The Prevalence of Trauma among People who have Experienced Homelessness in England

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Executive Summary

In April 2022, the research team was commissioned by Oasis Community Housing to explore the prevalence of trauma among individuals with experience of homelessness in England and consider the effectiveness of current support available to them, with a view to informing future policy. The findings presented in this report are based on the analysis of 115 questionnaires completed by Oasis Community Housing service users and a rapid review of the Big Lottery-funded 'Fulfilling Lives' programme research and evaluation reports.

Approximately three quarters of the questionnaire respondents were accessing services in the North East. One quarter were accessing services in London. The respondents were almost evenly split between males and females, at 54% and 43% respectively. 3% identified as non-binary. Just over a third were aged 16 to 25 and approximately half were aged 26 to 45. The remainder were aged 46 to 60. The majority were born in the UK and identified as White British. Those who identified as non-White were predominantly accessing services in London.

Homelessness or the risk of this was a key feature of most of the respondents' lives, 77% had been homeless and 13% reported being at risk of this at some point. Of those who had been homeless, the mean number of times was three and the mean length of time spent homeless was just over two and a half years. At the point of completing the questionnaire, the majority were either living in supported accommodation, rough sleeping or sofa-surfing.

Experiences of trauma were also extremely prevalent, at 92%. The nature of this included psychological, physical and sexual abuse and neglect as children, familial addiction often resulting in bereavement or being taken in local authority care, being victims and witnesses of domestic abuse or violent attacks, sexual or criminal exploitation, the removal of children, bereavement, physical pain and injury, serious illness, disability, incarceration, fleeing to the UK from abroad to escape persecution and war, prolonged separation from family and homelessness. Almost two-thirds of respondents reported four or more traumatic experiences, or trauma over a prolonged period of time. While this figure is high, it is likely to be an under-reporting of experiences.

Almost all respondents said trauma had negatively impacted their life. In 70% of cases, the impact was reported to be significant. The most prevalent impact, affecting 82% of respondents, was poor mental health. In many cases, this had resulted in self-harm. Other widely reported impacts were relationship difficulties, poor emotional regulation, low self-esteem, substance misuse and a limited sense of hope about the future. On average, respondents reported six broad types of impact as a result of trauma. The number of traumatic incidents experienced typically correlated with the number of impacts reported.

The prevalence, nature and impacts of trauma clearly intersected with factors such as age, stage in the life-course, gender, and refugee status. While much homelessness and trauma research has focused on childhood adversity, almost two-thirds of the respondents reported experiences of trauma in adolescence and adulthood, respectively. This highlights that trauma can occur at any age. Young adulthood appeared to be a key time when people with housing difficulties were particularly likely to have experienced trauma. Female respondents were more likely to report higher levels of trauma than male respondents and a higher mean number of impacts. They were also more likely to say that trauma had caused difficulties in the areas of relationships, self-care, self-harm and negative views of self. Male respondents were more likely to say trauma had led to substance misuse and offending. All of those seeking asylum reported experiences of trauma. Their experiences were often distinct to those born in the UK and included fleeing persecution, war, traumatic journeys to the UK, and acute physical and emotional separation from family.

Experiences of trauma and homelessness were clearly linked. 73% of respondents had experienced both homelessness and trauma, and two-thirds of respondents made links between trauma and their

housing situations. Trauma was often a direct trigger for homelessness or to have resulted in impacts that led to homelessness. In addition, over one-third reported that trauma was preventing them from moving on from homelessness. This was typically due to unresolved needs resulting from trauma. Those who had experienced homelessness were also likely to report a higher mean number of impacts of trauma than those who had not. This is likely to be in part because homelessness itself was widely reported to be traumatic and exposed individuals to a range of risks. Furthermore, those who had experienced homelessness were more likely to report five or more experiences of trauma or trauma over a prolonged period, thus indicating a link between the likelihood and chronicity of homelessness and the pervasiveness of past experiences of trauma.

Just over half of the respondents had accessed specialist help for trauma. Those whose trauma had led to a mental health diagnosis had typically found it easier to access specialist support. Others reported reaching a crisis point before this became available to them. While some described the support received as effective, it was more common for respondents to report negative experiences linked to well-known barriers to mainstream mental health support for those with multiple and complex needs. Several also reported re-traumatisation because of engagement.

Reflections on working with services more generally were largely positive. The majority reported feeling physically and psychologically safe when accessing services, listened to and said they had typically been supported to access the services they need. Participants spoke particularly positively about the support received from Oasis Community Housing, as well as addictions and recovery services. Half, however, felt they need more help than they are currently receiving. Support with housing and to deal with past traumas were the key areas of need highlighted.

There appeared to be significant overlap between the needs and experiences of the questionnaire respondents and the Fulfilling Lives beneficiaries. While the Fulfilling Lives programme did not systematically ask all beneficiaries about their experiences of trauma, there is a strong association between trauma and multiple disadvantage and much of the qualitative data contained in the reports highlighted experiences of trauma. There also appeared to be much overlap in terms of struggles accessing and engaging with services across the two groups. The Fulfilling Lives programme, however, highlighted that through system change, those with multiple and complex needs can be effectively supported to move forward in their lives. Effective mental health support is central to this. Outside of mainstream mental health services, some of the most effective mental health interventions and models of working identified through the programme were the use of system navigators and peer mentors; flexible, person-centred and bespoke mental health services; 'pre-treatment' support provided by non-clinical workers; and the use of psychologically-informed and trauma-informed approaches to engagement. It is also critical that health support is accompanied by support to address other needs, notably housing. The social and economic benefits of providing support that meets the unique needs of those with multiple and complex needs are significant.

Some of the key learning points to emerge from the research are:

- There is likely to be a very high prevalence of trauma amongst those with experience of homelessness in England. This is likely to be 'complex' and to have occurred at multiple stages of the life-course. The impacts are likely to be wide-ranging and to have resulted in other disadvantages.
- A complex and often mutually reinforcing relationship appears to exist between trauma and homelessness. In this research, trauma was often a precursor to homelessness but homelessness itself was often experienced as a form of trauma and increased the likelihood of exposure to further traumas and adverse impacts. It is thus futile to try to respond to the issue of homelessness without addressing trauma.
- Psychologically- and trauma- informed approaches to service delivery appear key to service user well-being and engagement. Mental health support also appears central to progression, but well-known barriers to support continue.

Moving forward, the research supports the following recommendations:

- Central government funding is made available to provide trauma-informed training for all frontline staff working in homelessness and related support services.
- Local authorities commit to only commissioning homelessness services and support that are person-centred, trauma-informed and psychologically-informed, where the individual is supported to make their own choices and identify what is important to them.
- Additional funding is made available to enable local authorities to appoint dedicated mental health professionals, who have an understanding of the traumas and other underlying issues experienced by people facing homelessness, in every local authority mental health service.
- Work is undertaken with NICE to promote Guideline [NG58] on Coexisting severe mental illness and substance misuse, with a view to encouraging wider uptake of the guideline.
- The Homelessness Reduction Act's Duty to Refer is extended or amended to create a new Duty to Collaborate, which extends to GPs, mental health and drug and alcohol services as important partners for local authority housing teams – with appropriate additional resources committed.
- There should be a cross-departmental focus on homelessness prevention. By investing in preventative measures, such as early mental health support, the result would be fewer households in crisis. These measures would reduce the number of people who become homeless (and critically, remain homeless for long periods of time) in the future.

Introduction

Overview of the Research

In April 2022, the research team was commissioned by Oasis Community Housing to explore the prevalence of trauma among individuals with experience of homelessness in England. The specific aims of the project were to:

- Compile and analyse data gathered by Oasis Community Housing about the prevalence and types of traumas experienced by service users and perspectives on the effectiveness of support currently being offered;
- Review the research and evaluation conducted as part of the Big Lottery-funded 'Fulfilling Lives' programme, with a focus on understanding the prevalence of trauma experienced by the Fulfilling Lives beneficiaries and the effectiveness of trauma-related interventions.

It was hoped the research would support Oasis Community Housing and related services to gain a deeper understanding of the prevalence, nature and impacts of trauma experienced by those accessing homelessness services and thus support future policy and practice developments.

Methodology

The research was carried out between April and August 2022. A mixed-methods approach was employed. Both qualitative and qualitative data was drawn upon to enable the research team to explore the complexities of the relationship between trauma and homelessness.

A brief literature review was undertaken, which reflected upon the most recent literature on the relationship between trauma and homelessness, and the application and efficacy of trauma-specific and trauma-informed interventions and approaches used across a range of sectors. The review drew on peer-reviewed and non-peer reviewed academic publications, policy documents and grey literature produced by authoritative sources. The research team drew upon this work to help inform and shape the planning, analysis and writing up of this project.

Primary data was collected through a questionnaire completed by Oasis Community Housing service users. The questionnaire was developed by Oasis Community Housing in partnership with the Centre for Homelessness Impact and the research team. The questionnaire was comprised of a mix of 17 open and closed questions, covering the following broad areas: basic demographic information (including age, gender, ethnicity, and refugee status); experiences of homelessness and the risk of this; experiences of trauma (including nature, frequency, stage in the life-course, and impacts); experiences of engagement with specialist mental health services; and experiences of engagement with homelessness and related services.

Frontline Oasis Community Housing staff approached service users about their participation in the research. All were provided with information about the project and consent forms ahead of their engagement with the questionnaire. It was made clear that participation was entirely voluntary, would be confidential and anonymous, participants could withdraw from the research at any point until the process of writing up had begun, and non-participation would not affect the ability of service users to access support from Oasis Community Housing. Service users were approached about participation in the research at the various premises and services that they were accessing, in the hope that these are environments which the participants perceive to be physically and psychologically safe. For purposes of ease and convenience, the questionnaires were supplied in hard copy. Support workers were available to support participants with completion as needed. Once completed, the anonymous questionnaires were collated centrally by the Head of Service Improvement and then shared with the research team.

In total, 115 questionnaires were completed across a 12-week period. This equates to a response rate of 19%. 598 individuals were engaged with by Oasis Community Housing during the data collection period, with the nature of engagement here varying from one-time conversations at a drop-in, for example, to regular engagement with individuals living in Oasis Community Housing's supported accommodation across the full duration of the research. The response rate, rather than the size of the sample, is the most important factor when determining the accuracy of a sample in predicting the characteristics of a population (Harding, 2022). The response rate to this survey compared favourably with that of other organisations when bearing in mind the client group and the short-term nature of their relationships with staff in many cases. For example, Taylor et al (2019) when conducting a European survey of the general public about homelessness achieved national response rates of 30.4% to 33.5%. The Independent Police Complaints Commission is one example of an organisation that has produced reports based on a considerably lower response rate than the one discussed here (House of Commons Home Affairs Committee, 2013). This indicates that the data presented in this report is as robust as is likely to be obtained with people who are homeless or threatened with homelessness.

Three quarters of those who completed the questionnaire were accessing services in the North East of England. The remaining quarter were accessing services in London. A breakdown of respondents by project and type of service is summarised below.

Name of Project/Service	**Type of Service**	**Participants**
Aspire	Employability	3
58:7	Crisis	5
Basis Beds	Crisis	17
Basis Gateshead	Crisis	19
Basis Sunderland	Crisis	23
Next Steps Accommodation Project (NSAP)	Crisis	2
Empower	Domestic abuse	6
Elizabeth House	Accommodation	5
Karis	Accommodation	1
Naomi Project	Accommodation	5
Southwark	Accommodation	29
Total		**115**

Most of the respondents (57%) were engaging with crisis support services, some of which include the provision of emergency accommodation. Given the difficulties of conducting research of this nature in services where relationships can be short term in nature and individuals are often presenting in crisis with pressing and immediate needs, this level of engagement with the questionnaire is a significant achievement. One third of participants (34%) were accessing accommodation-based services at the point of completion. 9% of participants were engaging with employability and domestic abuse services, some of which are group-based.

The research process followed Oasis Community Housing's internal ethics policy and was approved by Northumbria University's Research Ethics Committee. The committee requires that all researchers practice the highest ethical standards at all times. Of paramount importance throughout the research to all stakeholders was the desire to avoid any risk of harm to the participants (particularly re-

traumatisation). Several safety measures were put in place to ensure this. These included the importance of an empathetic approach being stressed at all staff briefings about the gathering of data, the careful design and piloting of the questionnaire used, and any distress experienced by respondents when completing the questionnaire prompting the ending of the exercise and/or the provision of appropriate emotional support.

The questionnaire data was input into and analysed using Statistical Package for Social Sciences (SPSS). After coding and typing the data into the programme, Frequencies and Means were sought for individual variables as appropriate. In addition, some calculations were performed to create new variables, e.g. for the number of impacts of trauma that respondents reported. Relationships between variables were examined using crosstables.

Alongside primary data collection, the publications and reports publicly available on the Fulfilling Lives website were reviewed. The Fulfilling Lives programme was an eight-year Big Lottery funded initiative, where voluntary-sector led partnerships across 12 areas sought to improve the lives of those with multiple and complex needs through improved access to joined-up and person-centred services. A key focus of the programme was 'systems change' – designing, piloting and evaluating new ways of working with those with multiple and complex needs (defined as individuals experiencing a combination of homelessness, substance misuse, offending and mental ill-health) (Lamb et al., 2019). The Fulfilling Lives archive is comprised of over 300 outputs. The nature of the publications and reports were reviewed and priority was given to reading: the national research and evaluation reports produced (which often provided a summary of and signposting to pertinent local evaluation reports and reports by theme); those that specifically related to trauma, mental health and trauma-informed approaches; and, the publications and reports relating to the Newcastle-Gateshead Fulfilling Lives partnership (of which Oasis Community Housing was part). Approximately 100 outputs were closely scrutinised, with a view to identifying the prevalence of trauma among the Fulfilling Lives beneficiaries, the influence of the programme on services, and the interventions that appeared to have most positively impacted on the mental health of those accessing them.

The key findings to emerge from the above process are summarised in the subsequent sections of this report.

Research Findings

The Demographic Profile of the Respondents

Of the 115 individuals who completed the questionnaire, 54% identified as male, 43% identified as female and 3% identified as non-binary.

The age categories that respondents placed themselves in are shown in the table below.

Age Category	Frequency	Percentage
16-20	25	22%
21-25	16	14%
26-30	12	10%
31-35	18	16%
36-40	13	11%
41-45	13	11%
46-50	12	10%
51-55	3	3%
56-60	3	3%
Total	**115**	**100%**

Over one third of the participants (36%) were aged 16 to 25 years old. 48% were aged 26 to 45 years old. The remainder (16%) were aged 46 to 60 years old.

The vast majority of the participants (86%) were born in the UK. Seven indicated that they were seeking or had sought asylum/refugee status. Most participants (71%) also described their ethnicity as 'White British'. Other options chosen by more than one respondent were 'any other White background' (5), 'other Black background' (4), 'other Asian background' (4), 'Black Caribbean' (4), Black African' (3), 'African' (2) and 'any other mixed ethnic background' (2).

Differences in terms of the nationality and ethnicity of the respondents using different projects largely reflected the location of the projects. Most respondents (25 of 33) who did not identify as White British were accessing services in Southwark, London, which has a significantly more diverse population than the North East of England.

The intersection of characteristics such as age, gender, ethnicity, and asylum/refugee status, with the respondents' experiences of trauma are discussed later in the report.

The Prevalence of Homelessness

Respondents were asked about their experiences of homelessness or the risk of this. Homelessness or the risk of this had featured in most of the respondents' lives, affecting 90% in total. This figure was broken down to 77% who said they had been homeless and 13% who reported being at risk of this at some point in their lives. By virtue of their engagement with Oasis Community Housing, it is likely that all respondents had either been homeless or at risk of this at some point in their lives. This suggests that some may have adopted a narrower definition of homelessness than that understood by the research team and Oasis Community Housing.

Nonetheless, experiences of homelessness varied significantly across the sample. Of those who had been homeless, the mean number of times was three, with the maximum being 20. When considering the total length of time that periods of homelessness had lasted, the mean was just over two and a half years, though this figure was increased by a small number of respondents who reported being homeless for a very large part of their lives. In several cases, participants reported being homeless for

over 10 years. In the most extreme case, one suggested that they had been homeless for 44 years. When this response was removed from the calculation, the mean time that a participant had been homeless reduced to two years.

Most of participants reported housing problems at the point of completing the questionnaire. Their housing situations at this point are shown in the table below.

Current Housing Status	**Frequency**	**Percentage**
Supported, temporary, hostel accommodation	68	59%
Sleeping rough	19	17%
Own tenancy	13	11%
Have own house	6	5%
Sofa surfing	4	4%
At risk of losing accommodation	3	3%
Living with mum	1	1%
Don't know/Not stated	1	1%
Total	**115**	**100%**

The most common housing situation was living in supported accommodation at 59%. This was followed by rough sleeping at 17%. A further 7% were sofa surfing or considered themselves to be at risk of losing their tenancy. Just 17% suggested they were living in settled accommodation.

The Prevalence and Experiences of Trauma

The term ‘trauma’ can mean different things, depending on the context. The concept is often used interchangeably by different professions to refer to a traumatic experience or event, the resulting injury or stress, or the long-term impacts and consequences. Furthermore, understanding of the ways that trauma can be inflicted, the nature of trauma stress symptoms and the effects of trauma stress continued to develop. As such, the concept is often described as contested, complex, loose and evolving (Briare & Scott, 2012; Haslam & McGrath, 2020).

In this research, the term trauma was used to refer to events or experiences that the respondents found to be traumatic, with the impacts and consequences of this discussed separately. Specifically, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) definition of trauma was used. This defines trauma as an event, series of events, or set of circumstances that individuals experience as physically or emotionally harmful or life threatening, and that have lasting adverse effects on their functioning and mental, physical, social, emotional, or spiritual well-being. A key strength of this definition is its recognition of the subjectivity of trauma and, indeed, project stakeholders were keen to adopt an approach which gave the respondents freedom to define trauma for themselves and was respectful of their reflections on past experiences. There was also concern not to traumatise any service users by asking them to review lists outlining events or experiences which are commonly understood to be traumatic. Adopting this approach, 92% of respondents said they had experienced trauma at some point in their lives.

A useful distinction found in the trauma literature is that between single incident and complex trauma. Single incident trauma refers to a single, unexpected, random event such as an assault or natural disaster that has a profound effect on the functioning or well-being of an individual. Complex trauma refers to traumatic experiences involving multiple events with interpersonal threats. These experiences typically arise within the context of a child’s relationships, occur during child development, and are chronic or repeated in nature. Complex trauma tends to pervade every aspect of an individual’s being (Crowe et al., 2021). The following table shows the number of traumatic incidents that the participants reported experiencing.

No. of traumatic incidents experienced	Frequency	Percentage
Once	15	14%
2-3 times	20	19%
4-5 times	14	13%
More than 5 times or for a prolonged period	53	50%
Don't know	4	4%
Total	**106**	**100%**

As the table shows, half of those who had experienced trauma had experienced this more than five times or for a prolonged period. A further 19% reported two to three experiences of trauma and 13% reported four to five experiences of trauma. It is reasonable to conclude therefore that complex trauma was experienced by a large majority of the respondents.

There was a clear gender dimension to the figures. The data revealed higher levels of trauma among female respondents. 59% of female respondents reported experiencing trauma five or more times or for a prolonged period of time, compared to 40% of male respondents.

Of further important note here is the likely under-reporting of experiences across the sample, but this is particularly likely in relation to the male respondents. The trauma literature suggests that trauma is often under-reported by males. This is attributed to males being less likely to recognise situations as abusive, tending to see their experiences as less severe compared to the experiences of females and males being less likely to disclose abuse (Morris and Webb, 2021). Across the board, however, several frontline Oasis Community Housing workers reported being aware of past experiences of trauma that were not disclosed when the questionnaires were completed and feeling that some participants did not recognise certain past experiences as traumatic. This was particularly in terms of early childhood experiences relating to family and household circumstances, such as parental substance misuse, parental domestic abuse, and the involvement of social services in the family home. The broader trauma literature also highlights the sometimes-poor reliability of self-report questionnaires when compared to practitioner records or interviews (Reuben et al., 2016).

Due to the absence of a 'checklist' of experiences, it was not possible to quantify the prevalence of different types of traumas experienced by participants, but a series of closed and open questions provided some insights in this regard. While discussed in detail in the following sections, what stands out is the type of trauma experienced by the respondents was wide-ranging and often acute. Experiences included often repeated and/or prolonged psychological, physical and sexual abuse and neglect as children, familial addiction often resulting in bereavement or being taken in local authority care, being victims and witnesses of domestic abuse or violent attacks, sexual or criminal exploitation, the removal of children, bereavement, physical pain and injury, serious illness, disability, incarceration, fleeing to the UK from abroad to escape persecution and war, prolonged separation from family and homelessness.

Childhood Trauma

The 106 respondents who said they had experienced trauma were asked when this trauma had occurred in their lives (more than one option could be selected). Almost 45% of the respondents reported experiencing trauma as a child.

It is broadly accepted that approximately 50% of the population in England endured one adverse childhood experience (ACE), while approximately 9% experienced four or more (Asmussen et al., 2020). The questionnaire did not ask how many adversities were experienced by the respondents during this time, but based on the qualitative data collected, it is reasonable to assume that the proportion who experienced four or more ACEs is higher than 9%. In an open-ended question where participants were asked about the nature of the traumas they had experienced, reports of childhood

adversity were common and, in several cases, participants wrote about multiple forms of childhood traumas. One such example here was:

> *'Five deaths, neglected, parents on drugs, abusive household, around drug dealers, social services, police'*

The nature of the traumas disclosed reflected widely used categorisations of ACEs. There were many examples of psychological, physical, and sexual abuse as children reported. A small snapshot of the qualitative data provided by respondents here included:

> *'Being abused by stepdad from five years old to 14 years old. My mum didn't look after me and my siblings right'*
>
> *'Sexually abused when 9 years old'*
>
> *'Locked in cupboards over weekends. Starved. Physical abuse. Emotional abuse. From age 7 to 27 years of age'*
>
> *'Abused by dad from age 9 to 14 years'*
>
> *'My mum would not let me do things independently which led to a life of control resulting in trauma. This was emotional, physical, gaslighting and isolation'*
>
> *'Multiple rapes from age 11'*

ACEs are also understood to include exposure to household dysfunction, such as exposure to substance abuse and mental illness, witnessing the violent treatment of a parent, and criminal behaviour in the household. Again, the qualitative data highlighted frequent exposure to household dysfunction in all of these forms, often in extreme ways. For example, several participants explained that several parents or siblings had committed suicide or attempted suicide as a result of mental ill-health. Others had lost family members due to substance misuse. Some of the experiences disclosed here included:

> *'Mum was a drug user so was around lots of bullies'*
>
> *'Witnessing parents injecting drugs, finding methods of drug use in the household at 1 years old'*
>
> *'Witnessing domestic violence between parents'*
>
> *'Parents tried to kill themselves when I came in from school'*
>
> *'Having a mum who was alcoholic, also watching her dying off the drink'*
>
> *'Lost mum aged 16 when she was 38 to a heroin addiction. Mum was pregnant and it happened very suddenly'*

Several participants reported being taken into care because of household dysfunction. There are two key points important to note here. Firstly, removal from the family in the interests of child safety often happened after trauma had already occurred. Secondly, removal as a solution sometimes had the consequences of multiplying and entrenching trauma in the lives of the respondents. Similar observations were made in the Fulfilling Lives research (Crowe et al., 2020).

Adolescent and Adult Trauma

A significant finding is the level of trauma experienced in adolescence and adulthood. 60% of respondents said they had experienced trauma as an adolescent and 61% as an adult. While much research on trauma has focused on childhood, these findings highlight the possibility of trauma occurring across the life-course and the need for services to be mindful of this.

It is also important to highlight the impact of a relatively high proportion of those aged 16 to 20 who completed the questionnaire. Only 10% of those aged 16 to 20 reported experiences of trauma as an adult. This figure rose to 67% for those aged 21 to 25 and to 80% for those aged 26 to 30. This suggests that young adulthood may be a time when people with housing difficulties are particularly likely to have experienced trauma.

It was sometimes difficult to identify which points in time the qualitative data provided related to and few respondents talked explicitly about the nature of the traumatic events which they experienced as adolescents. Where they did, they primarily related to relationship breakdown with family and being asked to leave the family home. As the leading cause of youth homelessness in the UK (Action for Children, 2022), this finding is unsurprising. Important to note, however, is that relationship breakdown with family was often attributed to other experiences of trauma and the impacts of this, such as the loss of a parent resulting in substance misuse and poor emotional regulation. In one case, the respondent's mother passed away due to illness when they were in prison at the age of 18. The inability of this respondent to see their mother before they passed away was highly traumatic and continued to have a significant impact on them.

As adults, the types of trauma experienced by the respondents were wide-ranging. These included poor physical health, long-term conditions, disability, being a victim of crime or (often serious) violence, family breakdown (including being a victim of domestic violence, or the removal of children from their care), bereavement (often parents and children), the loss of a job, occupational harm, and incarceration. Some of the qualitative comments provided here included:

> *'Had children, their father was abusive for 13 years, he now has the kids. Drug gang took over kitchen for 5 days and beat her while waiting for the father to return, then had to flee as a police witness'*
>
> *'Family dying'*
>
> *'Lost my kid'*
>
> *'Was in a house fire which caused severe burns. Has recently suffered an amputation as a result of this. Scars all down side of body'*
>
> *'Brain injury caused by stab to the head'*
>
> *'I was raped'*
>
> *'Been in the army, saw stuff'*
>
> *'I was a train driver and someone jumped in front of my train to kill themselves. There were body parts and blood everywhere and I still think about it all of the time'*
>
> *'Have cerebral palsy which makes me feel different to everyone else'*
>
> *'Daughter died at 6 weeks of cot death. Mam walked out due to drinking to ease the pain of grieving loss of daughter'*
>
> *'Going to prison'*

'Was assaulted. I was beaten up and woke up with sore ribs and my trousers were round my ankles'

'Had five children removed. One of them, I wasn't allowed to see at all. I had a c-section and she was removed straightaway'

The comments listed are not exhaustive of the experiences of trauma disclosed, but they provide a clear indication of the breadth and severity of the situations which the respondents had endured. They also highlight the difficult role of services working with adults with experiences of trauma. The impacts of these experiences and the support which might be useful to service users as a result will be very different dependent upon the nature of the trauma experienced, requiring frontline workers to have wide-ranging knowledge and skills.

Reflecting much of the broader literature on trauma and the findings of several of the Fulfilling Lives partnerships (Everitt, 2021; Lamb et al., 2019b; Headley and Crowe, 2020), it was also clear that the nature of trauma experienced by the participants (and the impacts of this which are discussed in the next section) were gendered. Experiences of interpersonal violence, sexual abuse and trauma associated with the removal of children from their care or separation from children were more commonly reported by female respondents. Several male respondents, however, also reported experiences of physical and sexual abuse and trauma associated with separation from children. It is important therefore that services are mindful of the gendered nature of trauma, but do not make assumptions about the types of trauma that service users may have experienced based on gender alone. Furthermore, while it is not uncommon for males to report lower levels of trauma than females, several factors can mask significant variations in experiences of trauma among men. This includes asylum and refugee status (Fleurant, 2019). All seven male respondents who reported asylum and refugee status reported experiences of trauma. These were often distinct to those of the other participants and included fleeing persecution, war, and traumatic journeys to the UK. For example, one respondent attributed their trauma to *'leaving home and family, travelling to a new country, war at home'*. Another reported being abandoned by their mother in their home country, while their mother travelled to the UK. They were left with grandparents who subsequently passed away, and then other relatives, who were neglectful and abusive. After a period of street homelessness, they travelled to the UK to try to find their mother. During this journey, they commented, '*Along the way, I saw many things. Many many things. People killed right in front of me and so much more*.' Once in the UK, the trauma did not end. This was followed by stress due to factors such as homelessness and lack of recourse to public funds, and loneliness and isolation due to separation from family. From here, it follows that asylum seekers are five times more likely to have mental health needs than the general population. Concerningly, they are also less likely to receive mental health support than the general population (McCarthy et al, 2020).

With trauma unaddressed, many participants described situations where the consequences of their traumas were preventing them from being able to engage with services as required or to move on from homelessness. Experiences of engagement with services and move on from homelessness are discussed in the next sections.

Homelessness as Trauma

A central theme in the data was homelessness as a form and source of trauma. There is much literature which supports this notion (Goodman et al., 1991; Deck & Platt, 2015; Hopper at al., 2010; Pope et al., 2020). Specifically, 28% of respondents reported trauma as a result of the process of *becoming* homeless and 38% reported trauma as a result of *being* homeless.

The experience of trauma of a result of becoming homeless seemed to be particularly acute among those who had fled domestic violence. This includes both those who needed to find a way of fleeing with dependent children and those who had been forced to leave their children in the family home. A

number reported trauma linked to rough sleeping. Here, they reported feelings and experiences of hunger, fear and vulnerability, violence, exploitation, stigma, poor physical health, addiction, loss, and isolation. Considering some of their experiences in more detail, one respondent recounted waking to find a friend deceased after taking heroin while they were rough sleeping together in a derelict building. Another reported struggling with feelings of judgement about being homeless from those they had known prior to becoming homeless. Another reported being sexually abused by someone they were reliant on for accommodation when homeless and one said they had slept with people to secure accommodation at times. Others talked about the difficulties of living in supported accommodation, reporting that they did not feel physically or psychologically safe in these environments. Linked to this, several of those who had fled domestic violence talked about continuing to live in fear of abuse from their former partners, needing to be careful about who they disclosed information to about their situation and location and the ongoing stress which this caused.

Critically, one participant stated, *'Every time I become homeless it's traumatic….and it doesn't get any better either'.* This quote is a poignant reminder that for many of the participants, homelessness was not an isolated experience. Many had experienced repeat homelessness.

It is important that services are mindful that homelessness is a form of trauma itself and support service users to manage the traumas associated with this, as well as the traumas which were the primary causes of homelessness. It is also important that services are mindful of the likely cumulative effects of repeat homelessness.

Once homeless, a further 15% of respondents said they had gone on to experience trauma that was unrelated to homelessness. The nature of these experiences were not always clear from the qualitative data.

The Impact of Trauma

Participants were asked about the extent to which trauma had impacted on their lives. Of 100 who answered the question, just 3% said trauma had caused no difficulties. Of the remainder, 70% said trauma had had a 'significant' impact on their life and 27% said trauma had impacted them 'somewhat'.

Types of Impact and Prevalence

104 respondents answered a series of questions about the type of difficulties that trauma had caused them. The frequency with which each type of difficulty was identified is shown in the table.

Impacts of Trauma	**Frequency**	**Percentage**
Mental health or emotional difficulties	94	90%
Relationship difficulties	75	72%
Difficulties in emotional management	70	67%
Negative view of self	67	64%
Self-care	65	63%
Substance misuse	63	61%
Limited sense of hope	58	56%
Ability to concentrate, think or learn	52	50%
Self-harm	48	46%
Offending behaviour	32	31%
Other impacts	10	10%

The most significant impacts of trauma on the lives of the participants were poor mental health or emotional difficulties. These were experienced by 90% of respondents. In 46% of cases, trauma had

resulted in acts of self-harm. In the qualitative comments made, several reported these to include overdoses, cutting and suicide attempts.

A further significant impact of trauma was relationship difficulties. This was reported by 72% of respondents. In the qualitative comments, a number reported problems developing trusting relationships (with partners and professionals), feelings of wanting to be alone, running away from home, and feeling unable to settle and remain in one place for any period of time.

Reports of maladaptive behaviours and risk taking were also prevalent. 67% of respondents said trauma had impacted on their ability to engage in emotional regulation. 63% of respondents said trauma had affected their ability to engage in self-care. 61% of respondents said trauma had resulted in problems of substance misuse. In 31% of cases, respondents said trauma had resulted in offending behaviour.

A lack of self-esteem, optimism about the future and an inability to concentrate, think and learn were also apparent. Almost two-thirds (64%) of respondents reported low self-esteem and over half (56% and 50% respectively) reported a limited sense of hope about the future and difficulties concentrating, thinking or learning.

Some of the qualitative comments provided about the impacts of trauma included:

> *'I've taken loads of overdoses and cut myself up'*
>
> *'I break down a lot'*
>
> *'[It] made me promiscuous when I was younger. Now I don't want men to touch me. It has ruined all of my relationships'*
>
> '*Because of my trauma and loneliness, I smoke cannabis to make me feel happy, but sometimes it does not make me happy'*
>
> *'[I] lost confidence in myself. It looks like there is no hope for me'*
>
> *'It has affected how I feel about everything. I always thought it was a problem with me'*

Ten participants suggested that trauma had impacted on their lives in other ways. The impacts cited here were financial difficulties, an eating disorder and sexual exploitation.

Reflecting the broader literature on trauma and gender (Milaney et al., 2020; Almuneef et al., 2018), the female respondents were more likely to say that trauma had caused difficulties in the areas of relationships, self-care, self-harm, negative views of self, limited sense of hope, and inability to concentrate, think and learn. The male respondents were more likely to say that trauma had led to substance misuse and offending behaviour. In the Fulfilling Lives programme, the female beneficiaries were also more likely to be affected by poor mental health, to have higher levels of risk of self-harm and to be more at risk from others (Moreton et al., 2017).

A further key finding was the level of overlap of reported impacts. On average, the respondents reported experiencing six broad types of impact. Four respondents (4%) reported experiencing all eleven types of impact listed. The qualitative data highlighted several interconnections whereby one or more impacts of trauma resulted in the subsequent experience of other types of impact. While it was not possible to establish any statistically significant 'clusterings' of impact, the interconnected, bi-directional and compounding impacts of trauma and trauma-stress symptoms was evident.

Key Factors affecting Impacts

Further investigation of the data sought to establish whether there were any factors linked to the number of impacts of trauma that the respondents reported.

There appeared to be little difference between the number of impacts according to when trauma had occurred in the respondents' lives. Those who had experienced trauma as a child reported a mean of 6.6 impacts, those who experienced trauma as an adolescent reported a mean of 6.6 and those who experienced trauma as an adult reported a mean of 6.4 impacts.

A correlation was found, however, between the number of impacts reported by participants and the number of traumatic incidents that they had experienced. Those who had experienced trauma more often had higher numbers of impacts, as shown in the table below.

No. of times trauma experienced	**Mean no. of impacts**	**No. of cases**
Once	4.3	15
2-3 times	5.3	20
4-5 times	6.9	14
More than 5 times or for a prolonged period	6.8	49
Don't know	4.0	4
Total	**6.0**	**102**

When considering the relationship between the number of impacts reported by a respondent and the project they were accessing, the numbers were too small among some projects to make comparisons meaningful. However, among the projects that provided higher rates of response, there were substantial differences in the mean number of traumatic impacts. Clients of Basis Sunderland had a mean of 7.4 impacts and for clients of Basis Beds, the figure was 7.5. Clients of Basis Gateshead and the Southwark project both had means of 4.8. The reasons for the disparities are not entirely clear, although a partial explanation is provided by the ethnic differences discussed shortly.

Significant differences also emerged when considering the gender of the respondents. Female respondents reported a higher mean number of impacts of trauma than the male respondents, at 6.5 compared to 5.7 respectively. A similar pattern was found when assessing the needs and vulnerabilities of the Fulfilling Lives beneficiaries at the point of entry onto the programme (Moreton et al., 2018; Lamb et al., 2019a).

A further factor explored was homelessness. Respondents who had experienced homelessness were likely to report higher numbers of impacts of trauma than those who had not, as shown in the table.

Homelessness history	**Mean no. of impacts**	**No. of cases**
Have been homeless	6.3	80
Have not been homeless but have been at risk	4.8	14
Not been homeless	5.1	9
Total	**6.0**	**103**

At what point a respondent experienced trauma in relation to their homelessness also appeared to affect the number of negative impacts reported. Although it was most common for trauma to have occurred prior to homelessness, respondents in this situation reported a mean number of 6.2 impacts. In contrast, those who experienced trauma after homeless (but not related) reported a mean of 6.4 impacts, those who experienced trauma while homeless reported a mean of 6.8 impacts and those who experienced trauma as a result of homelessness reported a mean of 7.4 impacts. Those who said trauma was preventing them from moving on from homelessness also reported a high number of mean impacts, averaging at 7.8. These findings are likely to be explained, in part, by the trauma associated

with becoming and being homeless as discussed earlier, and the additional complexities and challenges associated with addressing needs when individuals are homeless.

The small numbers of respondents in many ethnic groups means that caution must be exercised when looking at ethnic differences in the data. However, while there was only one respondent from a minority ethnic background who had not experienced trauma, mean numbers of impacts of trauma appeared to be lower for some ethnic groups than for others. This is demonstrated by the table below.

Ethnicity	**Mean no. of impacts**	**No. of cases**
Any other White background	6.7	3
White: UK	6.4	75
Other Asian background	4	3.5
Other Black background	4	3
Black African	3	3
Black Caribbean	3	2.3

There were no striking differences between age cohorts when considering numbers of impacts of trauma, with the 31 to 35 age group having the highest mean number (7.9) and the 56 to 60 group the lowest (3.0). The 31 to 35 age group were one of several age groups where 100% reported emotional difficulties and were also the most likely to report self-harm and a negative view of self.

The 31 to 35 age group were subsequently treated as a 'middle' group to compare with those aged 30 or less and those aged 36 or over. There was one striking difference between the age groups with 40.9% of those aged 30 or less saying that trauma had led to substance abuse, compared to 77.8% of those aged 31 to 35 and 73.8% of those aged 36+. This finding is consistent of those of Lamb et al (2019a), when examining the Fulfilling Lives data

Trauma and Homelessness

Studies that have explored levels of trauma among homeless populations indicate that these populations have a disproportionately higher prevalence of trauma survivors than that found in the general population data (Sundin and Baguley, 2015; Maguire et al., 2009; Pope et al., 2020; Bender et al., 2010; Buhrich et al., 2000; Wong et al., 2016; Zlotnik et al., 2010). Within this study, 94% of those with experience of homelessness also reported experiences of trauma.

Homelessness as a source and form of trauma was discussed earlier in the report. Considering the relationship between these two factors further, 65% of those who answered the question said trauma had affected their housing situation. The qualitative data indicated that trauma was often a key 'trigger' for homelessness. In other words, there was often a significant traumatic event or experience which resulted in homelessness. Among the sample, trauma in the form of war or the risk of persecution led to several participants needing to flee their home country. Several left settled accommodation due to trauma in the form of significant relationship breakdown with parents or partners, often as a result of neglect, abuse or domestic violence. One attributed their homelessness to the breakdown of their relationship which followed serious sexual assault by a stranger. Several participants reported that their household was evicted from housing when growing up due to their parent's substance misuse and one was evicted from their social housing tenancy due to their partner's drug dealing and violent behaviour. One participant left the property in which they were living following the death of a child as they could not cope living in the property without them. Another became homeless following a house fire, which left them with nowhere to go.

It was also common for the effects of trauma (such as poor emotional regulation, lack of self-care and addictions) to be a key contributor to experiences of homelessness. To give some examples, one participant was taken into local authority care as a child following years of growing up in an abusive

home. Several foster placements broke down, however, due to problems of emotional regulation which emerged as a result of the trauma experienced. Several said they lost settled accommodation due to rent arrears which occurred as a result of an inability to function following traumatic events such as the death of a partner. Several reported being evicted from supported accommodation due to mental health problems, poor emotional regulation and aggressive behaviours that stemmed from past experiences of trauma. Another reported repeat homelessness due to long-term addiction which stemmed from trauma. They reported drinking multiple litres of vodka per day and being in and out of hospital on a weekly basis at the point of completing the questionnaire. It is important to note here that similar to homelessness, the experience of addiction and mental ill-health were also said to be traumatic so the relationship between trauma, the impacts of trauma and homelessness was often bi-directional and could not always be easily disentangled.

The literature on trauma and homelessness suggests that trauma can impact on the chronicity of homelessness (Macia et al., 2020). This assertion was supported by the data in this study. 54% of those with experience of homelessness reported five or more experiences of trauma or trauma over a prolonged period of time. In addition, over one-third of participants (35%) reported feeling that trauma was preventing them from moving on from homelessness. Several reported difficulties accessing accommodation due to housing exclusions due to behaviours linked to past experiences of trauma. For example, one reported being excluded from a number of housing providers due to historical rent arrears which occurred following a bereavement. Another reported housing exclusions as a result of their criminal record. They said their reputation preceded them when applying for housing. It was most common, however, for respondents to attribute this to needs relating to the impacts of trauma being unresolved. Most reported concerns over their ability to sustain both supported accommodation and their own tenancy at the point of completing the questionnaire due to outstanding mental health needs, poor emotional regulation (sometimes resulting in aggressive behaviours), active addictions, inability to think and concentrate, and a lack of self-confidence. For example, one reported being unable to remain in supported accommodation for any significant period of time due to not feeling physically and psychologically safe in those environments following past experiences of abuse. Another reported concerns over their ability to sustain a tenancy as they have never had any stability in their life. Others reported concerns over their ability to manage a tenancy (including the payment of bills) due to difficulties thinking and concentrating and being in an early stage of recovery from addiction. Another reported concerns over the prospect of living alone after many years of communal living (in a children's home, prison and supported accommodation). While it was not possible to quantify the extent to which trauma had affected the length of time during which some of the participants had experienced homelessness, the data clearly indicated a relationship between these two factors. As a further point, many of the participants considered that housing stability would be necessary for them to fully address their needs relating to trauma, suggesting a 'catch-22' situation.

Specialist Trauma Support

66 respondents (64% of those who answered the question) said trauma had led to a mental health diagnosis. Conditions included anxiety, depression, post-traumatic stress disorder, personality disorder and paranoid schizophrenia. Several had been prescribed medication and had Community Psychiatric Nurse (CPN) workers to support with their conditions. 65 respondents (63% of those who answered the question) had accessed specialist help for trauma.

Those whose trauma had led to a mental health diagnosis and those who had tried to access specialist support reported an above average mean number of impacts of trauma compared to those who did not, at 6.6 and 7.1 impacts respectively. These two indicators also correlated with five or more experiencers of trauma or trauma over a prolonged period of time. This suggests that these sub-groups of participants were amongst those with the most acute need for support from services.

The most common form of specialist support accessed was Talking Therapies. This had typically been accessed with the support of GPs, though other services including Oasis Community Housing and

crisis teams were said to have helped with this on a small number of occasions. A small number had accessed in-house mental health support provided within supported accommodation. Broadly speaking, respondents who had been diagnosed with a mental health problem appeared better able to access specialist services. Without this, one participant reported being referred for support only after 'begging their doctor'. Several others said they were only 'taken seriously' and able to access support after reaching a crisis point.

Participants reported mixed views about the effectiveness of the support received. Some of the feedback given was highly positive, as outlined below.

> '*I've had therapy for PTSD which has made a significant difference for the positive'*
>
> *'Trauma therapy has been key for me. Specialised therapy is much more than standard counselling or traditional CBT'*

It was much more common, however, for participants to report negative feedback. Many of the problems discussed reflected well-known individual, service and systemic barriers to mainstream mental health support for those experiencing multiple disadvantages. This includes those identified through the Fulfilling Lives programme (CFE et al., 2020; Broadbridge & Blatchford, 2018; McCarthy et al, 2020; Revolving Doors Agency, 2020). Many reported long waiting times between referrals and support being provided, meaning the cumulative impacts of trauma had already taken hold. Here, one participant said:

> *'I would refer myself for help but I would have to wait too long to receive it. There would be more negative thoughts and feelings getting in my head during that time. By the time I received the help, I had different needs because of the lapse of time'*

Long waiting times were also said to be discouraging. One respondent requested specialist support for grief when in prison but was unable to access this due to long waiting times. They were supported by the prison chaplaincy instead. They described this as very helpful.

Several participants had had initial appointments but had no clarity about next steps. For example, one participant had had a brain scan, but had not received any follow up at the point of completing the questionnaire.

Co-occurring mental ill-health and substance misuse had resulted in several participants being excluded from assessment and support. Several had been told they would need to address their problems of addiction before mental health support could be provided. This is despite national NICE and Public Health England guidance requiring the provision of services for people with co-occurring issues. There were plentiful comments about this. A snapshot of these included:

> *'I am unable to access psychotherapy because my alcohol intake is too high'*
>
> *'I have not been able to get the help as they say I need to stop drinking'*
>
> *'Because I drink, I cannot get mental health support'*

Mental health treatment had also been withdrawn from one respondent due to their aggressive behaviour, which had resulted from the trauma which they had experienced and from another who was unable to attend their appointments due to being a victim of domestic abuse at the time. They missed several appointments due to incidents and needing to move into temporary accommodation.

An inability to engage with traditional and mainstream models of mental health service delivery was similarly reported by a number of respondents. One reported that accessing services was not an option for them until a significant period of time had passed following their most acute experience of trauma

because the prospect of booking, remembering and attending a formal appointment without someone to support them was too overwhelming. Others did not feel they connected with specialist support services due to: a lack of understanding of how the services could help or how they operated; the nature of service delivery (especially where telephone-based); feeling overwhelmed by the number of professionals they needed to engage with; feeling a lack of connection with workers; and/or, not feeling services understood the gravity of the trauma which they had experienced. Others felt traumatised by having to repeat their personal histories to each professional they engaged with. Some of the key comments provided here were:

> *'I feel I have to constantly repeat myself to mental health, services and often feel they don't believe me'*

> *'Not very helpful really. They didn't seem to understand me or my needs and I don't know how to explain them either. They didn't understand my feelings at the time'*

Where participants had not tried to access specialist support, the most frequently cited reasons for this were not being able to think clearly following a traumatic event; finding the thought of engagement with a service to be too overwhelming; and, not being aware of the support options available to them. Perhaps the most poignant response here was:

> *'I know I need to talk about the trauma, but I don't like to because I get upset and I don't like getting upset'*

Trauma-Informed Approaches to Support

Trauma-informed care (TIC) is an approach to support which acknowledges the impact that trauma may be having on the lives of service users, seeks to recognise the signs and symptoms of trauma in service users, integrates knowledge about trauma into policies, procedures, and practices, and actively resists re-traumatising or further traumatising individuals. Central components of TIC are the creation of physically and emotionally safe environments for service users, the development of trusting relationships with services through clear communication, working with service users collaboratively thus giving them a sense of choice and control over their support journeys, and empowering service users through a focus on their strengths and resources (Harris and Fallot, 2001). Across a range of fields, TIC has been associated with improved service user experiences and outcomes (Kahan et al., 2020; Miller and Najavits, 2012). While there is a burgeoning literature on TIC and multiple disadvantages, the homelessness sector as a whole has not yet fully embraced the approach, though commonalities exist with philosophies such as Psychologically-Informed Environments and Housing First which have been key features of homelessness policy and practice over the past decade (Dobson, 2019).

The questionnaire asked a series of questions about the participants' broad experiences of working with services. The questions were specifically designed to explore the extent to which services were following the principles of TIC. Respondents were asked whether they felt physically and emotionally safe when accessing services, whether they felt listened to and comfortable when talking to service providers, whether they had been supported to access the help they needed to address their needs, and whether they felt a sense of control over their futures in this context. The responses given are summarised in the table below.

Experience of engagement with services	**Always**	**Sometimes**	**Rarely**	**Never**	**Not Stated**
Felt physically safe when accessing services	61%	24%	3%	2%	10%
Felt emotionally safe/supported when	54%	29%	5%	2%	10%

accessing services					
Felt listened to when accessing services	48%	34%	6%	3%	10%
Felt supported to access services they needed	45%	36%	8%	2%	8%
Feel they have control over the future	28%	32%	14%	18%	8%

Overall, participants were largely positive about their experiences of engaging with services. The majority reported always or mostly feeling physically and emotionally safe when accessing support. Most also reported either always or mostly feeling listened to by providers.

Among those who were living in supported or hostel accommodation, 59% said that they always felt safe when accessing services, 54% said that they always felt emotionally supported, 46% said they always felt listened to, 50% said that they had been supported to access all the support that they need and 29% always felt that they had control over their future. These figures are very similar to the figures for the sample as a whole, suggesting little impact of living in Oasis Community Housing accommodation compared to engagement with other types of service.

A further exploration of the impact of the relationship between these questions and other variables, i.e. those associated with personal characteristics and the nature of trauma, showed that very few had any obvious impact. The most striking was that 37% of those who had experienced trauma as a result of becoming homeless said that they always felt listened to when accessing services, compared to 60% of those who had not experienced trauma as a result of becoming homeless.

84% of respondents reported feeling they could speak to a worker at Oasis Community Housing If they needed support and 63% reported feeling they could speak to another professional if needed. Most also reported either always or mostly feeling that they been supported to access the help they need to address their needs. While over 50% of respondents reported positively about a sense of control about their futures in the context of engagement with services, fewer positive responses were given here.

In the qualitative comments provided, the participants were overwhelmingly positive about the support received from Oasis Community Housing. Most related to the value of support provided through Basis services. Some of the feedback provided here included:

> *'I don't know what I'd do without support from Basis for simple things like a shower. Also to the soup kitchen which has kept me from starving. Being able to stay clean really helps and makes me feel better'*
>
> *'My support worker helped me to access services and helps me with the day-to-day things like appointments to move forward in life'*
>
> *'I am currently in a basis bed so have a great chance of making moves towards social housing status. I feel without this opportunity, I would never have had the chance'*

Several participants also spoke positively about the support received from various food banks and addictions and recovery services. For example, one participant said they self-medicated with alcohol for three years following the death of their father. Once they engaged with a recovery support service, they were immediately supported to address their problems of addiction and physical health. They continue to engage with the service today. In the main, respondents spoke less positively about the support received from social services, criminal justice agencies, a housing options team, and mental health services (as discussed in the previous section). Considering some of their experiences in more detail, several discussed having social workers but having either no contact with them or not feeling

supported by them. One talked about the lack of specialist mental health support available to them while in prison. Another reported a lack of support when they left prison. Another reported a reluctance by their probation worker to refer them for mental health support because they were not offending. This has resulted in the participant feeling that the service does not genuinely care about their well-being. One reported feeling unsupported by a local authority housing options team. The only housing offer made to them was a place in a hostel. They did not want to enter this type of accommodation so had been sleeping in their car for several months at the point of completing the questionnaire.

While the feedback about services in the main was promising, Oasis Community Housing staff reflected on the possibility that the power dynamics inherent in the relationship between support worker and the participants may have influenced answers about the experience of accessing services. It is also important to note that a significant minority of respondents reported rarely or never feeling physically and emotionally safe, listened to, and supported when accessing services, and lacking a sense of control. The previous sections of this report indicate that these feelings are mostly link back to the effects of trauma but developing a clear understanding of the reasons for this and responding accordingly could make a significant difference to service user experiences and outcomes.

Further key aspects of TIC are staff training, support, and supervision. These are for the benefit of both service users and staff (McCarthy et al., 2020). The importance of these aspects was highlighted through the research process. Staff reported that where completion of the questionnaire opened conversations about trauma with service users, some service users became distressed and required comfort and support from workers. In other cases, the conversations prompted the identification of useful courses of action and generated further support work, including referrals to GPs to discuss issues around mental health. Staff also had variable experiences in terms of how their own well-being was impacted by supporting the research. Exposure to trauma is a common feature of their work, but some reported that intentionally seeking conversations about traumatic events, sometimes in volume, was difficult for them. Support arrangements, like funded access to clinical supervision, are embedded within Oasis Community Housing, and at least one member of staff wanted to access this in light of their experiences gathering the data. It is positive that this support is available to staff, with a growing body of research emphasising the need and value of this (Reeves, 2015; Radis, 2020), and that the staff member felt sufficiently comfortable to disclose wanting to access the support available.

Lastly, participants were asked whether they needed any further help than they were currently receiving and if so, the nature of this. 48% of respondents said they needed more help. Interestingly, these respondents reported a higher mean number of impacts of trauma (6.7) than those who felt they were receiving all of the services needed (5.1). Support to access and sustain housing and specialist mental health support were the two key types of support requested. In addition, one participant said they would like support to access medication to help them to manage anxiety and sleep.

Insights from the Fulfilling Lives Programme

The Fulfilling Lives programme was an eight-year Big Lottery funded initiative which sought to improve the lives of those with multiple and complex needs through improved access to joined-up and person-centred services. A key focus of the programme was 'systems change' – designing, piloting and evaluating new ways of working with those with multiple and complex needs. Multiple and complex needs was defined by the programme as individuals experiencing at least two of the following: homelessness, substance misuse, offending and mental ill-health. Approximately £112 million was invested in voluntary sector-led partnerships across 12 areas in England. The partnerships were awarded funding in February 2014 and began working with beneficiaries between May and December 2014 (Lamb et al., 2019).

A further key aspect of the Fulfilling Lives programme was national and local research and evaluation. This involved detailed research with locally led delivery projects to track and assess the achievements of the initiative, to calculate the costs and social and economic benefits of the programme, and to identify what interventions and approaches work well for those with multiple and complex needs and in what circumstances. Over 300 outputs (including reports, briefings, toolkits, leaflets and presentations) were produced throughout the years of the programme and are publicly available on the Fulfilling Lives evaluation website. This section of the report discusses some of the key findings and learning to emerge from the programme that have most relevance to this piece of research.

The Profile of the Fulfilling Lives Beneficiaries and Comparisons with the Questionnaire Respondents

The national Fulfilling Lives evaluation reports indicate that over its lifespan, the 12 partnerships engaged with approximately 4,000 people with multiple and complex needs. The profile of beneficiaries was broadly male, White and aged between 25 and 44. There was a high prevalence of complex needs among beneficiaries at the point of entry to the programme. Substance misuse and mental health problems were most common. Almost all of the beneficiaries were affected by these Issues and 90% had both substance misuse and mental health needs. Most of the beneficiaries (52%) had all four needs at the point of entry into the programme and 42.5% had three needs. Just 5.5% had just two of the four needs (Lamb et al, 2019b).

The data which is available suggests a significant degree of overlap between those who completed the Oasis Community Housing questionnaire and the Fulfilling Lives beneficiaries, both in terms of demographic profile and the presence of multiple and complex needs. There are several points of departure, however. The Oasis Community Housing research involved a higher proportion of women, young participants (aged 16 to 25) and those from BAME backgrounds. In addition, mental health was the most prevalent need of the participants, with problems of offending and substance misuse being slightly less prevalent.

The Prevalence of Trauma among Fulfilling Lives Beneficiaries

Data about trauma was not systematically collected as part of the Fulfilling Lives programme. Beneficiaries were not routinely asked if they had experienced traumas and the nature of these. As such, no programme level data is available. However, it is reasonable to assume that the majority of beneficiaries had experience of trauma. The trauma literature makes clear that there is a strong association between trauma and multiple and complex needs (McCarthy et al, 2020) and the findings of the Oasis Community Housing questionnaire add to the extant evidence base as the multiple and complex needs of the participants were typically the result of trauma. Furthermore, many of the national and local level reports refer to the presence of complex trauma or a history of ACEs among beneficiaries and contain case studies which highlight the role of trauma in their life-courses. The types of traumas highlighted in the reports closely reflect the experiences of trauma disclosed by the questionnaire respondents (see for example Crowe et al., 2021; Burrows et al., 2021; Garrett et al,

2022; Hess et al., 2022; Hough, 2020; Ipsos MORI Social Research Institute, 2019; Lamb et al., 2019a; Van Zyl et al., 2022).

In light of widespread recognition of the impact of trauma on the lives of beneficiaries, a number of local partnerships developed and trialled specific services, interventions and models of working that took into account the effects of trauma (including specific types of trauma, for particular groups of beneficiaries). Notable is the level of consideration given by some partnerships to the gendered nature of trauma and what effective service provision for women affected by trauma might be (see for example Rogers et al, 2021; FLIC & Solace, 2019; Cordeiro, 2020).

The Influence and Impact of the Fulfilling Lives Programme

While the long-term impact of the Fulfilling Lives programme is yet to be known, the programme appears to have several notable achievements which are of relevance to this research.

Impact on Beneficiaries

The programme evidenced that despite high levels of need (and the likely high prevalence of complex trauma), it is possible to engage with and effectively support those with multiple disadvantages to reduce their levels of need and risk. The national evaluation data indicates that after approximately one year with Fulfilling Lives, beneficiaries who had remained engaged typically had overall lower levels of need and risk. Key areas of improvement were reductions in unintentional self-harm and housing need, improved impulse control, and better engagement with services. Beneficiaries also typically improved their levels of self-reliance and independence, with progress made in the areas of emotional and mental health, managing tenancies and accommodation, substance misuse, and social networks and relationships (Lamb et al., 2019c). All of these factors can result in trauma and/or can be considered trauma stress symptoms. It follows therefore that the Fulfilling Lives programme was helping to mitigate the causes and consequences of traumas that may have been experienced by the beneficiaries.

The Fulfilling Lives findings also indicate that relatively rapid progress can be made in addressing some of the immediate aspects of chaotic lives, but tackling underlying, more complex and entrenched issues, such as poor mental health resulting from trauma and substance misuse (which were key issues affecting the participants of this research) take longer. Furthermore, access to specialist help with complex needs is central to progression (Lamb et al., 2019c; CFE et al., 2020). The average time in the programme before positive move on was achieved was over two years (Moreton et al., 2018), highlighting the need for long term support to be available to those with multiple and complex needs. Furthermore, a key difference between those who had a planned move on from the programme and those who disengaged was progress in the area of social networks and relationships (Moreton et al., 2018), suggesting that a focus on social support within service delivery could be highly beneficial to users.

The Social and Economic Impacts of Addressing Multiple Disadvantage

The Fulfilling Lives programme was significant in identifying the barriers and challenges that those with multiple disadvantages face when trying to access mainstream services and the often ineffectiveness of support when received. The costs of multiple disadvantages are significant and impact a wide range of agencies and organisations. As well as the cost to the state of delivering public services, there are widespread societal costs associated with the unnecessary loss of life, crime and anti-social behaviour, to give just a few examples. Critically, however, the Fulfilling Lives programme also demonstrated that significant social and economic benefits can be derived through more joined-up and person-centred service delivery in this area. This includes significant net reductions in the average cost of service use, significant reductions in respect of a range of social harms, and critically, reductions in the premature loss of life (Moreton et al., 2021).

Impact on Systems and Services

The programme-level evidence also suggested that the Fulfilling Lives programme increased awareness and understanding across services of the experiences and needs of those affected by multiple disadvantages and the need for 'systems change', supported the professional development of the workforce, and facilitated the setting up of structures to support long-term collaboration and coordination across services. But as highlighted in this research, many barriers to effective support for those with multiple and complex needs remain and this is particularly true in terms of mental health services. It is promising to see therefore that the momentum developed through the Fulfilling Lives programme will continue through the newly launched Changing Futures programme and the ongoing work of the National Experts Citizen Group. It is also important however that the learning achieved through the Fulfilling Lives programme continues to be embraced at the local level.

Interventions and Models of Working that Support the Mental Health of Those Affected by Trauma

In light of the overlap between the experiences and needs of the Oasis Community Housing respondents and Fulfilling Lives programme beneficiaries, this final section considers the key insights to emerge from the programme about interventions and models of working that appeared to impact positively on the mental health of beneficiaries.

Navigators and Peer Mentors

This research has once again highlighted some of the difficulties that those with complex needs face to accessing mainstream services. One seemingly effective method of overcoming access issues identified through the Fulfilling Lives programme was the use of 'navigators'. The role of navigators is not new, but these are often sector-specific roles. In the Fulfilling Lives programme, service navigators typically provided holistic, cross-sector support to those experiencing multiple disadvantages. Across multiple local partnerships (including Birmingham Changing Futures Together, Opportunity Nottingham, and West Yorkshire Finding Independence), navigators played an important role in advocating on behalf of beneficiaries and standing up for their rights when required. Navigators also built positive working relationships with service providers in their area and helped to enhance understanding of the needs of people affected by multiple disadvantages. They also played a vital role in supporting beneficiaries to prepare for and attend appointments and assessments. With the support of navigators, the national and local evaluations showed increases in the proportion of beneficiaries being able to access and engage with support, particularly in the areas of mental health and substance misuse (Lamb et al., 2019ac; Bowpitt et al., 2016; Revolving Doors Agency, 2020; CRESR, 2016; Emerging Horizons, 2017). In addition to indicating the effectiveness of this approach, much learning also took place across the lifespan of the programme about the skills and qualities that make an effective navigator, the training needs of navigators, and the broader systems change that needs to take place to enable this role to be effective; notably (Broadbridge, 2018; Moreton et al., 2021; Parr et al., 2017). To this end, a number of partnerships developed toolkits and training for navigators to support with knowledge of legal entitlements and service referral pathways (such as the VOICES' Care Act Toolkit). Others provided opportunities for professionals from a variety of sectors and disciplines to come together to enhance understanding of different professions and services and how they can work more collaboratively. This included the creation of communities of practice, multi-agency training sessions and the co-location of mental health professionals within Fulfilling Lives teams. All were reported to have led to improved relationships and understanding of different services, what they do and how best to access them. Newcastle-Gateshead's Respond training was reported to be an effective example of this (CFE et al., 2020).

Similar to the navigator approach, most partnerships embraced the use of 'peer mentors' and evaluations generally reported a positive impact of this on beneficiaries. Peer mentors are individuals with lived experience of multiple needs who connect with beneficiaries. Typical peer mentor roles included helping to reach out to and engage beneficiaries in the programme, accompanying

beneficiaries to appointments, taking part in social activities with beneficiaries, and providing a role model for recovery. Evaluation reports suggest that beneficiaries tended to welcome support from peer mentors. Over time, they felt less isolated, more confident and more motivated to engage with and open up to services. Higher levels of service engagement subsequently resulted in improved outcomes across a range of areas, including physical health, mental health and social networks and relationships (FLIC, 2019; Emerging Horizons, 2017). Similar to navigators, the Fulfilling Lives research highlighted the importance of ensuring that peer mentor teams work closely with key-worker teams, all services are bought into the concept and effective training and ongoing support for peer mentors is provided (CFE et al., 2020; Moreton et al., 2018; Moreton et al., 2016).

Information Sharing

A further key issue identified through the Oasis Community Housing questionnaire and Fulfilling Lives programme is the impact of service users having to repeat their personal histories of trauma and support needs to multiple services. To tackle this, several partnerships developed common assessment tools and other mechanisms for sharing information about people across services, including mental health, housing and the criminal justice system. One example of this is Inspiring Change Manchester's GM-Think system. This is reportedly used by over 20 agencies to share information quickly and safely and has helped coordinate support through better communication between agencies and reduced the need for people to tell their stories multiple times (CFE et al., 2020).

Bespoke In-House Mental Health Services

In a bid to tackle well-known barriers to accessing mainstream mental health services for those with multiple and complex needs, several partnerships developed bespoke mental health services for those experiencing multiple disadvantages. Key pilot projects included Opportunity Nottingham's specialist mental health workers and West Yorkshire-Finding Independence's flexible psychological therapy service (CFE et al., 2020). The pilots provided beneficiaries with psychological support to help them manage mental health conditions and past trauma, allowing them to stabilise their behaviours and cope better day-to-day. The support also provided a stepping-stone into mainstream mental health services by helping people to meet sobriety requirements or being better prepared to take part in group work. The key to the success of these projects was working with beneficiaries in ways that were flexible and person-centred. Taking time to build trust between the therapists and beneficiaries was an important pre-cursor to treatment. Embedding therapists within trusted teams and services was an effective way of achieving this. It also facilitated knowledge exchange between staff. The beneficiaries interviewed for the purposes of evaluation welcomed the opportunity to access support in settings where they felt relaxed and comfortable, and they found the co-location of services to be convenient. More broadly, Fulfilling Lives therapists reached out to and worked with beneficiaries in their homes, cafes and parks, as well as from Fulfilling Lives premises. Appointments were also designed with people facing multiple disadvantage in mind. As such, they were longer than traditional appointment times, were often made for afternoons, and allowances were made for people turning up late or missing appointments (CFE et al., 2020; Murphy et al., 2020). However, these approaches essentially by-passed mainstream statutory services. The financial feasibility of this in the long term is difficult to assess.

Clinical Supervision Supporting Non-Specialist Client-Facing Workers

Some partnerships also provided 'pre-treatment' support to help beneficiaries better manage behaviour and relationships, preparing them to engage appropriately with therapy and other professionals. For example, the South East Partnership provided specialist therapeutic support to people who would ordinarily be considered 'not ready' for treatment. The qualitative evaluation data suggested that the support provided had a positive and meaningful impact on the beneficiaries and was successful in facilitating access to other specialist therapy (FLSEP, 2019). A key part of the success here was the provision of appropriate clinical supervision to non-specialist workers. To this

end, the partnership worked with clinicians to develop guidance about how to manage disclosures and behaviours that impact on access to formal treatment. The guidance included the suggestion that the focus of support should be on helping beneficiaries to build a stable psychological foundation ahead of treatment. This means targeting emotional regulation (addressing how trauma is presenting), rather than encouraging disclosures. Local evaluation suggests that clinical supervision supported worker well-being, lessened compassion fatigue, and created space for workers to think creatively, manage risk and develop trauma-informed and reflective practice (FLSEP, 2022).

Psychologically-Informed Environments (PIEs) and Trauma-Informed Services

PIEs and trauma-informed services are consciously designed to understand and address the emotional and psychological needs of service users, taking into account their past experiences. They are designed to support typically non-clinical staff to better understand and respond to the emotional and psychological needs of service users and to support service users to feel physically and emotionally safe when accessing services, resulting in better engagement and improved outcomes. The principles of psychologically-informed environments and trauma-informed support were widely used across Fulfilling Lives partnerships in a variety of ways. For example, the Liverpool Waves of Hope partnership piloted the value of a PIE-informed approach in one accommodation-based homelessness service (Nolan and Butler, 2018). The Newcastle-Gateshead partnership piloted the value of PIEs in a homeless drop-in centre, a supported accommodation project and a residential mental health rehabilitation and recovery unit (Boobis, 2016). Birmingham Changing Futures Together organised training for 200 front-line workers across 15 organisations working with individuals with multiple and complex needs (Revolving Doors Agency, 2019). In the main, the evaluation data suggests that most emphasis was placed on staff training on the principles and frameworks that underpin PIE and TIC, and regular opportunities for reflective practice. The data thus provides useful learning about implementing a PIE and evidence of perceived impact on staff, particularly in terms of changes in their knowledge, skills, relationships, confidence, resilience and working practices. The data also suggests that in some localities, the framework provided staff with a common language and a shared set of values across organisational boundaries. This has helped to create a greater sense of teams working together towards a common goal. Ultimately, this could result in those with multiple needs receiving more co-ordinated and effective support. There is less evidence on the impacts on beneficiaries, though it was reported that Liverpool's psychologically-informed accommodation service had a higher rate of successful move-on than accommodation services across Liverpool more generally (Nolan and Butler, 2018; CFE et al., 2020).

Housing Support

The findings of both the Oasis Community Housing questionnaire and the Fulfilling Lives research make clear that there is a strong link between poor mental health and other disadvantages, including homelessness and substance misuse (Lamb et al., 2019a; Moreton and Welford, 2022). It follows that mental health support needs to be provided alongside support to address other issues, such as securing appropriate accommodation, help with substance misuse and the development of positive social networks. Housing First is an evidence based, client-led approach to tackling homelessness that has been shown to be particularly effective for people experiencing multiple disadvantage. A number of Fulfilling Lives partnerships, including Inspiring Change Manchester, Fulfilling Lives Islington and Camden, VOICES and West Yorkshire Finding Independence, had Housing First schemes and reported these to be successful. The evaluation evidence suggested relatively high levels of tenancy sustainment, as well as improvements in the physical and mental health of beneficiaries, increases in their sense of hope for the future, and reductions in substance misuse and offending (CFE et al., 2020; Bimpson, 2018; FLIC, 2016; Crisp et al., 2018). A particularly notable feature of the Fulfilling Lives research was recognition of the distinct support needs of women who are homeless. As identified through this research also, women often have particularly complex experiences of trauma and complex and personal notions of safety. Support services and accommodation projects that feel unsafe are unlikely to be accessed or frequently used. Across the programme, the use of female navigators, the setting up of a women's drop-in, a women-only hostel and a specialist Housing First scheme for

women who had experienced domestic abuse were very positively received by beneficiaries (Moreton and Welford, 2022; FLIC, 2018; Inspiring Change Manchester, 2022).

Conclusion and Recommendations

This research sought to explore the prevalence of trauma among those with experience of homelessness and to consider what effective responses to the needs of this population group may be. The research identified a high prevalence of trauma among the research participants. Often the trauma experienced was complex and had occurred at multiple stages in the life-courses of the participants. The impacts of trauma on their lives were often wide-ranging and devastating, and resulted in the experience of multiple disadvantages, including poor metal health, substance misuse and homelessness. The experience of trauma and the impacts of this also clearly intersected in multiple ways with a number of other factors, including age, gender and refugee status. This intersectionality had a significant impact on the needs of the participants and accordingly, their needs from services.

The research also identified a complex and often mutually reinforcing relationship between trauma and homelessness. Within this study, trauma was most often a precursor to homelessness. Sometimes it was a direct trigger for this. In other cases, it was the longer-term impacts of trauma that ultimately led to homelessness. But homelessness itself was often experienced as trauma and increased the likelihood of exposure to further traumas and the negative impacts of trauma. Where complex and unresolved, past trauma and the impacts of this were key factors preventing move on from homelessness. The research thus further supports the argument that it is futile to try to solve the issue of homelessness without addressing trauma.

While participants generally spoke positively about their experiences of voluntary sector-led services and particularly the support received from Oasis Community Housing, positive experiences of support were not universal. Difficulties in relation to the accessibility and effectiveness of specialist mental health support and to a slightly lesser degree, housing, were widely reported. The importance of the principles of psychologically informed environments and TIC were also evident in the data. Engagement and satisfaction with services was typically reported where participants felt physically and emotionally safe accessing services and felt that service providers genuinely cared about their needs and well-being. Where these principles were felt to be absent, a reluctance or inability to access and engage with services, and experiences of re-traumatisation were apparent. It is vital that all services engaging with this client group acknowledge and understand the past and present harms experienced by service users to avoid reproducing further harms in the future.

The findings of this study largely reflect those found through the Fulfilling Lives programme. There was much overlap in terms of the life experiences, support needs and experiences of engagement with services between the participants of this study and the programme beneficiaries. It follows that much of the learning achieved through the programme is relevant here. Critically, the programme highlighted the importance of addressing mental health in order to make progress in other domains of multiple disadvantage, and modelled what more flexible and person-centred therapeutic services could look like.

To move forward, the research supports the following recommendations:

- Central government funding is made available to provide trauma-informed training for all frontline staff working in homelessness and related support services.
- Local authorities commit to only commissioning homelessness services and support services that are person-centred, trauma-informed and psychologically-informed, where the individual is supported to make their own choices and identify what is important to them.
- Additional funding is made available to enable local authorities to appoint dedicated mental health professionals, who have an understanding of the traumas and other underlying issues experienced by people facing homelessness, in every local authority mental health service.
- Work is undertaken with NICE to promote Guideline [NG58] on Coexisting severe mental illness and substance misuse, with a view to encouraging wider uptake of the guideline.

- The Homelessness Reduction Act's Duty to Refer is extended or amended to create a new Duty to Collaborate, which extends to GPs, mental health and drug and alcohol services as important partners for local authority housing teams – with appropriate additional resources committed.
- There should be a cross-departmental focus on homelessness prevention. By investing in preventative measures, such as early mental health support, the result would be fewer households in crisis. These measures would reduce the number of people who become homeless (and critically, remain homeless for long periods of time) in the future.

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