation into mainstream services;
- **Flexibility and visibility of the service –** in order to be effective at delivering the pre-treatment approach, the team have embodied high flexibility and visibility. Stakeholders attest to this and through the compilation of this report it has been clear that flexibility and visibility are prioritised and valued for the aim of increased engagement with service users. This demonstrates high quality barrier-less and person-centred care;
- **Psychological Formulations –** these have been well-received by stakeholders and frontline workers and offer opportunities for increased joined-up working and integration of services and expertise across the city. They have also supported trauma understanding and education;
- **Fostering a new holistic approach –** the service has identified a more holistic form of psychotherapeutic intervention that may be more beneficial to service users, and which complements the pre-treatment approach. The service is keen to continue to explore this and build upon their learning by trialling new approaches, such as groupwork and peer mentoring. The team also recognises the importance of a ‘hub’ or day centre of some kind. This work could start to build an evidence base for more holistic forms of psychotherapeutic intervention in the treatment of trauma and complex trauma. See Section 4 for more information;
- **Psychologically Informed Environments (PIEs) –** the service is supporting the awareness and development of PIEs across Hull, in close collaboration with other services such as Changing

Futures and MEAM. The service has good evidence for and experience of the value of PIEs that cannot be undervalued, and this works well alongside the pre-treatment approach. Further information on PIEs was shared in Section 1;

- **Partnership Working –** stakeholders and partner agencies have been highly positive in their experiences of working with the team and the service. The value of joined-up working is recognised and the team are seen as a key 'link' in the city's services for homelessness. Partner agencies wish the service to grow and continue to expand;
- **Regional and National Collaboration –** members of the team play a key role in wider regional and national emergence of good practice for working with homelessness, most notably through their participation in a national forum, consisting of other NHS and homelessness services from across the country. The Clinical Psychologist and the Clinical Lead in particular are recognised by national peers for their contributions to the field of learning and practice, and their insights and experience are highly valued. This is an opportunity for greater regional and national collaboration, supporting the innovation and transformation of mental health services for people who are experiencing homelessness. Importantly, this ongoing learning around trauma and complex trauma may be relevant to mainstream / CMHT services and thus support wider systems transformation;
- **Reflective Practice –** the team makes frequent use of reflective practice internally to support each other in their roles and is able to model this for partner agencies. The team also provides reflective practice to external organisations involved in homelessness support, and this is well-received. Reflective Practice is also a key component of Psychologically Informed Environments (PIEs), meaning the team is doing its best to "practise what we preach."

Areas of learning which may support future areas of good practice as well as build upon these ones have been explored at Section 4.

Conclusion

The *Homeless Mental Health Team* is making strong progress towards its outcomes and is beginning to make in-roads into longer term service impact across Hull.

Some of the most important outcomes and insights are to be gleaned through the Pre-Treatment Model for patients and relationships with other support services and professionals. Strong qualitative data is also emerging through the voices of service users and people who are experiencing homelessness and these voices contain important wisdom for the road ahead.

The service and the team are well-placed to trial a more holistic model of healing, with the flexibility to work differently and the passion to build effective pathways towards recovery. They also have access to co-production and lived experience through their existing service users which could be harnessed to support the emergence of a radical new, holistic offering.

Learning and recommendations towards achievement of this are offered in subsequent sections of this report.

SECTION 4

Learning, Challenges and Opportunities

Throughout the compilation of this report, team members, stakeholders and service users alike have identified learning, areas of growth, and opportunities across the *Homeless Mental Health Team.* This includes areas that may benefit from additional resourcing.

It can be helpful to view learning through the lens of offering **both** challenge (especially to the way we are used to doing things) and also opportunity (particularly the chance to do things differently), as opposed to an either/or interpretation.

This section has sought to capture learning, challenges, gaps and opportunities across the team's direct service. Inevitably, owing to the interconnected ecosystem of homelessness support across Hull, some of the learning and insights gathered here are applicable to the wider system. The distinction is made where emerging insights apply to the overall landscape of services.

Areas of Key Learning and which may benefit from additional resourcing

Dual Diagnosis and sharing staff expertise across services

The Homeless Mental Health Team noted that they may benefit from a support worker with expertise in dual diagnosis, be that a nurse, social worker or other. Other services in the city already have access to Dual Diagnosis expertise via nursing (e.g. ReNew). It may be worth exploring, as part of a 'take stock' exercise, where there are areas of greater collaboration available to services and what this may look like in practice e.g. sharing staff, co-locating. This would help to avoid unnecessary duplication of resourcing at the same time as bring services closer together into a 'One Team' approach. Since the compilation of this report, dual diagnosis capacity has been identified to support the Team.

Greater integration between services in Hull may look like the co-development of a shared Theory of Change or the adoption of shared outcomes across the city. This could be very innovative and contribute to the Trauma Informed City and MEAM initiatives. This forms a recommendation in Section 6.

Access to a Prescribing Function within the team

The service is unable to prescribe medication or advise on medication and may benefit from this function. It is believed at the time of writing that a new GP post is soon-to-be joining the service which would alleviate this for the team.

Greater Access to Nursing

Several stakeholders identified Mental Health Nursing as a gap in service provision. Hostels in particular felt they would benefit from nursing intervention, advice and guidance, ideally supporting both service users and hostel staff on a daily basis.

See further commentary below: 'Hostel Support Worker.'

More understanding of Neurodiversity and Trauma

It is thought that as many as 12% of rough sleepers in the UK present with behavioural characteristics consistent with autism (Making Every Adult Matter, 2020). Speaking with frontline workers across the city, it is probable that this percentage is much higher and as yet uninvestigated in Hull.

At present the trauma support needs of autistic and neurodiverse adults (including Dyslexia, ADHD, ADD and other diagnoses) are not well understood and can be missed, minimised or mis-formulated as 'challenging behaviours' (Morris, 2022).

Westminster is one MEAM region which has taken on this area of under-researched intersectionality, recognising the interplay and overlap of neurodiversity and trauma histories. Understanding more about the ways neurodiversity presents in homelessness as well as in traumatised adults may be a role for a specialist 'Neurodiversity Support Worker' or Research Consultant. It might also support patients to receive a diagnosis and come to have a greater understanding of how neurodiversity has impacted on their life experiences. This work might contribute towards a more 'neuro-inclusive' city and may inspire similar work across the region.

This is an area that can be developed for lived experience input and could draw from a wider neurodiverse population outside of homelessness to offer innovative and transformative insight into healing and recovery challenges.

Crisis Intervention / Liaison Support Worker

The service has gone to some lengths since its formation to establish its identity across the city and this has included clear communication around its role in crisis situations. The team, commissioners, and the majority of stakeholders understand that the *Homeless Mental Health Team* is not a crisis service and does not offer crisis intervention or assistance.

That said the team do work closely with the Crisis Team at Miranda House and it has been helpful to co-locate together.

In order to be able to offer a wider range of support to people who are experiencing homelessness and mental ill health, it could be worthwhile to explore a Crisis Intervention / Liaison Support Worker (or Nurse) that could work closely with crisis teams and blue lights services across the city, as well as manage a post-specific caseload. This may be particularly effective in outreach to hostels and supported living environments, as it may mean fewer instances of people who are experiencing homelessness becoming banned or evicted from premises.

> ***"When we first started there were some expectations from other services that we come in and "fix" service users' behaviours or stop them acting out."***
>
> ***"If someone is in and out of crisis, are we the right service for that person? And if it's not us, then who?"***
>
> ***"It sometimes feels as if nothing is happening for the client we've referred and their mental health."***

A dedicated Hostel Support Worker

Frontline workers based within hostels and supported accommodation were generous with their time during the compilation of this report. They are positive and enthusiastic about the work of the *Homeless Mental Health Team* and many of them have taken up the offer of reflective practice from the team.

In order to offer additional mental health support into hostels, staff would welcome a Hostel Support Worker role or similar to focus on mental health and be exclusively based between the hostels. This would predominantly offer support to residents but would ideally be available to offer advice, guidance and encouragement to staff too, particularly when they aren't sure what the best course of action is for a service user.

The hostels would like greater consistency in the mental health drop-ins, and more feedback from the team on referral progress and what is happening for service users, without breaking confidentiality or consent. There is also concern that Hull City Council service users (through the Rough Sleepers Initiative or MEAM) appear to receive priority over hostel residents e.g. they are seen first, however it was felt that the Changing Futures Programme was proactively addressing this. Closer working with hostels and more regular check-ins with staff may support greater integration and joined-up working across the city.

It is also noted that a Mental Health Support Worker (or Nurse) would be able to support hostels in the creation of Psychologically Informed Environments (PIEs) and perhaps aid in accelerating this process across the city.

Development of a reimagined and bold new Holistic Psychology / Psychotherapeutic Support Model

The team has been honest that there are normally no more than a handful of service users ready and willing to work with the Clinical Psychologist at any one time. At the time of writing, the Psychologist's caseload was 5 patients (this does not include additional formulations that may be requested for other service users).

Throughout the compilation of this report it became evident that many stakeholders and service users, as well as the Homeless Mental Health Team, felt that non-clinical interventions and a more holistic model of support may draw increased engagement and better outcomes for people who are experiencing homelessness and mental ill health. This may mean moving towards to an ambitious *'build-it-and-they-will come'* philosophy, being bolder and braver in what we do and what we commission.

Some ideas offered by stakeholders and echoed by service users are listed below:

- Hostel staff felt that **holistic and practical groups** would be worth piloting, as it's difficult to predict what will bring residents out of their rooms. Groups might be based around art classes, crafts, baking, collage-making and pottery. These might not be marketed as 'mental health' but the Homeless Mental Health Team could co-facilitate these or just be on hand to support with engagement and interaction. Groups may be similar to the work of Activities Coordinators in residential care homes in terms of their variety.

The Homeless Mental Health Team have also observed that service users **respond and engage well outside / outdoors** e.g. taken for a walk or away from the hostel (or supported living) environment. Holistic provision might explore outdoors-based groups and activities such as gardening, nature and woodland walks, bushcraft, whittling and woodwork, fire-lighting, conservation, access to green spaces, forest bathing, hedge-laying and tree planting, wildlife-spotting and outdoor therapy.

- The team and other stakeholders felt that the city was lacking in dedicated and accessible **Day Centres** for people who are experiencing homelessness. Unlike other cities such as Leeds and Manchester, service users have very few places to go to during the daytime, as demonstrated in our service users' stories in Section 2. Because of this, people may be more likely to rely on substances to get through the day, or roam around city centres with no real purpose or safe place to go. Dedicated day centres would offer a warm space, food, activities and safety. Upon exploring this concept further with stakeholders and service users, the following picture began to emerge of what such a Day Centre could look like:

Operated as a 'cooperative' or social enterprise, day centre users, staff and volunteers are equal, feel valued, and there is no hierarchy. It is a bustling hub which is bright, warm and inviting, with nice seating areas and sofas – the sort of place you'd be proud to be seen at, and happy to send your children to, or say that you worked there. There could be a public café, where centre users can volunteer and build up their skills and qualifications, and feel that they're giving back to the community. But also a space to provide food and areas for cooking and baking. There would be a salon, where people can get their hair cut or their nails done, or even go for a massage or physiotherapy. There would be a games room for pool, darts, board games and video games. A gym and a sauna, maybe even a swimming pool! The Centre would provide access to exercise classes and personal trainers, strength and conditioning, even nutritionists and health coaching. There could be dance classes, yoga classes, and meditation. There could be a communal lounge area with a small stage, to host Open Mic Nights and live music, with local musicians coming along to play to all the community – not just centre users and staff. There could even be comedy nights and karaoke or a choir and singing lessons. Outside there would be a big garden, with gardening opportunities and an allotment to grow vegetables. There would be trees, plenty of trees, and bird boxes and bat boxes to encourage wildlife. There would be designated quiet areas too, and a sensory garden to support neurodiverse visitors or people who just want to get away from modern life for a bit. There would be a big car park, a 'crash pad' with maybe 5 bedrooms for emergencies, and air conditioning for those hot summer months. Everyone in the community could use the Centre equally, but knowing it is there to support vulnerable people to get their lives back.

It is noted that this is outside the remit of the *Homeless Mental Health Team* but it may be something that it can influence or contribute evidence for.

- **Day Trips** and **Days Out** were identified by the majority of stakeholders as being a missing area of service provision that would improve lives and mental health quickly, but it is again noted that this may not be within the remit of the service itself. Frontline workers note that many of their service users have never left Hull in their lifetime. Some people have never seen the sea or visited the seaside, and other childhood rites of passage that many of us take for granted were absent in their lives. One hostel worker told a story about a young man who packed an entire suitcase for a day trip to Flamingo Land, complete with sweets for the journey, explaining that he had "never been on holiday before." She remembers his reaction when he saw a tiger for the first time. Pets and animals, particularly dogs, are popular amongst all service users spoken to and it would be worth exploring if animals and contact-with-animals could be incorporated into more support and provision.

- **Clinical Psychology in homelessness and mental health –** throughout discussions with stakeholders a key theme emerged around the role and efficacy of clinical psychology across the service. Although many stakeholders noted the value of the Clinical Psychologist within the service, in particular for support to patient formulations and reflective practice, the role of 'psychology' itself was less well understood. This included the psychotherapeutic interventions on offer – many frontline workers and professionals were unclear on what these were and how they were being offered to patients.

Although the 'psychology in hostels' model forms a part of the service specification and may work well in other areas of the country, this is yet to be realised in Hull. The team have been open and honest about their patients' appetite for psychology and a psychological approach, and it remains unclear how effective this model has been to date.

Furthermore, stakeholders and commissioners have felt that the provision of psychology has not been visible or present enough for a specialist mental health service and that this could be improved, e.g. within community settings/hubs and hostels.

It is possible that a disconnect has arisen between the original service specification and the efficacy of what works in practice for this patient cohort. The Clinical Psychologist within the service shared important observations of the appropriateness of the traditional psychological frameworks – that to an extent these require unlearning and re-envisioning for the patient cohort, particularly within the delivery of the Pre-Treatment Model.

This was echoed by senior stakeholders who felt that the service would benefit from more creativity and a "letting go" of psychological frameworks. Several key stakeholders felt that an "emotionally available and consistent adult" who could work purely on self-esteem was one of the most powerful interventions for this patient cohort – professionals who could help people see that there is "more to life" and a different future is possible. This might involve an approach more similar to coaching. Other ideas included integrating people more with their local community and groups/activities, encouraging reliance on the community instead of on professionals: "social isolation kills us, not our heart conditions." Stakeholders emphasised more flexible, dynamic and outside-the-box thinking, including more public health-driven initiatives and non-clinical intervention. Human connection was emphasised as well as co-produced personal plans with 'one named contact' and lead worker for each individual.

Other stakeholders felt that the rule book could be torn up completely, especially as the service isn't constrained by the Mental Health Act. This is something echoed by the team too: "let's be prepared to be radical and different."

It is acknowledged that recovery is unique to each individual and that their aspirations need to be front and centre of any therapeutic work. It was noted that 'what' service offers this holistic, non-clinical approach to the patient cohort isn't necessarily important, whether it is the *Homeless Mental Health Team* or it isn't, but it is what's needed. The rules of what it means to be a psychologist could be completely taken off and redefined. Perhaps instead of direct one-to-one provision, the psychologist could support the creation of therapeutic environments and building of relationships.

Upon further exploration of this theme with the team, it is clear that the value of the Clinical Psychology Role is high and a key part of leadership across the service – supporting patient formulations, reflective practice and team wellbeing, application of specialist clinical knowledge, working with psychosis, hearing voices, and looking for possible brain injuries etc:

> ***"Without a psychologist in the team, backing us up, everyone is stabbing in the dark."***
>
> ***"If we know there's a strong history of trauma or particular complexity, the psychologist takes the lead on building the pre-treatment relationship."***
>
> ***"A lot of the client base isn't ready for psychological intervention, it's unrealistic. It took time for us to see where psychology fits within the service."***
>
> ***"We are supporting individuals to get to the level where they can engage with other services, such as CMHT. The core basis of our relationship is the self-esteem and trust work, but once that's in place you still need the expertise to offer the specialist service. You need qualified staff to do that."***
>
> ***"You can't quantify some of the stuff that psychology brings – it is hidden benefits."***

At the time of writing, additional psychology capacity was in development across the city, between different services such as ReNew and Changing Futures. The *Homeless Mental Health Team* is keen to collaborate closely with this new capacity and

form a ‘psychology hub’ or similar to best realise and meet the needs of the homeless community.

A refinement and re-prioritisation of the psychological intervention and service model is offered as one of the recommendations of this report for further co-development and exploration, see Section 6.

- **Provision of ‘bottom-up’ psychotherapeutic approaches –** talking therapies such as traditional psychology may not always be the most appropriate recovery tool for this patient cohort. These are known as *‘top-down’ approaches* because they generally work mind-to-body or cognitively, rationalising problems and talking through issues. A more holistic *bottom-up approach* would consist of body-to-mind or ‘nervous system awareness’ modalities such as somatic experiencing, bodywork, breathwork and movement. The bottom-up approach offers practical, go-to tools that service users may respond well to in the here and now, and may support staff to quickly reframe ‘challenging behaviours’ as wholly understandable trauma responses. Freelance or independent practitioners from holistic, non-clinical backgrounds might be brought in to trial these approaches with service users, one-to-one and in groups, to determine if a bottom-up approach would reach and resonate with people who are experiencing homelessness. Generally talking about trauma and traumatic experiences is not at the forefront of these healing modalities, because the emphasis is on “felt sense” and reconnection to the physical body and environment*, therefore these approaches may resonate with service users who are deemed to be pre-contemplative in their stage of recovery.

  A greater focus on education, training and awareness around the **Autonomic Nervous System** and its fight/flight/freeze responses – in Polyvagal Theory known as hyper-arousal and hypo-arousal – may also be beneficial for frontline workers and emergency services across the city (Dana, 2018). This is because it may support the re-framing of what are currently seen as challenging and chaotic behaviours in service users, towards a radically compassionate understanding of dysregulation in the body following an individual’s overwhelm beyond their window of tolerance.

  In this sense coping behaviours may not be seen as ‘lifestyle choices’ nor even personalities, but rather recognised as the innately intelligent and protective survival function (Hübl, 2020) of an individual in deep suffering and turmoil who is doing the best they can at any given moment. Organisations and systems may become more confident at taking on the role of ‘corporate parent’ with the centring of safety, authentic connection and co-regulation at the heart of commissioning, services and teams – benefiting staff and service users alike. This could begin a radical reimagining of mental health services. Please see Section 5 for additional commentary.

  *”Felt Sense” is a therapeutic concept brought into the mainstream by trauma therapist Peter Levine. It is the bringing of awareness into the body of the ever-changing internal landscape of emotional, energetic, and sensory activity. Another way of describing felt sense would be ‘attunement.’ You are becoming attuned to and able to notice the subtle and overt layers of feeling and sensing in and of your body and its ecosystem.

Greater emphasis on Equality, Diversity, Inclusion and ‘Cultural Humility’

Hull as a city has a large population of EU and non-EU migrant workers and settlers, in particular based along the Beverley Road corridor. During the compilation of this report several stakeholders noted the subtle and sometimes overt cultural differences in states of homelessness for EU and non-EU citizens. Some of these issues have been highlighted below, along with suggestions from stakeholders that may support improvement of care for these communities.

Please note the following feedback relates to support services more generally across Hull, rather than specifically the *Homeless Mental Health Team*:

- **Translation and Language Barriers –** the *Homeless Mental Health Team* and other support services in the city have 24/7 access to remote translation services when they need them via telephone. It was flagged that there is little literature and campaign materials in other languages though, such as Polish, Czech, Slovakian, and Latvian (to name a few commonly spoken languages in Hull). It would be helpful to have more information available in these and other languages to explain

what support is available for members of these communities who are experiencing homelessness and mental ill health. The city may also consider posters or bus stop campaigns in other languages to support wider access to services, concentrating these in culturally diverse streets and neighbourhoods. It is noted that some people may speak some English, and be able to hold a conversation, but this is not the same as being able to speak about private issues. It is also common for some people to speak English, but not read or write it. If someone's English is limited it can affect self-esteem, and stakeholders had observed service users pretending to understand when they actually could not;

- **Cultural differences in perceptions of Mental Health and Mental Illness –** it was flagged that stigma and prejudice around mental health and mental illness is still present in some EU countries. Though further research on this is beyond the scope of this report, anecdotal evidence suggested that anxiety, trauma and depression have much more negative connotations when translated to their equivalent meanings in Polish and other languages. This might affect translation services and conversations using translators and interpreters. It was also noted that in Poland, employers don't recognise mental health, and there is an under-funded healthcare and welfare system. People are less likely to ask for help or rely on public services in Poland and so often have the same mindset when they come to Britain;

- **More diverse staff –** it was suggested that services should reflect their communities and this wasn't happening yet e.g. too few Polish-speaking workers in a city like Hull with a large Polish population; similarly there could be a Kurdish worker to support the Kurdish community, etc;

- **Modern Slavery awareness –** some people experiencing homelessness have been victims of modern slavery and trafficking. More education and awareness would be helpful in hospitals and healthcare services so staff can spot the signs of modern slavery and exploitation.

Cultural Humility is an oft-cited component of trauma informed systems, organisations and care, which has gained particular prominence in Canada and the United States.

In *Implementing a Trauma-Informed Public Health System in San Francisco* (2019), Loomis et al. outline cultural humility as a focus on "learning about social, racial, and cultural backgrounds, how they affect relationships, and how they are related to trauma. We come from diverse social and cultural groups that may experience and react to trauma differently. When we are open to understanding these differences and respond to them sensitively we make each other feel understood and wellness is enhanced."

Generally, cultural humility work is closely linked to anti-racism efforts and the unpacking of systemic advantage for particular social and racial groups. Recognising the interconnectedness of trauma and racism (as well as other forms of systemic and historical oppression e.g. sexism, ageism, ableism, homophobia, religious intolerance) is key to the delivery of culturally-humble services.

Additionally, the Homeless Mental Health Team has identified ***women's specific support and care*** as an area for growth and closer inquiry. The team have observed that women's experiences of homelessness are unique to men's experiences, that there are nuances to the skills and expertise needed to be effective at providing healing environments and interventions, and that there are often high levels of hidden homelessness. The team would like to grow this area and their offerings for women in the future.

Areas of Challenge & Opportunity

Absence of Lived Experience input

There is an absence of lived experience input across the majority of homelessness services in the city, including the *Homeless Mental Health Team*. At the time of writing it is noted that the Changing Futures Programme is taking active steps to address this.

Mental health services in particular would benefit from the presence of 'experts by experience.' It would not be necessary to look for people who are still in the grips of homelessness, addiction and mental health crisis. Services could seek individuals further down the recovery path, or from sister mental health pathways such as PTSD services. Services might

also draw upon people from a wider geographic area, as there will be similarities in experience across major cities in England, with many of the drivers of homelessness and mental health being the same wherever you go.

It is worth thinking more creatively about the capture and inclusion of Lived Experience input and leadership. It is hoped that Section 2 of this report: *Voices of Hull's Homeless Citizens* may inspire a transcendent perception change amongst staff and public towards individuals who appear to lead dysfunctional lives. More commentary around this is offered at Section 5.

Navigating the relationship with Community Mental Health Teams (CMHT)

Throughout the insights-gathering process it became clear that stakeholders and team members feel there are grey areas surrounding the role of CMHT and its relationship to the service. A practical example of this would be confusion over whether patients can be open to both services at the same time and contrasting views amongst stakeholders and commissioners around this.

Another example would be that the Homeless Mental Health Team feels they could have a role to play in CMHT transformation, but this is not yet defined and opportunities for closer strategic work have not yet presented themselves.

Stakeholders are extremely positive about the specialist Homeless Mental Health Team (being aware of historic CMHT failure to support this patient cohort in particular where substance use is present) but it is queried whether greater co-working and integration between the two teams might be possible and actively pursued. A stakeholder within Hull City Council felt that the *Homeless Mental Health Team* could play a more active role 'behind-the-scenes' liaising with CMHT staff, brokering services and inpatient care, and navigating the mental health system on a whole for patients. It is felt that the service could offer challenge to CMHT services where possible in order to improve care in the city, or more of an active 'critical friend' role.

In conversations with the team it is clearly communicated that they too can have the same difficulties and frustrations in navigating the mental health system as patients can – indicating a wider systems question outside the scope of this report.

Meanwhile, there remains confusion amongst commissioners and providers around patients who are active cases within both CMHT and the *Homeless Mental Health Team.* For stakeholders and commissioners it is felt that patients should be open cases in both services if they wish to be so. Within the wider organisational governance of Humber Teaching NHS Foundation Trust it appears that this might not be possible, and would therefore restrict the team's involvement. Further clarification should be sought in this area in order to agree a forward plan.

Opportunities for joint strategic work and shared learning between the *Homeless Mental Health Team,* CMHT and other mental health teams might also be pursued (e.g. neurodiversity services, trauma teams).

Discharge and Aftercare

At the time of writing no patients have yet been discharged into mainstream services following intervention coming to a close, but there remains confusion over what this would look like and how it would work in practice.

It is currently assumed that CMHT would receive patients discharged from the service, but there are concerns over training and capacity within CMHT to meet the needs of the cohort. It is expected that a 'handover' between clinical staff would take place and as much information shared as possible for a smooth transition between teams. Without examples of this happening it is difficult to offer further commentary at this time.

Another area of concern raised by the team was around aftercare. Although some service users are moving onto community groups and activities such as gardening and fishing, and being supported in this process by the team, there is limited other aftercare available or clarity on what this would look like. The team are keen to "do endings well" recognising that many of their service users have abandonment trauma and separation anxiety.

A more complete aftercare offer, which may look similar to social prescribing, would support service user transition into community life and may reduce demand or dependency on mainstream services. The team are also clear that service users can be re-referred back into the service at any time.

Always "meeting people where they're at"

The service already works flexibly and innovatively through its Pre-Treatment Model to meet patients in the present moment, at a level they can tolerate in the here and now. Some stakeholders felt this could go

further with a refinement of the team's physical outreach activities and schedules. This might mean consistency in timings and dates of hostel outreach, more frequent drop-ins, and in general working around the routines of service users.

At the time of writing, work was already underway in the team to attend hostels on a more regular basis.

There is no offer for people who refuse support or do not want to work with the service

It was highlighted by the team that there is no offer in the city for service users who refuse help, refuse to engage, or who simply do not want to work with the *Homeless Mental Health Team.* There are no easy answers to this, but it is worth exploring whether a holistic model utilising non-clinical staff would be more appealing to patients, or conducting a Needs Assessment with people who prefer not to engage.

It is worth noting again that people who are experiencing homelessness often do not trust mental health services for valid reasons (such as negative past experiences, stigmatisation, and prejudice). There is a need for mental health services to look inwards as well as outwards at how they may change to address this – inwards at where they themselves may need to change as services and frameworks, and outwards at reparation and trust-building within communities. This is not about blaming and fault-finding but about creating softer introspection opportunities and compassionate professional inquiry.

Section 5, which is next, begins to offer some commentary around flipping our perceptions of service users upside down, moving away from viewing them as 'receivers of care' towards a more radical view of service users / patients as 'our teachers of healing' which may be of interest.

The Pros and Cons of Diagnoses and Diagnostic Frameworks

There were varied views amongst the team and stakeholders around the role of diagnostic frameworks in mental health, particularly in the context of homelessness, substance use and complex trauma. This is an important area for further exploration and innovation particularly in relation to Dual Diagnosis and the emergence of radical healing models.

For example, formal diagnosis can be extremely helpful in the process of brokering care packages for individuals, e.g. a diagnosis of schizophrenia may "open doors" for a patient, or using the right clinical language between mental health professionals can secure inpatient care more efficiently when its needed. On the other hand diagnosis can impact on the provision of non-judgemental, trauma informed care, such as in the presence of personality disorders and hearing voices. Where for some patients diagnosis can secure care, for others it is a risk to their care, quality of life and access to services.

In general it was expressed by several stakeholders that the mental health system in its current form is based largely upon responding to symptoms and behaviours – as opposed to a more trauma informed view of the wholeness of a person, their interests and their strengths.

Patient formulations were also highlighted. Some stakeholders felt that it wasn't good practice to develop a formulation without meeting a service user in-person, with an overreliance on other professionals' notes – which are always going to be based on someone else's assumptions about a person and limited to a point in time (the past).

It was the preference going forwards that the Homeless Mental Health Team ensure they have met a service user several times before formulating.

Further commentary around how we can evolve the ways that we talk about service users, 'sickness' and diagnosis is offered in Section 5.

A Reprioritisation of Rough Sleepers

As part of the recommended 'take-stock' and refinement exercise, several stakeholders were interested in a lessened focus on hostels and supported living, and a renewed focus on the city's rough sleepers. This is in contrast to earlier comments from hostel staff who have requested more support and input from the service and mental health professionals.

Feedback was also received to recommend that tasks such as registering patients with a GP, making prescription changes, signposting and befriending could instead be carried out by hostel support workers or other support agencies, rather than mental health teams, in order to free up capacity for psychotherapeutic work.

As part of a refinement exercise it may be worth exploring such a reprioritisation in more depth:

> ***"Everyone in a hostel has mental health needs."***
>
> ***"Everything gets worse as soon as you become homeless."***
>
> ***"The hostels alone can fill the workload of the team. Can there be more focus on Russell Street and the Trees?"***

Please note the following areas of challenge and opportunity have been observed more generally across homelessness services in the city and are offered here as added value to this report:

Shortage of Housing and Suitable Accommodation across Hull
Stakeholders were honest about a shortage of suitable housing for people who are experiencing homelessness, and this is a common theme and concern at operational meetings. This is exacerbated, at the time of writing, by the rise in cost of living and energy prices, and the coming closure of William Booth.

Furthermore there is felt to be an over-reliance on hostel provision and hostel-type care, which are not felt to offer appropriate healing environments. It was felt that Russell Street (a smaller, more personalised space) was the closest Hull had to the environment stakeholders and commissioners have in mind.

In order to provide truly trauma informed and psychologically informed environments, it is felt that more funding and housing stock is needed. This impacts on being able to provide more holistic, non-clinical work with service users:

> ***"We need to totally get rid of every single hostel and instead have many small, spacious, and airy spaces – warm homes – making sure all of Maslow's Hierarchy is met. There should be private areas and communal areas. If you smash it up it gets done again, no questions asked."***
>
> ***"We need stepping stones out of housing into the community. A lot of people won't cope at first in an individual house and need 24/7 support. But this is the value of a safe, warm space and human connection. None of this is a clinical intervention."***

Oversharing or Unnecessary Sharing of Service User Information
Please note that this insight has emerged from stakeholders across the city and should be read as applicable to the wider ecosystem of services, indicating that there may be systemic cultural issues at play that are beyond the scope of this report per se, but which stakeholders felt were too important to leave out with this report offering an opportunity to voice them. It is beyond the scope of this report to identify whether this is a cultural issue beyond homelessness services or across mental health services as a whole.

Several stakeholders felt that the use of patient / service user information in some system meetings and environments was unnecessary at times. Examples of this included discussing the romantic relationships of service users (e.g. where these were seen as problematic or unhelpful to recovery/intervention efforts) or the sexualised / sexual behaviour of female service users. One stakeholder asked: "how would clients feel to know we are discussing them in this way?

With lived experience input still minimal across some services in the city, it is possible that some professional sharing has become less-boundaried in the acceleration towards more integrated and joined-up working. Where there is a need to share information more quickly between services, and link together more efficiently, there is perhaps less clarity around the information suitable for open discussion in multi-agency and well-attended operational and partnership meetings.

This is an area that the *Homeless Mental Health Team* could support and influence in the drive towards psychologically informed environments and trauma informed organisational change:

> ***"The pool of service users is small, all agencies are likely to know of the person even if they haven't met them or worked with them. So why is it okay to share that information when people aren't needing-to-know? It is very exposing for the service user."***
>
> ***"There is sometimes a quick-ness about meetings, getting things done, which isn't patient-focused. It feels too focus-led and shouldn't be this way. Where is the strengths-based approach? We have lost the individuality."***
>
> ***"If service users were present at some meetings the information we chose to share would change. I think we'd be more strengths-based. We wouldn't talk about behaviours. Behaviour suggests it's conscious and manipulative. It feels dismissive."***
>
> ***"It can be reductionist and dispassionate in the way we talk about people, because we are all professionals together and understand the language we're using. If there was someone in the room I think it would encourage us to use more empathetic language."***
>
> ***"There is lots of good multi-agency work going on, we just need to funnel and focus some of this. Maybe guidelines with a terms of reference might help."***

Complex Doesn't Have to be Complex – Speaking a New Language of Healing
From a trauma informed perspective there is possibly an unconscious normalisation of language used amongst professionals and services e.g. 'complex needs' and patients seen to be presenting with complexity and chaos.

When unguarded this can lead to desensitisation within services and workplaces that misses the humanity of the individuals under our care.

'Complex' and 'chaotic' were the two most used phrases to describe people who are experiencing homelessness and mental ill health, during the compilation of this report.

The perception of 'difficulty' or 'complexity' when treating or coming towards patients can itself become an obstacle, as it means there has already been a defaulting to the deficit-based model. If we are only seeing complexity, or "complexity-first" before anything else (such as strengths and talents) then our behaviour towards an individual is already biased before we step into the room. The same deficit-based thinking is present in the use of 'chaos,' 'chaotic lifestyles,' and 'challenging behaviours' when discussing service users.

We have to ask ourselves how it would feel to be called challenging, chaotic or that our lifestyle is chaotic, even if the patient themselves sometimes refers to their life in this way. We then need to consider what happens within professional services and teams when complexity and chaos is made the dominant perception over a long period of time.

Being seen to exist in a world of chaos strengthens the perception of difficulty and expectation of complexity. It contributes to a working environment amongst professionals where healing is hard, takes a long time, has many setbacks, or may not be possible at all. This has an impact on staff morale and compassion fatigue, contributing to a feeling of 'stuckness' in the system, where all ideas for an individual have been exhausted and it is unclear how to provide powerful interventions that will work and turn peoples' lives around – particular where the ratio of resource to patient is high.

This is not criticism but rather an opportunity to explore a new language of healing.

Mark Finnis, a leading trauma informed educator in the UK, talks about the ways in which ***"our language creates the reality we get."*** If services and professionals were to shift language away from chaos, complexity, and challenging behaviours – flipping these on their heads in some cases – what response might we see in both patients and patient outcomes? How might staff feel going into a room with a person for the first time? Might we co-create a new reality for service user recovery alongside the populations we serve? Might systems discover creative new ways of delivering services to under-reached groups and neighbourhoods?

When we change our language about something, it automatically encourages us to change our perception of it – this can support us to usurp narratives and the current paradigms – moving services and society towards a new reality.

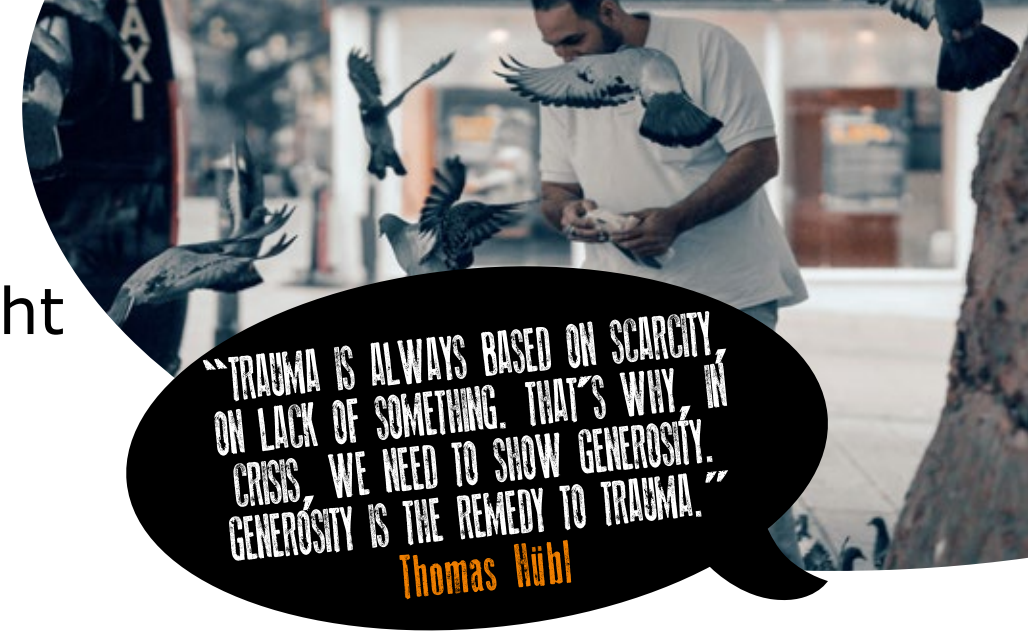
An exploration of more trauma informed language is beyond the scope of this report and would benefit from lived experience input. Some early suggestions have been provided below to support ideas and brainstorming. It is possible to sense subtle changes in energy when leaning into the alternative phrases:

Current Phrasing	**Alternative, Trauma-Sensitive Phrasing**
Complex Needs	Unique needs; individual needs; vulnerability
Complex Patient	*Retired from use*
Complex Behaviours	*Retired from use*
Chaos	Vulnerability; hyper-marginalisation; suffering
Chaotic	Safety-seeking; overwhelmed; frantic; deep suffering
Chaotic lifestyle	Love-seeking; safety-seeking; dysregulated; frantic
Difficult / challenging	Safety-seeking; trauma responsive; signifying pain
Lifestyle choice	*If used at all:* trauma-based decision making; extreme survival skills, or similar
Hard-to-reach / engage	Under-reached; marginalised; under-engaged; under-served; less included; seldom-heard
Attention-seeking	Attachment-needing
Pre-treat, pre-treatment	Relation-centred; restorative; restore relation.

The use of 'complex trauma' and 'Complex PTSD' are not included in the above as they remain valuable terms in validating a person's suffering and life experiences and understanding the parts of life and relationships which feel difficult or inaccessible to them. They did not arise as problematic (when used in trauma informed contexts and environments) in the compilation of this report.

Towards a New Model of Healing

– A Trauma Informed Insight into Emergent and Non-Emergent Processes



In this section we briefly explore a trauma informed insight into our services, organisations, and systems before offering reflection on this report and its potential role in shaping future evolution and growth.

We will then move onto recommendations in the next section. If you would like to read the report recommendations now, please turn to Section 6.

Trauma in Services, Organisations and Systems

In his work on collective trauma, systems thought leader and international facilitator Thomas Hübl presents a model for the creation of "healing architectures." This means services, organisations and systems built upon the foundations of relationality, attunement, safety and coherence (Hübl, Pocket Project, 2021). These foundations are at the heart of trauma informed systems transformation and can support us to create new models of healing.

It can be helpful to define trauma from a systems' perspective and the way it presents in our cultures and processes before bringing awareness to the tools that can support us to transform them.

Trauma is "the inner response within an individual or collective when facing a situation which is utterly overwhelming" (Pocket Project, 2021). In response to overwhelm the individual or collective must experience a nervous system response – e.g. fight, flight, freeze – in order to preserve life and survive. If this response isn't integrated and processed after the original overwhelm takes place then it goes on to remain stagnant in the body and nervous system, over time coming to threaten the life and wellbeing of what it was trying to preserve.

We can think of unprocessed trauma as ***non-emergent*** – characterised by repetition compulsion, separation, fragmentation, numbing and stuckness. It has frozen habits that seem trapped in time, and it suppresses our potential under heavy layers of frost. We can explore our organisations and systems through this lens of what is emergent and what is non-emergent, recognising where trauma has supported our self-preservation and sheer survival.

Because it is inherently life-protecting, trauma can be seen as an intelligent process developed over millions of years to serve life as a survival mechanism. We pay a price for trauma, but nevertheless it is still working *for* us. It isn't dysfunctional, but it has a function we don't always understand (Hübl, see works of).

When we look at trauma we are looking at intelligence – be that in our systems, organisations or our service users and patients. We are looking upon something which in our crucial moments as human beings and collectives was *right* and which worked for us – protecting, serving, preserving life.

Healing Organisations and Healing Systems

We can build healing architectures around these heavy layers of frost, gently supporting them over time to loosen and thaw. Relationality, attunement, safety and coherence are key to this process – because they are ***emergent*** processes. They are the healing medicine which non-emergence (trauma) needs.

We can work with emergent processes to create radical new models of healing, to fuel trauma informed practice and leadership, and to integrate our collective traumatic legacies and history.

In healing organisations we nurture and sustain relational sensing capacity, presence-building practices, and psychological safety – between staff as well as service users. We can see much overlap with Psychologically Informed Environments (PIEs) and the Pre-Treatment Model which the *Homeless Mental Health Team* relies upon.

The below commentary is offered as a helpful revisioning in the movement towards healing-centred organisations, systems and processes.

Areas of the *Homeless Mental Health Team* which can be observed as ***emergent*** might include:

- Prioritisation of relationship-building and trust-building with service users and partner agencies, including prioritisation over outcomes monitoring;
- Barrierless, non-judgemental referral processes
- Reflective Practice
- Holistic, person-centred, strengths-based approach, including peer support / mentoring
- Patient Formulations to the degree that they create greater alignment, relationality and understanding *service-to-service* and *services-to-service-user*
- Awareness raising of PIEs and trauma informed care across Hull; contributions to Trauma Informed City initiatives; contributions to wider regional and national collaboration and best practice showcasing
- Flexibility and visibility of the service; a malleability to respond
- Platforming and recognition of service user / patient wisdom e.g. expressed through Section 2 of this report, and reflected in Pre-Treatment Model.

Process / Organisation / Service	Characteristics, Signs, Responses
'Emergent' ***(Healing-Based)***	Relational, connected, safe, creative, embodied, innovation, presence, attunement, coherence, courage, co-regulated, collaborative, inclusive, equitable, compassionate, love-driven, able to update and integrate new information, conscious
'Non-Emergent' ***(Trauma-Based)***	Dis-related, repetitive, non-creative, stagnant, fragmented, disconnect, over-activity or hyper-activity, reactive, isolation or isolated parts, othering and differencing, numbing, frozen, silence, dysregulated, fear-driven, not able to update or integrate new information, often unconscious

An emergent organisation or service is a healing one.

Meanwhile a non-emergent organisation or service is trauma-based and at times, retraumatising to itself, stuck in repetitive cycles which are often characterised by over-activity and dis-relationality.

Areas of the *Homeless Mental Health Team* (and possibly wider mental health services) which can be observed as ***non-emergent*** might include:

- Under-use of lived experience across services and service design
- Under-use of lived experience input / service user input to Patient Formulations
- Current psychological frameworks; focus on the clinically-led model at the expense of non-clinical innovation
- Organisation of services around symptoms, behaviours, diagnosis / diagnostic frameworks
- Caseloads – these are felt to be too high across all services / sectors

- Language and professional abbreviations e.g. complex, complexity, complex needs, chaotic, chaotic lifestyles, lifestyle choices etc
- Evaluation and monitoring, e.g. “not counting what counts” such as too much focus on quantitative data analysis and an undervaluing of qualitative evidence (new approaches to outcomes capture would support services to transition towards emergent and healing processes – this may look like evaluation models that are co-produced with lived experience leadership)
- Resourcing and service capacity – feeling that you are being spread very thinly.

Non-emergent processes are usually unconscious processes and can be difficult to spot. They can often be identified by how tired they make us. When we come across an unconscious process within an organisation, service or system, our energy drops to a low level (e.g. fatigue, tiredness, silence, dissociation) or increases to an over-activated level (e.g. agitation, irritability, anger, stress). We may encounter these reactions during or after meetings and work events, thus we can come to know the sticking points of trauma at play within our organisations (Hübl, see works of).

Identifying the parts of our services and systems that would benefit from increased ‘conscious process’ i.e. relationality, attunement, creativity and presence, supports us on the journey towards realising new models of healing.

This applies a trauma informed insight to unlock the frozen potential of our staff, service users / patients, partnerships and communities.

The *Homeless Mental Health Team* has a unique role to play in the emergence of new models of care for people who are experiencing homelessness.

Usurping the Narrative, Envisioning New Paradigms of Healing

Transitioning to a healing-oriented organisation or service means attaining equality between providers and receivers of care. It means seeing people as capable of healing, believing in their wholeness, their ability to become who they were meant to be, and challenging negative forces that try to divide us or separate us (Pocket Project, Hübl, 2022).

In particular the movement towards radical new models of healing means increased cultural humility (see Section 4) and diversity of voices. This means making space for under-heard and marginalised communities and social groups, such as those facing multiple disadvantage or systemic oppression. It also means facing the shadows that confront our own lives as professionals and frontline workers, and users of services ourselves.

This work, which can be guided by emergent process and trauma informed leadership, usurps existing narratives and begins the integration of collective trauma. As trauma becomes ‘unstuck’ and is held within coherent, relational containers, it is transformed into collective wisdom and post-traumatic growth.

Across homelessness and mental health services, we may ask ourselves radical new questions to support this paradigm-shift:

How can we meet crisis with generosity and abundance?

What can I learn from my service users?

How can we flip the paradigm on its head so our patients become our teachers, our guides, our supporters?

What is preventing us from connecting with the people / communities we work with?

Why do we keep saying they won’t engage with us?

Why are we reading about a patient’s past history before we meet them? (besides risk assessment)

How do I see a patient as brand new in every moment?

What does it mean to come towards communities from a place of love, instead of fear?

How can I teach everybody I meet today that their needs are beautiful?

What would happen if I moved towards my patients from a place of appreciation?

What does unconditional acceptance towards my service users (and myself)

look like?

How can we create love on prescription, or what would love-based commissioning look like?

Why are people with lived experience not managing our services – how can we say to them ‘we need your help’ instead of ‘what help do you need’?

What would happen if we asked our service users to design our services?

Is it possible that our patients the answers?

What would happen if we saw no order of difficulty / hierarchy in healing or problems?

What would happen if we saw wholeness instead of sickness?

How does my own healing contribute to the healing of the system?

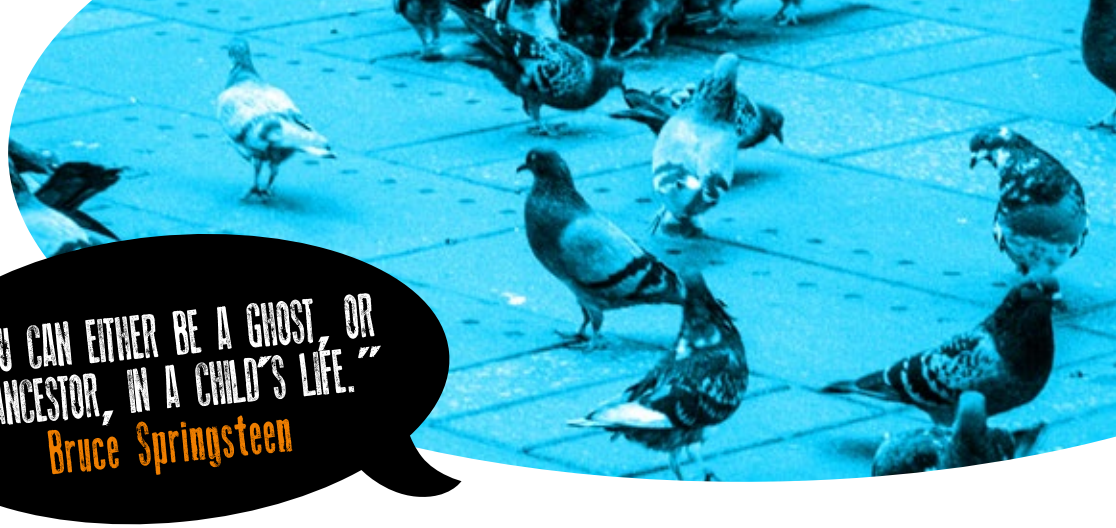
How can I show up as love today, for myself, my colleagues and my patients?

Where am I not believing in myself or my service users?

SECTION 6

In Search of Radical Healing

– What Now & Recommendations



Throughout this report, the *Homeless Mental Health Team* has demonstrated its key role in the pioneering of a narrative-shifting, trauma informed care pathway across Hull. As a programme in receipt of pilot funding from NHS England, it is leading the way in the exploration and identification of effective care for hyper-marginalised communities, and the role statutory services have to play in this.

Working closely together with partner agencies, and influencing national perspectives, the service and the passionate team behind it are also beginning to harness the voices and insights of people who are experiencing homelessness to create new visions of healing from trauma.

Going forwards the team is well-placed to explore bold and ambitious, paradigm-usurping models of care for service users who have traditionally been seen and labelled as complex, chaotic and difficult-to-engage. The Pre-Treatment pathway is an emergent example of efforts in this direction, and the wider system of mental health and homelessness support has much to gain from this programme. The team itself is also well-placed to support and develop the learning and recommendations that have emerged during the compilation of this report, e.g. where insights have reflected the wider system of services across the city.

To support continuous movement towards radical healing, the following recommendations are offered – please note these are in no particular order:

1. **A "funnel and focus" exercise to refine the service, pause-and-reflect, and take stock of where we have come from and where we are going:**

Feedback from stakeholders, commissioners, staff and service users has indicated that there is potential for greater refinement of the *Homeless Mental Health Team.* This would take into account the changing landscape of homelessness provision in Hull over the last two years, the new provision that is due to come on-stream over the next six months, and learning to date from the programme's journey. A refinement process would support the service to better understand its position amongst the wider landscape of services, cement its identity, and clarify its role in the ongoing integration of health and care across the city – particularly in relation to the Changing Futures programme.

This may mean looking at amendments to the original service specification to understand how it can be delivered to best meet the needs of the patient cohort, taking on board the areas of good practice, the strengths of the team, and the wider context of trauma informed transformation in the city. This would be an opportunity to cement the identity of the service across Hull, understand any remaining interdependencies with other services, address areas of overlap, and really bring forth the creative potential and knowledge of the team.

This exercise could form part of an 'innovation day' or similar, and might offer the chance to understand and resolve any disconnect between services, commissioners and stakeholders. This exercise would be a moment of pause-and-reflection and should include lived experience input as well as input from other homelessness providers as feels most appropriate and supportive.

If additional funding or resource is identified as part of this process, some suggestions for how this could be targeted were offered in Section 4 of this report and are also included within these recommendations.

Building in time for intentional pause and reflection may support wider trauma informed transformation across the city, contributing to the evolution of system and organisational cultures that have been traditionally based on over-activity, hyper-activity and reactivity. It can also strengthen relationships between commissioners, providers and communities of service users.

2. **A new, holistic and multi-sector Directory of Services for the city:**
The Directory of Services would include all services and groups / activities / community initiatives across Hull (and perhaps into East Riding) that might benefit patients and service users. This should be multi-sector, including health, care, voluntary and community sector, and social enterprises. It may also include private businesses that offer volunteering opportunities or mentoring and peer support, for example collaboration with local sports teams and gyms, leisure centres etc.

Staff and frontline workers across all services might be offered education and training on use of the Directory, and a partnership approach devised to keep it up to date.

Eventually service users might move onto volunteering with the *Homeless Mental Health Team,* e.g. buddy system / accompanying other service users to groups and activities; peer support; mentoring; coaching.

Where possible, and where there are gaps in provision, funding could be made available to voluntary, community and social enterprise organisations to set up new groups and initiatives.

3. **'Nothing about me, without me' – prioritising Lived Experience input, co-production and leadership:**
Co-production (e.g. of care and support plans), choice, and shared decision making are key elements of personalised care (NHS England, 2018). Mental health services are working hard to move towards care pathways which have increased lived experience leadership and input.

The *Homeless Mental Health Team* has an opportunity to do this innovatively and differently, to be ambitious and bold in the example it sets for sister services across CMHT, Crisis and other mental health settings. The Pre-Treatment Model offers an opportunity to bring forth the voices of patients and appreciate the wisdom they have to share with professionals and staff. Patients have much to teach us as demonstrated in Section 2.

Suggested areas for increased service user input: patient formulations; Psychologically Informed Environments; Directory of Services; new approaches to outcomes capture and evaluation / monitoring.

4. **Expansion of the Pre-Treatment Pathway to include holistic and real-time therapeutic interventions, some of which make use of non-clinical staff and approaches:**
The Pre-Treatment Model's approach of offering more informal, holistic engagement is supported by feedback across service users and staff (see Sections 2, 3 and 4). It is evident from this report and existing international research into the Pre-Treatment Model (see References) that this approach encourages positive outcomes when supporting people who are experiencing homelessness.

At times however, the focus on building trust, safety and relationship can distract from the need for providing real-time therapeutic interventions and support right now for individuals. Many homelessness and crisis services have grappled with this issue, and there is much debate to be had around what therapeutic interventions specifically would work well in the here and now, particularly where trauma, complex trauma, addiction or psychosis may be present.

There is an appetite amongst service users and the city's stakeholders for the service to deliver therapeutic interventions more readily alongside the pre-treatment pathway. There is a potential gap around the team's capacity to offer this themselves: additional upskilling might be required or dedicated members of staff / providers brought on board to do this.

This would also be an opportune time to explore holistic therapeutic interventions within a trauma therapy framework, which make use of non-clinical staff and non-traditional psychological approaches. This was discussed at length in Section 4 under: “Development of a reimagined and bold new Holistic Psychology / Psychotherapeutic Support Model” (see page 42). For example, many stakeholders felt that the service would benefit from more creativity and a “letting go” of traditional psychological frameworks. Several key stakeholders felt that an “emotionally available and consistent adult” who could work purely on self-esteem was one of the most powerful interventions for this patient cohort.

Whether the service delivers this internally or commissions external providers – such as the voluntary sector, social enterprises, consultants or trained professionals – could be explored.

Examples of non-clinical and / or holistic therapeutic interventions include: outdoors-based groups and activities such as gardening, nature and woodland walks, bushcraft, whittling and woodwork, fire-lighting, conservation, access to green spaces, forest bathing, hedge-laying and tree planting, wildlife-spotting, bird-watching, time spent with animals, and outdoor therapy. Indoor-based groups and activities such as sports and exercise, museums, trips, cinema, live music, theatre, dance and dancing, art classes, crafts, baking, collage-making and pottery. Somatic-based therapeutic interventions such as bodywork, breathwork, movement and dance. Internal Family Systems (IFS), parts work, and ‘inner child’ healing could also be explored, perhaps in piloted group settings initially.

Men’s Groups and Women’s Groups should also be explored and could receive input or mentoring from the voluntary sector, such as Andy’s Man Club and Purple House. Access to experiences of safe and authentic ‘brotherhood’ and ‘sisterhood’ feel of particular significance from speaking to service users in Section 2, some of whom have never experienced role models or reliable parental figures. It is important to recognise other organisations / sectors already do this type of work well and statutory services should refer to and learn from what is already there.

Duplication and unnecessary repetition of holistic provision should be avoided and the recommended Directory of Services would support that process. All of this could be explored as part of the pause-and-reflection process suggested under Recommendation 1.

5. **Provision of a new Day Centre, Healing Hub, or Combined Health Centre for homelessness in Hull:**
This was explored at length in Section 4. A one-stop, go-to space which is warm, welcoming, and above all safe would transform outcomes for people who are experiencing homelessness across the city. In imagining a setting for radical healing to take place, we can ask ourselves the question: “how can we meet crisis with generosity and abundance?”

Such a setting should be developed in partnership with experts-by-experience, who could be drawn from across the UK and not just Hull, to ensure we are bringing in good practice and innovation from other cities and countries.

A centre or hub could house a range of services together under one roof, including food banks and a café or charity shop to offer work experience, as well as your traditional physical and mental health teams. It could also act as a base for the realisation of holistic and non-clinical therapeutic interventions, such as a sensory garden and green spaces, room for workshops and activities, and places to relax such as a gym and cosy lounges. Everyone in the community could use the centre/hub, but knowing it is there to support our most vulnerable citizens to get their lives back.

The provision of a centre or hub would also: support sustainable, long-term discharge and aftercare pathways; increase support to hostels and short-term accommodation in the city; improve life experiences of service users, some of whom have never left Hull; offer a space to increase our understanding of cultural diversity within Hull’s communities; support de-pathologising of trauma and health inequalities across the city; contribute to trauma informed transformation; offer an alternative variety of support to under-reached service users; as well as many more exciting possibilities.

This report and future impact capture will hopefully contribute towards the case for a new Day Centre(s) or equivalent across Hull for people who are experiencing homelessness and mental ill health to make use of. This is an opportunity for greater system integration and could house services and activities for CMHT, Crisis and Veteran patients too.

The Jean Bishop Integrated Care Centre is a good example of what is possible when partners come together and a similar process for patients experiencing hyper-marginalisation and complex trauma across the city would be welcomed. The realisation of a multi-agency Day Centre, Hub or Combined Health Centre would be in support of emergent, radical healing in Hull. This would set Hull apart by demonstrating an unconditional commitment to society's most vulnerable citizens.

6. **'Counting what counts' – reimagining outcomes capture and data evaluation / monitoring:**
Outcomes capture and evaluation is not straightforward for the *Homeless Mental Health Team* owing to the unique working relationship between staff and patients within the Pre-Treatment Model.

This could be an opportunity to explore and develop alternative evaluation frameworks that can be adapted across trauma informed mental health services. Is there another way, a better way, for us to count what really counts? What does success look like in the eyes of our service users?

For example, beyond the use of measurement tools and patient questionnaires, how can we capture and demonstrate: improved quality of life; increased ability to cope; feeling listened to and as if people want to hear what you have to say; feeling loveable and like a valuable human being; feeling safe; feeling joy.

Services across Hull working with people who are experiencing homelessness and multiple disadvantage may wish to use this as an opportunity to collaborate on shared outcomes and shared theories of change.

7. **Recognise and celebrate the needs of staff as well as service users:**
Much of this report has focused on meeting the needs of patients and service users. It is important that the same due regard and consideration is given to the needs of staff, volunteers and frontline workers.

During the compilation of this report, there were numerous themes picked up from stakeholders that high workloads, long hours, and overwhelmed statutory services mean people are struggling in the wake of the Covid-19 pandemic and the anticipated economic recession. In some cases this is leading to moral injury, where staff or services are unable to provide the level and or choice of support and care that they want to offer their clients and patients. We could view this through a trauma informed lens to understand better the non-emergent processes at play, that may be deeply historical and multi-faceted, and which have led to unsustainable working cultures and public expectations. It is only by sitting with this complexity and giving safe and attuned space to it that we will be able to find a clear path forwards, perhaps in partnership with the public and service users.

Although it is outside the scope of this report to explore this topic further, it is recommended that system leaders recognise that true trauma informed transformation includes *everybody* and meets the needs of everybody, including themselves as leaders. We may ask how we can radically celebrate each other more often and lift up our working environments to a place where quality of life and quality of love is at the heart of our cultures and practices.

8. **Across services and systems, make the brave move towards trauma informed language and styles of communication based on love, equality and acceptance:**
The Homeless Mental Health Team has a unique role to play in the emergence of new models of care for people who are experiencing homelessness. This is a time for usurping narratives around what healing looks like and how we talk about healing.

From a trauma informed perspective, there is an unconscious normalisation of language used amongst professionals and services across Hull e.g. 'complex needs' and patients seen to be presenting with chaos and complexity. When unguarded this can lead to inadvertent desensitisation within services and workplaces that unintentionally misses the humanity of the individuals under our care.

With lived experience input still minimal across some services in the city, it is possible that some professional sharing has become less-boundaried in the acceleration towards more integrated and joined-up working. This has a direct impact on communication styles, with over-sharing of beneficiary information creating an ethical concern for some stakeholders. This is a systemic issue interdependent with the trauma processes at play within our cultures and organisations; as such it should be attended to with curiosity and love, rather than blame or fault-finding.

It is an area that the Homeless Mental Health Team could support and influence in the drive towards psychologically informed environments and trauma informed organisational change. For example, the time may be ripe for retiring terminology including 'complex,' 'chaotic,' and 'difficult/ challenging.' We may move away from seeing people as presenting with complex needs, instead moving towards the emergent view of unique needs, and teaching each other – and ourselves – that our needs are beautiful and demonstrate our innate deserving of love and acceptance. Much of this philosophy is already held by services and professionals across the city, and it is mainly a case of bringing our language up to date with our values and practices.

When we change our language about something, it automatically encourages us to change our perceptions. This can support us to usurp narratives and current paradigms based on deficit and dysfunction, moving services and society towards new realities based on our strengths and wholeness.

More commentary and suggestions on trauma sensitive language was offered in Section 4.

Thank you for taking the time to read this report. For any further information or queries please contact the *Homeless Mental Health Team* or *Hull Health and Care Partnership.*

References

Conolly, John, *Introduction: Pretreatment Inclusion* taken from *Pretreatment In Action: Interactive Exploration from Homelessness to Housing Stabilization,* Loving Healing Press, 2021

Dana, Deb, *The Polyvagal Theory in Therapy: Engaging the Rhythm of Regulation,* W. W. Norton & Company, 2018

Department of Communities and Local Government, *Psychologically Informed Services for Homeless People: Good Practice Guide,* 2012

Finnis, Mark, Restorative and Relational Systems Practitioner, please see *L30 Relational Systems*, https://l30relationalsystems.co.uk/team/

Hübl, Thomas, *Healing Collective Trauma: A Process for Integrating Our Intergenerational and Cultural Wounds,* Sounds True, 2020

Levine, Peter A., *Waking the Tiger: Healing Trauma,* North Atlantic Books, 1997

Levy, Jay S. MSW, *Pretreatment In Action: Interactive Exploration from Homelessness to Housing Stabilization,* Loving Healing Press, 2021

Loomis B, Epstein K, Dauria EF, Dolce L., *Implementing a Trauma-Informed Public Health System in San Francisco, California*, Health Education & Behaviour, Society for Public Health Education, 2019

Making Every Adult Matter, *MEAM in Practice,* http://meam.org.uk/publications/meam-in-practice/, October 2020, accessed 3rd August 2022 (Author Not Stated)

Morris, Deborah, *Advances in Autism: Call for Papers,* https://www.emeraldgrouppublishing.com/calls-for-papers/meeting-trauma-needs-autistic-people, accessed 28th September 2022

NHS England, *Comprehensive Model of Personalised Care,* 2018

Pocket Project, *Trauma Informed Leadership Course* and *Collective Trauma Integration Process (CTIP),* www.pocketproject.org, 2021-22

Ritchie, Claire, *No One Left Out – Website Resources,* www.nooneleftout.co.uk, accessed 26th September 2022

Rosenberg, Marshall B., PhD, *Nonviolent Communication: A Language of Life,* Second Edition, Puddle Dancer Press, 2005

Service Specification: *Rough Sleepers Mental Health Outreach Service*, NHS Hull Clinical Commissioning Group, 2019-2020

Westminster City Council, *Psychologically Informed Environments: No One Left Out,* 2015

Appendices

Appendix A:
Copy of Stakeholder Insights – Hull Rough Sleepers Mental Health Service

We are seeking the views of stakeholders and frontline professionals/ staff/volunteers who have had contact with or made use of the Hull Rough Sleepers Mental Health Service.

Sharing your views and experiences will support the Evaluation Report in its understanding of the service and how it may evolve in the future, ensuring we showcase good practice and capture any lessons learned.

There are 10 questions which should take 10-15 minutes to complete. Thank you very much for your time.

[Evaluator Contact Details here]

1) Are you familiar with the Hull Rough Sleepers Mental Health Service, and if so, please tell us how?

2) Have you found it easy to find information about this service and make referrals into it?

3) How many referrals have you made into the Hull Rough Sleepers Mental Health Service, to the best of your knowledge? [options provided]

4) Have you been satisfied with your contact and communication with this service?

5) If you could think of one way that this service could be improved in the short-term, what would this be?

6) Do you feel that this service is meeting the needs of the homeless community across Hull? [options provided]

7) If you had to offer ideas around long term improvement of mental health services for the homeless community in Hull, what would these be?

8) Are there any areas of best practice which you are aware of, and which you can share with us in the Comment Box below?

9) Finally, is there anything else you would like to tell us which hasn't been covered in the above questions?

10) If you would like to have a follow-up conversation with the Evaluator, please provide your contact details below. Otherwise, please submit your responses now -- and thank you!