- Suzanne Mooney
- Montserrat Fargas Malet
- Deirdre O'Neill

Implementing Trauma Informed Approaches in Northern Ireland

Case Study: Belfast Inclusion Health Service

QUEEN'S UNIVERSITY BELFAST

SBNI
Safeguarding Board for Northern Ireland

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Abbreviations

ACE: Adverse Childhood Experience
CYP: Children and young people
EPPOC: cross-Executive Programme on Paramilitarism and Organised Crime
HSC: Health and Social Care
REA: Rapid Evidence Assessment
SAMHSA: Substance Abuse & Mental Health Services Administration USA
SBNI: Safeguarding Board for Northern Ireland
TIA: Trauma Informed Approach
TIC: Trauma Informed Care
TIP: Trauma Informed Practice
V/C: Voluntary and Community

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Introduction to Case Studies

1.1 Introduction

This case study is part of a larger research study which sought to review the implementation of trauma informed approaches (TIAs) in Northern Ireland (NI). This study was commissioned by the Safeguarding Board NI (SBNI) and undertaken by a research team based at Queen's University Belfast (QUB), primarily made up of academics and researchers based at the School of Social Sciences, Education and Social Work (SSESW) (including Dr Suzanne Mooney, Principal Investigator; Dr Montse Fargas-Malet, Research Fellow; Professor Lisa Bunting; Dr Lorna Montgomery; Dr Mandi McDonald; Dr Colm Walsh; Professor Davy Hayes), in close collaboration with Ms Deirdre O'Neill in the QUB School of Nursing and Midwifery (SONM). Each case study involved a smaller number of the team members. The full review of TIA implementation in NI consisted of four distinct components:

(i) **a rapid evidence assessment** of national and international literature reviews about the key components of effective TIA implementation to embed and sustain developments in diverse real world settings and methods for the evaluation of effectiveness. This REA builds on the findings of the systematic evidence review conducted by team members on behalf of SBNI in 2018-19 (Bunting et al., 2019a);

(ii) **progress mapping** of TIA implementation across key sectors and organisations in NI via a bespoke online survey;

(iii) **a strategic overview** of senior managers and professionals' assessment of TIA implementation in their area of expertise and the region as a whole via a series of online focus groups; and

(iv) **four in-depth case studies** of selected cross-sector trauma-informed implementation initiatives in NI.

Each review component built on the findings of the other elements and concluded with a distinctive output. The outputs of all four components were brought together and recommendations provided for how SBNI and partner agencies could progress the implementation of TIAs in NI. The full report (Mooney et al., 2024a) and Executive Summary Report (Mooney et al., 2024b) are available online via the SBNI website https://www.safeguardingni.org/trauma-informed-approaches/latest-research

1.2 Case Studies Overview

Methodology

An integrated process and outcomes evaluation approach was adopted to establish a comprehensive understanding of the implementation of four selected trauma-informed initiatives specifically enquiring about: 1) what was implemented; 2) how it was implemented; 3) what difference it made and to whom; as well as 4) perceived enablers and barriers within the service context and 5) transferable implementation learning. The primary aim was to show what TIA implementation looked like in diverse settings and capture important organisational learning, which could be applied to other service settings wishing to progress TIA implementation. In these ways, it was anticipated that the case studies would help provide a vision for ongoing development. Case study methods encompassed three core activities: 1) analysis of relevant documentation or information related to the TI initiative provided by the case study service; 2) a focus group with key people associated with the development or leadership of the initiative; and 3) a focus group of staff drawn from different positions across the organisation who had differential experience of the TIA initiative. All focus groups were conducted online, recorded and transcribed.

Selection

Case study organisations or services were selected by the QUB Research Team from the online survey submissions (Element 2) where respondents had indicated an interest in case study participation. All the case studies selected had implemented TIAs across the three primary implementation domains adopted by this study i.e. (i) organisational development, (ii) workforce development and support, and (iii) service design and delivery (see below for further detail). Four case studies were identified using critical case sampling, taking account of: organisation/service size; target population (adult/child); service setting; geographical remit; and service sector.

General description of the case studies

The four case studies selected were drawn from different types of service settings, including Education, Justice, and Health and Social Care. They also involved both statutory and voluntary/community organisations of different sizes, serving different populations (see Table 1.1). Each case study organisation presented unique implementation strategies and initiatives, relevant to their service setting, purpose and population. Each case study is available separately on the SBNI website.

Table 1.1: Case study description

	Type	Setting	Size	Service users	Area
Youth Justice Agency	Statutory	Justice	100-500 employees	Children/ young people	Regional
Fane Street Primary School	Statutory	Education	Less than 100	Children/ young people	Belfast
Salvation Army UK/ Thorndale Family Service	Voluntary	Multiple settings/ Social Care	500 plus employees	Children, young people & adults	UK/ Regional
Belfast Inclusion Health Service	Statutory	Health	500 plus employees	Adults	Belfast HSC Trust

1.3 A brief note on terminology and conceptualisation

The overarching term of **Trauma Informed Approaches (TIAs)** was adopted in this review to encompass Trauma Informed Practice (TIP) and Trauma Informed Care (TIC) as a means to reflect the relevance of TIAs for organisations which do not provide frontline services as well as those which do.

TIA Implementation domains: In the interest of achieving relevance for this cross-sector TIA organisational implementation review, the research team sought to merge and adapt the primary implementation frameworks available i.e. SAMHSA's (2014) ten implementation domains; Hanson and Lang's (2016) implementation framework for child welfare and justice settings; and the Trauma and Learning Partnership Initiative (TLPI) framework (Cole et al., 2013), which considered the development of trauma-sensitive schools. The following overarching framework was thus proposed encompassing three core implementation domains (organisational development; workforce development and support; and service design and delivery). Within each overarching domain, there are a number of specific implementation foci or indicators which require attention. It is acknowledged that while whole system TIA implementation includes action across at least two of these core domains, not all implementation indicators will be relevant to every organisation, dependent upon their purpose and mandate. For example, the service design and delivery domain may have different resonance dependent upon whether the organisation is a frontline service provider or a support, regulatory, commissioning or governance body (See Figure 1.1). These implementation domains and indicators were used in the analysis of each case study.

Organisational development: a range of organisational developments including governance and leadership; financing and resourcing; review of policies and procedures; the physical environment; enhanced service user involvement; progress monitoring and evaluation.

Workforce development and staff support: training and development initiatives directly related to supporting staff understanding of the impact of trauma and adversity on service users and ongoing support/supervision/training to embed practice change; support for staff wellbeing.

Service design and delivery: initiatives which sought to embed trauma-informed practices into their universal service delivery (e.g. an intentionality towards enhanced relational connection with service users; reduced use of practices which might retraumatise etc.); integrating recognition of service users' trauma history into assessment, planning and intervention; or increased access to targeted trauma-focused services and interventions i.e. specialist interventions for service user cohorts, such as group work or therapeutic modalities.

Figure 1.1: TIA Implementation Domains

Case Study: Belfast Inclusion Health Service

2.1 The Context

The Belfast Inclusion Health Service (BIHS) supports the health and social care needs of people experiencing homelessness. The service is hosted in a centralised hub and brings services out of the clinic setting onto the streets, to wrap care around people who need it most, where they need it. The BIHS Manager and Nurse Consultant has led the service from its inception in 1999. The service was the first of its kind in NI, with the subsequent development of similar services across the rest of NI. The current BIHS staff team encompasses 21 multidisciplinary professionals (see Table 2.1), who bring prior experience in acute mental health, accident and emergency as well as general population mental health, general health and podiatry care. The service has witnessed the sharp growth of homelessness and the impact this has had on increasing service demands.

Table 2.1: BIHS Team Structure

Team Structure: Total of 21 MDT Members
Service Manager/Nurse Consultant
General Practitioner Services
Psychotherapist
Nurses (Adult Nurses RGN and one mental health nurse RMN)
Senior Social Work Practitioner
Dentist
Podiatrist
Support workers (supporting blood born virus service users)
Administration staff

Two focus groups were undertaken as part of this case study, one with the service manager and the psychotherapist to explore TIA implementation from the leadership perspective (Senior Management Focus Group) and a further with four staff members, including the psychotherapist (Staff Focus Group). The BIHS service manager and staff reported how the profile of their service user population has changed over recent years, with a noted increase of younger women. Many of these young women were reported as having had care experience, with additional concerns related to sexual exploitation, human trafficking, drug use in conjunction with poor physical and mental health. Reasons for becoming homeless were thought to be varied for this population, including leaving the care system with no employment or income, breakdown of relationships, and living in areas with high levels of poverty and social deprivation.

Other issues of note for the more general BIHS population, included those who had lost rented accommodation as they could no longer afford to pay bills, due to the increase in the cost of living. Many homeless people were also known to suffer from mental ill health, sometimes as a direct result of being homeless. Staff were also aware that many had suffered significant adverse and traumatic experiences as children and in their adult lives. Some service users with severe and enduring mental illness were noted to have become institutionalised and were no longer able to look after their own needs independently, without supports in place, while others had experience of the prison system, often leaving the prison estate with no accommodation.

2.2 Trauma Informed Implementation

2.2.1 TIA alignment with service ethos and practice

BIHS service managers noted how they had been formally introduced to trauma informed practice through training and ongoing support from the SBNI TIP team in 2021. Service managers had already been aware of and influenced by the Sanctuary Model, a trauma informed model of clinical practice and organisational development initiated by Sandra Bloom. They reported how trauma informed approaches (TIAs) fitted well with the service ethos and way of working with their service users, in particular the focus on 'safety' which was noted as 'elusive' for many homeless people:

"And when we started the... formal training with the Safeguarding Board back in 21, it was just kind of... in many ways empowering and reinforcing some of the approaches we were doing to focus on the person because for some of these young people.... this was things that [we] were very clear about was this safety, that people would feel safe coming to our clinic because that's one of the principles. And safety is something that is elusive for some of these individuals with rough sleeping and hanging around with certain peer groups."
(Senior Manager Focus Group)

While aware of trauma to varying degrees in previous employment, staff focus group participants spoke of how their awareness of service users' trauma histories had increased since joining the homelessness service and the introduction of TIP through the SBNI training:

"...and I guess in my previous post..., so [there was] a lot of complexity and complex issues in patients, although we never talked about trauma previously. I actually realise now we were probably doing a lot of trauma informed practice... because a lot of them were very, very unwell and a lot of them had a lot of trauma backgrounds. And again, we just never really thought about it until I really came on to this team."
(Staff Focus Group)

There was recognition of the very high prevalence of trauma experience in this population with staff noting how it would be 'very rare' to meeting someone who had not experienced trauma and adversity of some sort:

"I'm a mental health nurse... So trauma has always been part of my experience. It's always been very much talked about within work and probably more so since going to the prison and then coming here (...) And so you're very aware with everybody you meet that there's trauma, it would be very rare to meet somebody that has not endured some traumatic experience."
(Staff Focus Group)

While nurses had always worked with people with 'severe life experiences', participants remarked how the introduction of the language of adverse childhood experiences (ACEs), the trauma lens and trauma informed practice had brought new words, terms and 'a frame of reference' to describe their everyday practice:

"But I think all throughout your career you maybe didn't have the words to identify what trauma informed practice was, but you did kind of be aware that a lot of people came from different backgrounds and different sort of experiences in their life. And you kind of always maybe made your introductions or your assessments based on the person that was in front of you. And it's only now that you kind of hear with the [trauma] lens and... the theoretical background related to trauma informed [practice] that you realised that the role you were doing all those years was very, very practical in relation to dealing with people with severe life experiences. And as people talk about nowadays, adverse childhood experiences as well. So I think that's something we've always done as nurses throughout our careers, but maybe nobody kind of had a word or a term or a frame of reference to actually identify what you were doing on a daily basis."
(Staff Focus Group)

Focus group participants reported a range of ways that the TIA framework had influenced their service across all three implementation domains, i.e., Organisational Development, Workforce Development and Support; and Service Design and Delivery.

2.2.2 Organisational Development

In the organisational development domain, there was a recognition of the importance of adopting a **'multi-agency, multi-disciplinary approach'** to caring for the homeless population in the knowledge of their complex needs and co-morbidities, and their critical interface with other services. Over the years, this had led to the building of the **multi-disciplinary team at BIHS**, which had developed to meet emerging needs ensuring service users timely access to a range of health services that they might not otherwise receive 'if left to their own devices'. This included physical and mental health services, dentistry, podiatry and psychotherapy, when appropriate:

"...I think actually also being able to access the other services really quickly... it helps me within the team... [I can] say oh, I'm 'OK, I'm going to see [name] this afternoon. The mental health nurse. I will get her to give you a call. I'll also refer you to our dentist. Hopefully they'll be able to see you. And I'll say to [nurse] about needing to get your dressing done on your leg or whatever. (...) so being able to access everybody within the team helps me as a team member as well, it's all good when you can see all the work that can be done quicker than it would be within the normal health service, or maybe not at all for our client group if they were to be left to their own devices, you know."
(Staff Focus Group)

A recent **example of service innovation** was the development of the support worker team, which is dedicated to offering support to individuals with blood borne virus (BBV) and medication concordance, with a noted increase in screening and diagnosis, and changes in profile and practices. Research conducted by the team (Maisa et al., 2019) looked at the injecting behaviours of this population. Based on interviews with service users, this team developed a range of strategies to enhance engagement and raise awareness about harm reduction amongst service users and staff in other agencies. This included putting up BBV awareness posters into hostel facilities and providing hostel staff and service users with pocket sized harm reduction information leaflets.

Inter-agency collaboration was another key area for development aligned with TIA implementation. The BIHS Service Manager and Nurse Consultant explained how she had brought interfacing services together to undertake the SBNI TIP training in the knowledge that BIHS is 'not an island' and that one service was 'never going to solve' homelessness 'on their own'. Thus, the importance of the 'whole multi-agency multi-disciplinary approach' was affirmed and promoted:

"So whenever [SBNI] did the training at the first time, she did it with us as a team and then I invited her back. So I brought in all the agencies that we would work alongside. Now that would have been like the police and... the Northern Ireland Housing Executive. It was the community and voluntary sector. It was our own staff team here and there was some hostel staff that came along that day, and the ambulance service. So a lot of these services already had trauma informed training... but you know, if you ask them like, what was it like, nobody could really answer you. So it was really nice to bring that whole multi-agency, multi-disciplinary approach... because..., we are not an island and we're never going to solve this problem on our own. We need all those sectors around us to actually, you know, help us to deliver services and deliver them safely and meaningful."
(Senior Manager Focus Group)

In addition, the **development of pathways between services** was reported by the service manager as instrumental in effective service delivery for this highly vulnerable population. It was noted that service delivery for the general population did not fit the needs of this service user population with the need for a tailored and 'flexible approach' 'outside the normal box'. This involved working closely with other services and systems to advocate for their service users to challenge and change everyday practices with enlightening case examples provided to ensure homeless people received appropriate healthcare:

"Our pathways are very important... we've had to go first of all and lay the foundation and lay that advocacy at the door and... actually be quite assertive on how we challenge attitudes and how we challenge systems, set systems that our service users just don't fall into, like I'm thinking of, you know, you move into a hostel, you might stay there for a short time, you do something wrong. You'll be put out. You've been to hepatology. You've had your liver scan and they've sent you an appointment letter for your next appointment. But you never get it because you're not there. But it's easy to tick a box and say, well, they didn't turn up today and that's my targets, but that's not how you can work with this service user. We have to have a really flexible approach and we have to be like working outside the normal box."
(Senior management focus group)

A key example of service user advocacy and promoting service collaboration was a **quality improvement project** undertaken to improve the interface between the Accident and Emergency Department, the Ambulance Service and Alcohol Liaison Services. This had led to the development of a **pathway with the Emergency Department** (ED) with inter-agency agreements about how to offer compassionate, effective care for highly vulnerable individuals, while also seeking to manage over-use of services. The BIHS service manager noted a series of strategies that had been developed in this regard, including a BIHS ED in-reach/ outreach nurse, who could be contacted by ED administrators, as many of the more vulnerable clients could not manage the normal waiting required:

"... if you go into ED today, (...) and you book on and you've given them whatever scenario is wrong with you, you are then asked to sit outside and wait ... our service users have addiction issues, so they're not going to wait for hours, because they can't wait for hours on their next drug. So what the pathway looks like is - ED will then contact us if there are specific concerns. We have an in-reach/outreach nurse pathway to ED."
(Senior management focus group)

In addition, they had linked in with the ED IT system to ensure that hostel addresses were red flagged, which would alert the ED team to the person's status as experiencing homelessness:

"At the beginning, nobody knew that these people were actually in homeless hostels. (...) so we set up a meeting with the IT system in ED and we gave them all the addresses of the homeless [hostels]. So now that's a red flag."
(Senior management focus group)

Posters with the BIHS telephone number and the Housing Executive were also displayed as they raised awareness of BIHS with staff. It was noted, however, that due to the high turnover of ED staff, other strategies were required with BIHS staff attending regular ED meetings as a means of ensuring awareness of BIHS outreach services:

"We also put posters up in ED with the team contact numbers, and the NIHE Contacts should the staff need help re. housing for the person. As a team we have met with ED staff to raise awareness. (...) they do like a [team meeting] throughout the morning, every now and again, like a team where four people come in at a time and they're updated on different things. And so we've been to those meetings and I've also been to meetings with the consultants, and we've made real inroads with ED there."
(Senior management focus group)

Similar communication and referral pathways were developed with the Ambulance Service to try and limit the over-use of emergency services by vulnerable clients:

"And the same with the Ambulance Service. If somebody calls an ambulance like 30 times in the month, someone of them will ring us and say, 'this person's in [name of] hostel' and we will then go and find out from the person, why is it that you're ringing the ambulance every day? and then we'll try and explain to them, you know, this is why you don't need to do that."
(Senior management focus group)

A more recent example of inter-disciplinary and inter-agency work across the city of Belfast spoken about positively in the senior management focus group was the establishment of the new **'complex lives team'**, of which BIHS is a part. This 'whole systems approach model', adapted from Doncaster, England, is where different agencies meet every week to discuss the needs of complex service users, thus coordinating and promoting more effective responses to service users with complex lives and needs:

"There's a new complex lives team... it's a whole systems approach model from Doncaster... and we're trying to adapt it into Northern Ireland (...) where we are very different. So there's lots of different things, but there's lots of really good learning from that. So at the minute we have..., this happens like once a week. So we have what's called an MDT team, and that's the Housing Executive, Trust staff, the police, probation, social work staff and support workers. And they sit around a table every week and they are currently discussing about 80 of our very complex service users. And so from that comes tasks and actions."
(Senior management focus group)

2.2.3 Workforce training and development

Workforce training and development was reported by staff members as having been important in helping the team develop and maintain a trauma informed understanding of their service users, with a noted shift away from a 'medical approach to mental health' toward a much *greater appreciation of a person's life history:*

"... in terms of understanding and thinking about mental health, the understanding has vastly improved over the years where we had a very medical kind of approach to mental health, and even like maybe in acute mental health, the focus would have been on getting somebody on medication, getting them stabilised, getting them home, whereas now there's a lot more talk about what's led the person to be where they're at today, what could have been done differently, what services could they bring in now to make a change, so that's improved greatly."
(Staff Focus Group)

"Just saying what's wrong with somebody to asking what's happening (...) the language is shifting so much... from focusing on the person, something that has to be fixed to something different."
(Staff Focus Group)

Staff members spoke of how using the 'trauma lens', introduced during the SBNI training, had helped them become more *understanding of service users' presenting behaviours.* For some, this helped build greater insight and personal tolerance, particularly when responding to challenging behaviours from some service users who may have been 'frustrated' by how they were treated by previous services:

"...the training that we done on the trauma informed practice and some of the videos ... made you realise that you know, sometimes as a health professional, you might have taken it sometimes a bit personally when people might have been angry with you or brought out their frustrations on you, and this [training] maybe gives you a bit of insight into being aware and not taking things personally, that it is... the system, rather than you as an individual, that the person is frustrated with actually, and the way the system maybe has dealt with them over the years as well that has caused that level of maybe frustration and trauma to that person."
(Staff Focus Group)

This was reported to have led to the development of a different approach toward service users, with *much greater service tolerance* thought to be required to work with this client group, unlike the zero tolerance approach adopted by other Trust services:

"I think it also makes you approach things differently, (...) you know, the zero tolerance policy that the [HSC] Trust has, we can't have that with our client group. It has to be 100% tolerance, you know, otherwise we wouldn't see anybody if we had zero tolerance. So it does make you approach and look at everything differently as soon as you're meeting that person, you know your introductions, how you approach them."
(Staff Focus Group)

This was described by one staff member as a much 'softer approach', with effort required to 'take service users as they are on that day' and not take personal offence when met with challenging behaviours:

"Yeah, definitely,... it's just improved my understanding and my awareness of [trauma]. Just I definitely approach things a lot, a lot more softer I guess with this client group, and you just realise you have to take them as they are on that day and... you definitely don't take offence by anything that's said or yelled at you or screamed at you, or sometimes you're shoved out of the way,... You don't really take offence. That's just how they are on that day. So the training has definitely helped me. Yeah, because again, that wouldn't have been really in our backgrounds very much in the past."
(Staff Focus Group)

Working with service users with such complex needs and adverse life experiences was reported as demanding for staff in many ways which wasn't thought to be always appreciated:

"But I think sometimes people romanticise this job, (...) I think people don't fully appreciate, it's a job related to very hard graft."
(Staff Focus Group)

As well as regularly coping with challenging behaviours, this population of service users were reported as hard to engage with sometimes 'disappointing' results in spite of staff's best efforts. It was noted that this could be 'discouraging' for staff:

"Sometimes for the staff, that's really disappointing, because we are very often with service users, 20 steps forward and 25 steps back (...) and that can be discouraging."
(Senior manager focus group)

In addition, deaths of service users were reported as a relatively common occurrence given that the team work with people at times of crisis. The risk of a secondary trauma impact on staff members was evident:

"Yeah, sometimes it's like a video in my head of all the people who have died (...) and that's kind of challenging at times. I remember one time in one of the hostels, they used to keep a list of everyone who had died. And I think you know, it was maybe up to four A4 pages, so it was, at one point."
(Staff Focus Group)

Given the demanding nature of the work therefore, both senior managers and staff spoke of different **personal and workforce support strategies** needed to manage these demands. Staff spoke of how, over time, they had learnt coping strategies which allowed them to 'mentally park' or contain the work:

"You just get to a personal space where you just learn to mentally park it.... And then just leave your [work] and then you're on your home life. So my drive home, I have about an hour and a bit drive home. Yeah, I you know, that's my decompress time before I then enter my house with my husband and kids and stuff, you know? And you just learn a way of probably without even thinking about it, just that's it for the day and I'm not going to think about it again or try not to until I go back into work now (...) So I think... you'd be in trouble if you can't park it. ... I don't know how long you could stay in this job if you couldn't. Yeah. Or maybe any job if you can't learn to leave it.
(Staff Focus Group)

Senior managers and staff also spoke of the importance of **building trusting team relationships** as a means of managing demands, supporting staff wellbeing and talking with colleagues and senior staff about the impact on themselves to ensure everyone felt valued and supported in their role:

"And we talk out about the different impacts on ourselves. We do talk that out around the team." (Staff Focus Group)
"Because it's very important for all of us in this role. It's hard enough, and we need to make everybody in their role feel they are valued (...) and it is very important that nobody in the team feels that they failed."
(Senior manager focus group)

The service manager noted the importance of the annual service development review, team building days and staff consultation to help build team relationships and ensure staff concerns were listened to:

"We'd have a yearly service development review, and those one-to-ones, and even with team building, we've had several team building days, and also..., you know, we like, we ask for staff opinion because if staff are not happy with what they're doing, it's very important to ask staff, are they happy? and to get staff to have that trust in each other, to be able to... openly say, well, 'you know what? you know, I'm not happy with that' or 'how do you think I should...?' and to also allow staff that freedom to not work with somebody. Alright. Because... we have someone at the minute who has made threats against one of our support workers and it's saying, 'That's OK. I don't expect you to work with that person, in fact, my risk assessment would tell you that I don't want you to work with that person. Do you know? So it's all those things."
(Senior manager focus group)

A number of **formal and informal reflective practice and supervision opportunities** were reported as important workforce support strategies to manage such tensions to enable staff time to reflect on themselves and the service users collectively. The "Monday huddle" and morning check-ins were examples given of how the team meet collectively to check in with each other and discuss the service needs of the coming day or week:

"We have a team huddle every Monday morning and (...) we've a cup of tea every morning before we start, where we discuss things and how you're feeling and, you know, not just work sometimes, the normal things about home as usual, but you know, that's very important."
(Senior manager focus group)

As well as team meetings and group opportunities, senior managers also noted the importance of compassionate holistic one-to-one supervision:

"we also do one-to-one supervision. So sometimes people aren't feeling free in a group to, you know, say what they think or how they're feeling."
(Senior manager focus group)

Staff members also spoke of how they take time together as a team to remember people who have died or attend remembrance services at hostels, all of which were thought to make a difference to staff wellbeing:

"I know if there's been any deaths, you know, cause a lot of our clients will, you know, there will be young deaths. So,... somebody phones through [to alert the team to a death], then we all just sit down and come in here, whoever is here maybe have a wee cup of tea for 10 or 15 minutes and just sort of have a wee chat about the person, and then you just have to get up and get on with it then. But you know, it's just trying to take those very small moments to reflect on the person and just get on with it then,... but all those little things make a little bit of difference."
(Staff Focus Group)

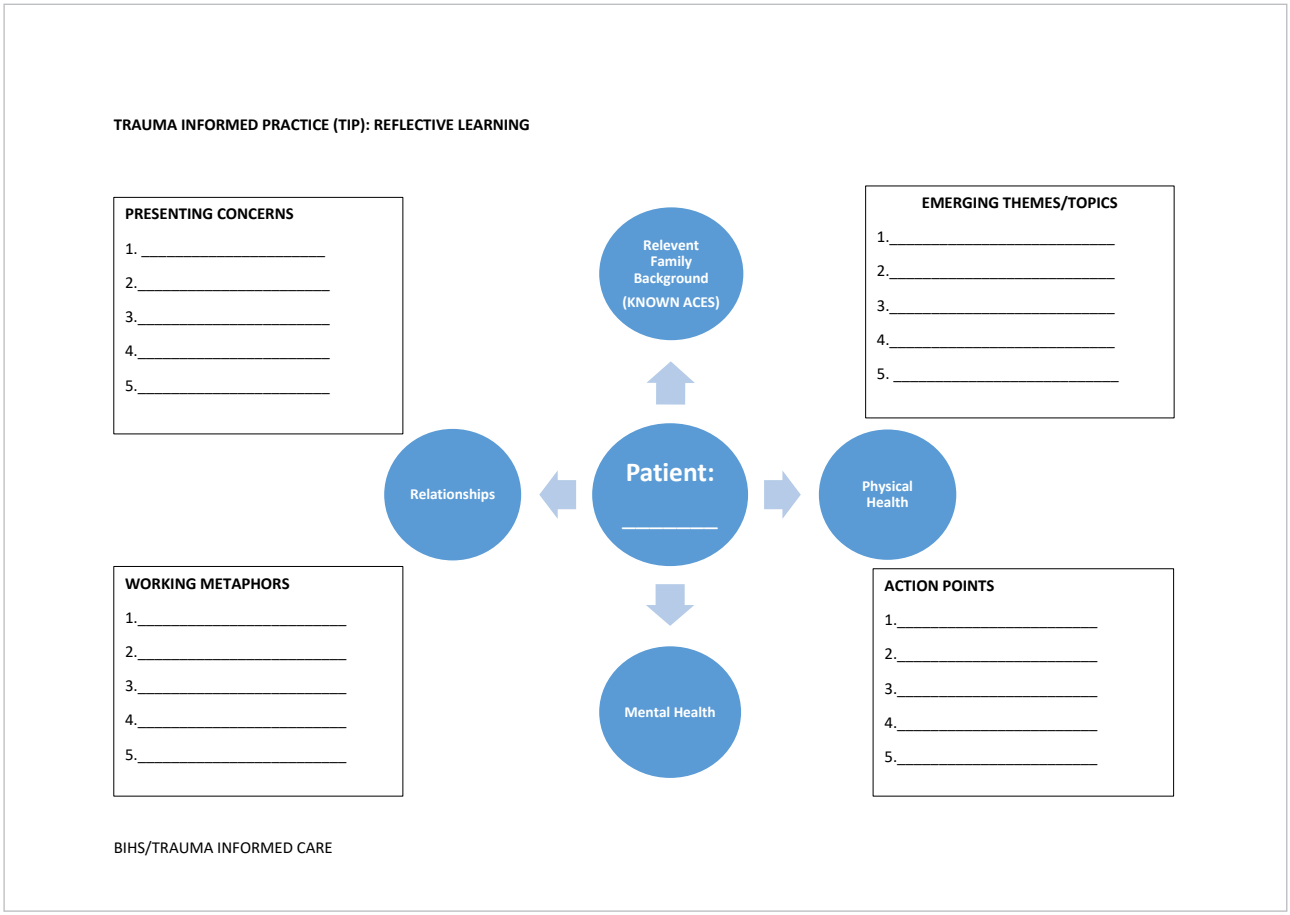
Given the complexity of the work, reflective practice opportunities were noted by staff as helping them 'take a step back', not get 'frustrated', share learning and work out how to take the work forward. This was thought to be particularly important for this client population given the complexity of presentation and need frequently encountered:

"I think sometimes we can all get bogged down by our clients because they're so complex and they're quite intense and they're so, they're coming to you with so many things wrong, and you're trying to pick that apart and figure out where you start. So to prevent you getting frustrated, sometimes it helps you to take a step back and look at it, and look at their life and what they've been through and what they've overcome. And it helps you then process why they maybe are the way they are, or how they communicate is the way they communicate." (Staff Focus Group)
"...that close interaction with your other team members and really trying to focus quite intensely on a patient is really good for the team as well I think you know."
(Staff Focus Group)

Reflective case reviews were reported to have been used for the 'most complex cases' whereby, using the reflective learning template (see Figure 2.1), staff were helped to build a better collective understanding of the service user's needs in different areas:

"We put the patient in the middle… and then there'll be three or four of us sit down and then… we'll look at the presenting concerns and then we look at emerging topics around that person. So… we work with some metaphors (…) and we'll have lots of images around that. And then we have action points, but we all build up around things like relevant family background and knowledge of ACEs, their physical health, their mental health and relationships. (…) So we take… like a flip chart paper, and we sit down and you have so many viewpoints, because the nurses might be working with the podiatrist. [Nurse consultant] might be overseeing them, and she's heard something from another agency about this person, say to do with housing, and we just kind of reflect on the person and how … are we doing the best for them with what we've got available."
(Senior manager focus group)

Figure 2.1: BIHS Trauma Informed Practice Reflective Learning diagram (provided by BIHS)



However, despite the value of such reflective practice opportunities and the 'wealth of wisdom and knowledge in the team', it was reported as difficult to get the protected time to undertake such activities as regularly as they would like due to the fast paced demands of the service:

"We don't have the time to do it regularly. That's the problem (…) That's one of the barriers at times for implementing [TIP]. It's just the busyness here, you know, so, we just don't always have this space and time for reflective practice. But when we do, it's really enlightening because there's such a wealth of wisdom and knowledge within the team."
(Senior manager focus group)

2.2.4 Service design and delivery

Focus group participants spoke of many ways they believed trauma informed principles were manifest in how they delivered their services at BIHS. This included enhanced service user engagement; enhanced assessment including an understanding of service users' trauma history; improved service access, enhanced interventions and outreach activities.

Enhanced engagement: Staff at BIHS described how adopting a 'trauma lens' had led them to develop a 'softer' 'compassionate' and 'empathetic' approach to their work with their vulnerable client group. While clients' behaviours could be frequently challenging, great personal and team efforts were extended to create a 'sense of safety' as people enter the service hub, thus avoiding retraumatising or repeating client's previous, often negative, service experiences:

"So it's a sense of even though we're not in the most glamorous part of the city, but when people walk through the door of the hub, there's a sense of feeling safe stepping out of the harshness of some of their daily world. And that was very evident and poignant for the individuals who are receiving, you know, having to come for multiple blood tests, and the care of the nursing staff (...) the empathy and the compassion, these values... and in no way was there any sense of going back, you know, to retraumatising people about what they'd been through."
(Senior management focus group)

Staff and service managers spoke of their tolerance for challenging behaviours, never barring service users, but instead seeking to de-escalate tensions and frustrations and ensure clients felt welcomed and safe from the outset:

"... we're certainly sensitive in our approach, we're certainly inclusive, even if people have like [presented in a challenging manner], we never bar them, you know, we'll say, now, go out and get yourself a cup of tea, calm down, come back. And I think how our tone, our body language, how we say things to them is all... how we make them feel the minute they come in the door, you know, and introducing yourself."
(Senior management focus group)

Staff described how the engagement process with this client group could not be rushed, requiring 'patience' and 'learning to listen' as a way of building the service user's 'confidence and trust' in the professional relationship over time:

"It's a question of patience, so it is... and just trying to, you know, engage on, you know, ... on a day when that person is ready to engage, you know what I mean, you learn on this job not to ask too many questions either. And you learn to listen, and by listening then the person gets the opportunity then to maybe build up trust and confidence in you. (...) And no judgment is right. Absolutely."
(Staff Focus Group)

Thus, building trust with service users was described as an essential every day and ongoing professional task to help service users engage with the service and their own needs:

"And then they you know, whether it's a fist bump or a hug at the end of the treatment, or just a wee rub on the shoulder, whatever... I feel that [the service users] need that and they like that, you know and again it just helps gain more trust, it just takes time with this client group to build up that trust."
(Staff Focus Group)

"Yeah, it's a challenge for people to throw off those layers as [staff member] was saying, you know what I mean and expose themselves definitely, you know."
(Staff Focus Group)

To effectively engage this most vulnerable service user group was recognised to require individual staff members to be able to adapt their service to 'the unique needs' of the person. Meeting 'the person where they are at' rather than a 'one size fits all' approach was considered essential to build 'rapport' with service users and thus enable effective engagement:

"It would break your heart sometimes (...) let's just call it at an individual level and we don't try to say one size fits all at all.... you have to really fit the unique needs of that individual... we always see them as a person. But it takes time for them... if we try to peel back those layers, it's never going to work. And what we discover is that with the rapport, they let the masks down and that's where the work happens."
(Senior management focus group)

Great emphasis was placed on the professional values of being non-judgemental, compassionate and empathetic which were thought to be at the heart of establishing this trust. Staff described how they explicitly expressed their 'no judgement' stance to service users as a means of supporting them to 'open up about the past' or address 'any other areas of their life':

"And no judgment either. And we would say that to them, 'just to let you know, there's no judgment here whatsoever, but if you're ready to discuss something else, feel free'. Or 'if you need any help with any other area in your life, there's no judgment. Just let us know. Doesn't have to be today or you can let us know another day'."
(Staff Focus Group)

"..., it's the values people trust. Without the trust, nothing's going to happen. And once the trust is there, they commit. And well, [staff members] said non-judgemental. Who are we to judge what's going on in their life, and... in that world of therapy over time, they begin to trust themselves to open up about the past, not just opening up to [nurse] and myself. They begin to trust to open up about their past, and then they're opening up to themselves. And that's sometimes, that's make or break ... they'll come back and they'll stay with that or it's just too difficult to stay with."
(Staff Focus Group)

Enhanced assessment: Although listening and not asking 'too many questions' was deemed important during initial encounters, staff also discussed the importance of 'asking the right questions' in a 'direct' but 'sensitive'. This skill was noted as different to asking clients 'to repeat their story over and over'. In contrast, asking questions 'for the right reasons' in an 'open' and 'honest' manner was considered essential to getting the information to help clients 'move forward'. This was thought to be noticed and appreciated by service users:

"So you both said about not asking too many questions. And I think that what we mean by that is that our clients sometimes will have to repeat their story over and over and over again to different services, they feel they need to tell everything to get what they actually need to access things. But I think it's very important to be asking questions. I think it's just about asking the right questions, and I think to get as much information as possible about, as long as you're getting that information for the right reasons and you're going to do something with it... but I find that our clients are incredibly open, and I found that in prison and found that in this job too, that you're better just asking and being direct, being sensitive about it, but being direct about what you're asking, being honest with them and... explaining why you're asking certain things. I think they're incredibly responsive to that and appreciate that a lot more than other client groups would. And so I think it's important to get all the information that you can know about where somebody's been to help them kind of move forward."
(Staff Focus Group)

Enhanced intervention – 'small things make a big difference': The importance of touch was noted in the staff focus group as an important means to build trust. The podiatrist described her work with clients with a deeper understanding of the use of touch with this population, many of whom would have experienced previous harmful touch or aggression. The small everyday gesture of allowing someone to attend to their feet was reported therefore as symbolic for the homeless population and often a moment of breakthrough in the relationship:

"I think touch for a lot of our patients is very important as well. (...) Yeah. I just feel feet in particular are a very, very vulnerable part of the body and... I didn't really realise until I started doing the homeless team because, you know, patients coming into normal podiatry, they just got up and sit on the couch, they make their appointments and some of them are in a position where they have no choice. You know they have foot wounds, they

have to be seen regularly but... this client group, it's almost like you have to persuade them to let you see their feet. And it's all about this very, very, very vulnerable part of the body. And you know a lot of them will say I have never let anybody touch my feet ever before. So this is the first time and once you kind of get that, it's almost like a little trust thing between you and I also realised just by doing this post, especially when you're out on the medical bus that they need, they need that touch. (...) They like that touch, I feel. (...) You know, eventually when you realise they trust you, hugs, handshakes and so it's just, it's a very different client group, just the approach is different for me."
(Staff Focus Group)

In a similar vein, staff spoke of how seemingly 'small things' can make a 'big difference' with this vulnerable population, with service users reported to be very appreciative of when staff 'do what they say they are going to do'. This is perhaps indicative of clients' prior experiences of being let down by services, thus repairing some relational damage in these small everyday actions:

"I think they just appreciate the fact that they know, they can now come to us and hopefully everybody in the team, and they trust that we do what we say we're going to do when we say we're going to do it. I think that's really important, even if it's only making a telephone call to somebody or something about them. So it's small. It is the small things that make a big difference."
(Staff Focus Group)

Staff spoke of the importance of focusing on the 'small wins' (such as a person turning up for an appointment) as a means of managing their 'frustration' with the wider system failures which were perceived as making it very difficult for the service user to break out of 'the cycle' of homelessness and associated difficulties:

"It's very difficult... I think some days are harder than others. Yeah. And we see some, as you can imagine, some really sad cases and there are things that hit home with you or that you take home with you when you think about what people have been through and then a system that keeps that cycle going for them. And when you can't, you feel like you can't help to get them out of it. But whenever it's our job as healthcare professionals to, I know we try and fix things and in this job there is no fixing anything for anybody and, for me that's incredibly frustrating, I find that really frustrating and, we try and focus on the small wins I think most of the time, so if somebody turns up for an appointment, we see that as a win. If somebody stays off drink for or drugs for a couple of days, we see that as a win. And we try to focus on that as much as possible, yeah."
(Staff Focus Group)

Multi-disciplinary working - improved access to the right service: Focus group participants spoke of the importance of the multi-disciplinary team at BIHS so that clients could be redirected to other specialisms as need became apparent. Given the complex life experiences of the homeless population, staff described how addressing need in one area of people's lives could sometimes surface other needs with the combination of physical, social and mental health needs apparent over time. The usefulness of reflective practice in cases of complexity was noted with staff members able to pool their expertise and knowledge of the individual to ensure more effective service delivery. As an example, the podiatrist spoke of a client who had initially been contacting her every two weeks to get his toe nails clipped. This frequency of engagement and the client's desire to cut his toenails very low almost removing the nail bed, had led to a complex case discussion with team members. Understanding the client's nail clipping through the lens of trauma and self harm helped reframe service engagement with a referral made to BIHS psychotherapy for this client. As a result of his therapeutic engagement, this form of self harm reduced over time:

"This is very basic foot care, no issues. But actually the deeper that [we] sat down and looked into it.... and the deeper we looked and realised he was actually self harming through his feet, so he could never get his nails short enough. (...) So this is probably a perfect example of really looking through the trauma lens. What is this doing? Why is he walking 10 or 15 miles a day? In steel toe-capped boots in the middle of summer? and it was all to do with... once we went down the line of trauma and self harm through his feet."
(Staff Focus Group)

"We just sat down and mapped it down out on a piece of paper and sharing our learning. And then [nurse] was able to add in bits... as [nurse] would have known him from about 13 years ago before he went.... He had come out of prison and that added other layers of complexity onto the guy's life, but he had definitely had some neurological challenges himself because of his drug misuse over the years."
(Staff Focus Group)

Improving access to talking therapies: Staff members spoke with frustration about the perceived lack of trauma-focused therapeutic services for their client group, with long waiting lists reported or insurmountable hurdles in the eligibility criteria, such as clients needing to be substance-free for at least one year. Staff members spoke highly of the value of the 'flexible' and 'accessible' in-house psychotherapy service developed at BIHS which they could refer clients to when they were in 'a relatively stable place':

"...a lot of our clients wouldn't meet the criteria to access services, so if we didn't have [psychotherapist] here, there would be a lot less people getting talking therapy that they need. So [psychotherapist] is very flexible and basically all we really ask, is that somebody's in a relatively stable place. I wouldn't be referring anybody to [psychotherapist e] that I knew was really, really chaotic. And so there's been a lot of referrals went through and interestingly (...) but yes, [psychotherapist] will literally see anybody, there's never an issue, it is so easily accessible as a service, it is something that you wouldn't get like really anywhere else. So if we didn't have [psychotherapist], that would be a massive hole in our service provision."
(Staff Focus Group)

Interestingly, this service was reported to be well received by their clients. Given the chaotic lives of many service users, attendance was not left to chance but supported by several engagement strategies. This included referral being followed up by a text reminder to support clients to engage:

"They [service users] do engage, and yes, it's here in the building, and out of chaos, they still manage to be here. Now, we have a wonderful support team who contact them the day before, just as a reminder, you get people even phoning up asking when is their next appointments. So there's something about their commitment, and they honour their commitment... this isn't, you know, six sessions, this is long term therapy."
(Staff Focus Group)

Other engagement strategies, included co-facilitating initial therapeutic sessions with the mental health nurse whom clients had already built up a trusting relationship, thus facilitating 'warm handovers' and maximising the likelihood of engagement:

"These guys really come along and quite often... [mental health nurse] and I [psychotherapist] co-facilitate the sessions. We co-facilitate certain people and it just adds a layer of trust, as [nurse] has built up the relationship, the rapport and then when [nurse] comes into the therapeutic setting, it's almost as if [nurse] is gently moving them on to my world based on the trust and the relationships she has built with them."
(Staff Focus Group)

Outreach services: The importance of the service being accessible and inclusive for the population they serve was emphasised by focus group participants and is evident in how BIHS services are delivered. BIHS delivers their services in innovative and creative ways, outside the 'medical box'. For example, the outreach Street Mobile allows staff to take much needed services to the streets and hostels where their target population can be found, and provide a range of health services such as flu vaccines and general health checks. The team currently serve 27 facilities. Such facilities include general hostels as well as those with a specialist remit, such as "wet hostels" (first opened by De Paul in NI), addiction recovery, drug user, offender, and temporary hostel accommodation. This "doorstep" service is offered whereby the team bring the service to the hostel, rather than expecting the service users to come to them. Non-standard accommodations, such as boutique hotels, were also used during the COVID pandemic to ensure no break in service while facilitating social distancing:

"We have a very different model, so we do door to door, we call it doorstep delivery. So we go to the hostels, we bring services to the hostels, and this is very important because you need to be where they're at."
(Senior management focus group)

2.3 Outcomes and Perceived Benefits

Obvious **benefits for service users** were identified during the focus group interviews, in terms of *feeling valued, listened to and not judged.* Thus, staff stressed the importance of listening to and spending time with service users, as a core means of allowing different issues to emerge:

"...whether they're coming for a physical health or psychological health or just for a chat. They're just calling in for a chat. They really feel empowered that can talk about any aspect of their life."
(Senior management focus group)

"because of the approach... [the service user] started to open up more about other aspects of his life and then was volunteering how he had been feeling suicidal earlier in the week. Yeah. And with just... kind of valuing that he was an important person, suddenly things started moving with GP's and getting appointments and from being pretty glum and down on it. Yeah... when we were leaving... Yeah, there was a brightness and a lightness about him. ... and we just listened. We had just spent time with him."
(Staff focus group)

Staff also described *'holding hope' for service users,* as it clearly made a difference in empowering them to change their own situation, particularly when they felt 'hopeless' themselves:

"... sometimes [service users] might be feeling hopeless. And one of the things we try to do is kind of hold the hope for them... we're holding that hope that there's something can change... just recently we had one person in... he's getting accommodation and he's rethinking all his addictions and has increased his attending appointments."
(Senior management focus group)

However, it was also argued that some benefits for the service users of BIHS took time to be realised, especially, in terms of their mental health. Staff noted how over-time, progress can sometimes manifest in small changes or actions as service users in recovery re-discover their 'hopes and dreams':

"So we discover that you know, it's much as we might love solution-focused approaches, this is very much in the mental health side of things, it's a slow burner, but my goodness, the difference it makes over time where people come in moving from describing their issues to starting to reflect on them, and then maybe even taking some small actions... and it can be as simple as making the phone call to a parent or calling down to a parental house where they haven't been in years, and so... (...) when [staff member] and I talked about things, it's those who are well on in recovery move into another places, we're now calling it discovery, and the discovery is those hopes and dreams, you know, they still have them."
(Senior management focus group)

Another key benefit mentioned by staff was that, due to having such a multidisciplinary team readily available within BIHS, service users were *able to access all types of health services quicker* than would have been possible through the 'normal health service'. Indeed, it was thought that many service users would simply not have accessed those services 'if left to own devices'. This was reported to sometimes lead to acute health issues being discovered and onward referral:

"... so being able to access everybody within the team..., it's all good when you can see all the work that can be done quicker than it would be within the normal health service, or maybe not at all for our client group if they were to be left to their own devices, you know."
(Staff focus group)

However, focus group participants argued that sometimes it was hard to see big benefits for their service users, especially when staff and the service user may have different goals. An example was provided of how a service user had refused accommodation in spite of service efforts. This was noted as sometimes difficult to accept for the healthcare professionals who wish to help:

"last week we met ... to look at these four men around their housing, around what can we do for them?... so we're the nursing end of what we were doing, the nursing assessment, Housing Executive were there, and they were looking at what they could offer with regards to accommodation,

and with regards to like even emergency accommodation, and then the support workers were looking at... well how can we support them when they're out in the street and we bring the bus to them, so we'll still see them out there. Now, sadly, we got two of them actually accommodation, but ... one was in the hospital and when they got out last week, he wouldn't accept it. So there is that other issue that what we want for them is sometimes not what they want, and it's very difficult..., although I've learned to accept this over the years, but it's very difficult as a health professional when your ethos is to help, to cure, to sustain, to do whatever, and they don't want that."
(Senior Management Focus Group)

A range of **benefits for staff** were also identified, *including increased personal and job satisfaction.* Staff talked about feeling able to make a positive difference in people's lives and getting so much back from service users:

"I think [the service users] are just so grateful for what you do, that you get so much back from them, whether they're actually... loads of them are so charismatic and funny and witty, despite the circumstances that they have been put into, and as I say those wee hugs and all the rest of it, you feel, it just makes you feel so good... even just simple things that you can do for them."
(Staff focus group)

More general societal benefits were also identified, in terms of significant **cost benefits for public services**, particularly through the development of service pathways. For example, in the brief case vignette below, effective inter-agency liaison and focused intervention was noted to significantly *reduce the time and cost of emergency and other services:*

"There was one lady who had mental health issues and she arrived every day at ED with all her bag and baggage, and she was hanging stuff all around the ED and she was lying over three chairs and she would have been seen, but she may have been seen by me today, X tomorrow, Y the next day, and everybody was doing these assessments and everybody was doing the same bloods, but nobody actually was talking to each other about this person, and I mean psychiatric team..., (...) And you know, by us actually collaborating together, it stopped the ambulances being called. (...) And we talked to her, and she did listen now, and she didn't... (...) and then as taxis would leave her off, then the security men would talk to the taxi to say... so there was a whole group of people in there and eventually, we actually got her not to come to ED for maybe three, four months and the cost of that was phenomenal. (...) Like we're talking about thousands of pounds"
(Senior Management Focus Group)

2.4 Enablers, Barriers and Challenges

Both staff and senior managers spoke of factors that had assisted TIA implementation, as well as some barriers and challenges to progress. These are summarised in the table below, with key issues examined in further depth.

Enablers

Training, workforce development and reflective practice opportunities were reported as important to the implementation of trauma informed approaches in BIHS. Even though staff had expertise in dealing with trauma, the openness and willingness to continue to learn and reflect on practice had allowed for a dialogue of ongoing shared learning as a service. Significant additional benefits were also thought to be gained from bringing services together to undertake joint training as a means to promote inter-agency communication and collaboration, in the knowledge that clients engage with multiple services and that no one service was ever going to be enough on its own to meet service users' complex needs.

Table 2.2. Enablers, Barrier & Challenges (BIHS)

Enablers	Barriers & Challenges
Bespoke training for staff & inter-agency groups	Systemic barriers to accessing services including stigma
Ongoing reflective practice opportunities to support staff wellbeing, practice development & targeted intervention	Bureaucracy in navigating healthcare systems
Service user consultation	Lack of specialist services for particular client group e.g. dual diagnosis services, step down facilities
Stable staff team	Current threshold criteria for therapeutic services too high for service users with complex needs
The integration of multi-disciplinary skills in the team	Long waiting lists for trauma-focused services
Outreach & advocacy with interfacing agencies & services – pathway development	Housing, education, justice and social care system failings
Knowledge exchange with other agencies & governmental departments	Need for early intervention with children and families
	High staff turnover in public services
	Lack of funding, resources & governmental commitment

Ongoing reflective practice opportunities were noted as essential in order to support staff wellbeing, avoid burn out and promote more targeted intervention, particularly when working with crisis or complex presentations:

"You want to be the best and you want to do the best and you want to do everything. But then suddenly you get burnt out... and you know you absolutely need to step back. We step back and just say, you know what is really important. Sometimes we're firefighting and we're sticking on plasters. Sometimes we just need to...[step] back and say, right, you know what? What's really the priority? What do we need to do?"
(Senior Management Focus Group)

Another key enabler that was stressed in the senior management focus group was **consultation with service users** when designing service delivery. It was argued that consultation ensured that services were accessible and meaningful, and met the particular needs of their targeted groups. This appeared to have been undertaken in BIHS using a range of informal approaches as well as more formal structured methods such as questionnaires and focus groups:

"There's no point in arranging services and nobody coming to them, and they have to be meaningful, and in order to set up those services, we do discuss this with the service users. It's absolutely paramount that (...) you know, we ask the service user. I'll give you an example. When we had our first outbreak of hepatitis C and heroin use. (...) I didn't know what it really was like for you as a person. So the best place to start was actually to go and to talk to the service user. 'You tell me what it's like to be a heroin user, because I don't know'. And they really respected that, and we got a lot of rich data from that, that really helped us then to set up meaningful services that would help them."
(Senior Management Focus Group)

"We've set up focus groups, and the reason was because none of us understood the cocaine, and it suddenly came in like a tsunami, and we were left with all these comorbidities of health problems. And... so we needed to understand. I'm sure we went round half of our hostels, but we specifically picked hostels where we knew people injected drugs, and we sat down with them. We had focus groups (...) and again, we learned loads from that taking out ACE quesionnaire
(Senior Management Focus Group)

Stability within the staff team and consistency of staff was perceived as another strength of the service while had assisted TIA implementation. Staff spoke of the importance for service users to 'know people by name' and have the same professionals available to them. This was contrasted with the instability that they had encountered in other services:

"... it's a different type of stability here. The stability is for example knowing [names of staff members]. Some of the team are available and they're known by name, so... they're not getting a different social worker every time, they're meeting the consistency of people on the team and that consistency, you know, people really appreciate that."
(Staff focus group)

In addition, the **multi-disciplinary skills mix** within the BIHS team was noted as a key strength which enabled the service to meet the many different needs of their clients as they emerged during the course of engagement. It also helped enrich case discussions with each staff member bringing insight to their area of specialism as a means of better understanding service user presentations.

Central to the success of the BIHS was the development of pathways and working agreements with interfacing agencies. This had involved consistent **outreach efforts** from BIHS, building relationships and connections over time and advocating on behalf of their vulnerable service user population in order to effect change. Knowledge exchange with other service providers and governmental departments about the homeless population and their needs was considered an essential task in advancing trauma informed approaches with perceived misunderstandings about the work with this population of service users. The service manager spoke of using anonymised vignettes at such events as a way to help other agencies understand the complexity of service users' lives:

"... just this week, I've been to two conferences... people do not understand about homelessness. And you know afterwards.... I was amazed at the questions, and that was from Commissioners, from Department of Health, you know, and so it's really good to like advocate for your service users. And I always talk about, you know, trauma informed stuff. I always talk about their [adverse childhood experiences]."
(Senior Manager Focus Group)

Barriers and Challenges

Key systemic challenges were identified, relating to the fact that, in general, the national health service was not designed to be inclusive or accessible to the homeless persons that the BIHS serves. It was argued that despite BIHS best efforts and the introduction of trauma informed approaches, other service providers were not used to working in this way, thus jeopardising the sustainability of such care provision:

"... it's like accessibility, availability, and approachability. And so we [at BIHS] try and have all three, but then we encounter other services where they're inaccessible and they're unapproachable, and sometimes unavailable. And that's where, you know, things probably fall down in that trauma informed practice, being sustained because we tried to sustain it, but sometimes it's, you know, you just can't sustain it because you're not getting the buy-in from other people (...) what we discover is other people [are] applying criteria or other assessment factors... to see whether that... onward pathway referral will be appropriate and even if it does go, we might never hear."
(Senior Management Focus Group)

A range of **barriers to accessing healthcare** were thus identified for the homeless population. These included not having a fixed abode, follow-up appointments not reaching the patient, and early discharge from services as a result of nonattendance or perceived disengagement. While BIHS attempted to be very flexible and approachable, this was not the case for all services. Challenges navigating the 'bureaucracy' of the system were reported as frustrations for both staff and service users:

"You know being fit to navigate through the bureaucracy (...) it is very frustrating for us to navigate the bureaucracy as well to try and get help for people as well. It is so frustrating. I will give you an example, I'm trying to get [a person] to a fracture clinic. I had phoned at least three or four times. I've been on the call 10 minutes and sometimes I don't have that 10 minutes to sit any longer, how frustrating is that for our service users... who are not articulate, maybe to try and negotiate and get through to the Royal Hospital to get follow up appointments and that as well. So that's the frustration."
(Staff focus group)

Limited flexibility was also a noted barrier to accessing healthcare with facilities generally closing at 5pm. In addition, the homeless population was reported to suffer stigma when seeking to access alternative services, with even BIHS staff members feeling unwelcome:

"We've got these lovely, huge health and wellbeing centres and they're closed at five o'clock at night, and they're never open for anything else to the next morning again, and there's all these beautiful spaces. But they're not a space that wanted our service users ever. And we had actually disputes. (...) So it was awful that we, you know, it was almost like we had to hide our service users, you know, we couldn't bring them in"
(Senior Management Focus Group)

Focus group participants also spoke of their frustration about the **lack of specialist services** for their particular client group, with a plea to 'do something different'. While noting that many of their clients would need trauma-focussed therapeutic interventions at some point, they reported that the **current threshold criteria to access such services were often too high** for this group. Criteria such as being a year substance free were seen as 'artificial barriers' to service users accessing services which they might benefit from. It was argued that services needed a different, more flexible approach to enhance service accessibility:

"... we need to do something different I think is the answer and... for example, when I was in the prison there was a whole team of psychotherapy in the prison, CBT service in the prison, but nobody could access it because the criteria was so high that none of the guys met it. So they're sitting in [prison], they're wanting them to be free from substances for, you know, a year before they will even consider to start in any form of therapy. That's them. And so of course that's a road to nowhere for the clients."
(Staff focus group)

"One of my frustrations would be that there, yes, there's an awful lot more talk about trauma now and a lot more talk about trauma informed practice, but there's no services there for people. So we're talking about all these things and we know what people need, but we have no services or resources there for them and all of our clients, probably at some stage in their life, will need some form of trauma informed therapy. And unfortunately, a lot of our clients would not even come anywhere near to meeting the criteria to get that sort of therapy because of the other difficulties that they have, mainly alcohol and drugs. So they are at a disadvantage before they even start, for us trying to even get our clients to the point where they might be ready to do something like that, you're years and years down the line to getting them stabilised."
(Staff focus group)

"...this whole different way of working and artificial barriers about being free from substance misuse for a year, they're just artificial made up barriers, there could be much better ways..., they're just man-made or person-made barriers to [service access]."
(Staff focus group)

This lack of onward services that their client group could readily access was described as a source of 'sadness' and 'frustration'. Even when service users did meet the entrance criteria, **waiting lists for trauma-focused services** were reported as extremely lengthy (up to three years), which often led to re-lapse:

"I think our clients don't fit in any particular box and so, there's so many complexities with them and we do understand like if you have somebody who is heavily misusing drugs or alcohol they are in no place to start any form of therapy and that would be dangerous and you wouldn't even try to approach that. But for anybody that is in a stable place and is ready to deal with issues from the past, the waiting, the waiting lists are absolutely horrendous. So you could be sitting on it on a list for three years before you would even get called to get that ...I have a client who went through the whole process with community mental health, community addictions and got a referral to the trauma team, which was the right referral for him, got an assessment and now is sitting on the waiting list and has been told 'Well, maybe get back to you in about 3 years.' And so that client has relapsed now."
(Staff focus group)

"And you know, just the sadness of that story..., where somebody had got into a stage of recovery where they were needing to move on, and they relapsed because the system couldn't facilitate them. You know ... we never see it as if it's going back to square one, we know we've made some progress, but it just is a bit harder to sustain."
(Staff focus group)

As well as barriers in accessing services, gaps in service provision to meet the complex needs of service users were also noted. Staff voiced frustration regarding the lack of development of Dual Diagnosis services and step down care models with a call for the development of other forms of service delivery when people were 'relatively stable'. Such service gaps were reported to leave staff feeling as if they were 'firefighting continuously' but 'getting nowhere':

"And so I think the services need to look at maybe can we do something different. So if we had somebody who was relatively stable and who was maybe not abusing substances to a dangerous level, could there be some form of groups or... other techniques that we could be doing to try and get guys engaged and keep working with them and try and deal with..., like dual diagnosis, there's a service that's needed as well that they've been promising for years that has not been forthcoming in this country to..., you know, that's the frustration. I think for us that we feel like we're firefighting continuously and we're getting nowhere with our clients.... how [our clients] must feel."
(Staff Focus Group)

"There's no proper step down care models for people to come to work on that trauma of the past or the present. There's nowhere that you go into... You're going to rehab for three months or five or six months, but we're talking somewhere, when you're in recovery, that you then have... There is no in-between. (...) You're just back a revolving door"
(Senior Management Focus Group)

In addition to these service gaps, focus group participants spoke of most of their clients had been **failed by other systems** earlier in their lives. Examples provided included leaving the care system with insufficient support, excluded from school at an early age or coming out of prison with no accommodation. The lack of sufficient appropriate social housing was also noted as a key challenge which kept people 'trapped' in a 'cycle' of homelessness. Such systemic failings were reported to leave staff and service users feeling both 'powerless' and 'hopeless':

"... most of our clients have fell through the net at some stage or another, whether it be at the early ages in school, or Social services, the care system, then coming into mental health services, prison... there's so many experiences that they've had when they have been failed, for want of a better word. And it's not about putting blame on anybody or systems or anything. But things are not working, and there needs to be conversations around why they're not working and what can we do to fix those things for people otherwise, you know, especially in prison when you talk about with clients. Whenever I was working in prison and clients here too, they just go in and out of prison continuously, in a cycle and they nearly become labelled, but nobody actually looks at, why are they coming into prison again? What's not working here? What can be done differently? ... and we're talking about petty crime, we're not talking about people who are committing really serious offences, but people are being arrested on a Friday for drunk and disorderly, you know, getting put back out on the Monday, getting rearrested again, and then you have the clients that have been in prison for maybe 18 months..., got their life sorted out. (...) they have been doing some education in prison, have been working, have been abstinent and then they get released on Friday with no home to go to. That's wrong as well."
(Staff Focus Group)

"It's probably worth saying about the housing situation that we're having to deal with as well. So for a lot of our clients, they can't get out get out of this cycle that they're in, because there's not really any housing for them to go to. So they're trapped in a cycle of going from hostel to hostel. Non-standard accommodation that's not fit for purpose. So you wouldn't put like an animal in, never made a human being, and that's been signed off on by all agencies to say that that's OK, because there's no other options. So you're putting people into really dire environments sometimes, and you wonder why their mental health deteriorates, why they're feeling suicidal, why they're taking alcohol and drugs. Like if you put me into one of those places, I would probably be an addict as well. And you're up against it constantly with the Housing Executive and you're fighting... that's a losing battle every day for us, we do not have any power to help with the housing situation. And sometimes there's literally no options for our clients to go to, and that it is kind of like a self-fulfilling prophecy. Then they just go further and further into that cycle. And there's no way out. So hopelessness, a real powerlessness over the whole situation for us, as well as them."
(Staff Focus Group)

Early intervention for children and families was a noted service gap with focus group participants identifying the need for different forms of intervention earlier in the life course, before individuals reach adult services:

"...by the time folks come into our world and we're firefighting the adult adverse experiences and the aspect of all the stuff that's maybe behind it and all the learned behaviors dealing with life and community from their childhood. So it would be a case to say while we're at our end, it's the resources much earlier in these people's lives... needs all the resources. You know... before you ever get to this stage in life."
(Staff focus group)

In addition, focus group participants spoke of their frustration about **misconceptions about the work** in the media and other services:

"And it's very difficult, unless you're actually working within the team and you're hands on sometimes... to really get people to understand how difficult the client group can be at times, just even in terms of engaging and. just trying to get them to appointments, trying to get them to engage so what you're talking about and that's... you almost need hands on to really, really appreciate it. And so like when I hear stuff on the news and that now about homeless and that, I just think you haven't a clue, because you're not sitting, you're not actually working within that population or that group of people. You need to be doing that. It's like any disease or any illness. So I think that... you can read about it, but actually unless you're experiencing it first-hand yourself or with the family member or something, you really don't. You just don't get the real depth of how desperate it is, you know."
(Staff Focus Group)

The high turnover of staff in many health and social care contexts was noted as a challenge to promoting trauma informed approaches. This constant turnover was thought to detrimentally impact development 'momentum' with professional relationship networks and understanding having to be constantly re-built:

".... some of the barriers are... (...) such a turnover of staff... like you could maybe have a different staff team next month than you had this month. And you know it's the same like... [in] community children's services, it was [name] who sort of championed that we would have this. Then, [name] is now retired. So I'm not saying the appetite is not there, but I'm not sure the momentum is just the way it was. [But] I think that's life and it's the same like if you're talking about [staffing in] Emergency Departments, you know, you get a whole set of people like thinking your way and then a new set come along and you have to try and do that over again."
(Senior Management Focus Group)

Finally, focus group participants reported the **lack of funding, resources, and governmental commitment** to meeting the needs of the homeless population as a significant barrier to progress:

"So I think it's great that there's a lot more talk and understanding and education across the board and the Health Trust generally, but still, no funding, no commitment to making any resources to help people actually address all these difficulties. That would be my frustration with it."
(Staff Focus Group)

2.5 Next Steps

BIHS reported their intention to continue to develop their service as the main team providing bespoke healthcare to the homeless community in Belfast. There are plans in place to provide training for new members of staff as well as offer support to other homelessness services across Northern Ireland. The team recognised their development with implementing trauma informed approaches and suggested that TIA training should be rolled out across all professionals working in health and social care. Queen's University Belfast School of Nursing and Midwifery plans to work alongside the BIHS team in further developing case studies for use in undergraduate nursing training.

2.6 Lessons learned

A number of implementation priorities emerged from focus group discussions which participants felt were central to TIA service development. Primary amongst those was **the need for close collaboration with other interfacing service providers and the establishment of agreed service user pathways** to meet the needs of the homeless population:

"I think the developing of pathways and the signpostings and making those connections with... other services that are meaningful and make a difference to the homeless are the most important of all."
(Senior Management Focus Group)

'Getting to know your service user' was also reported as key to any TIA developments, with evidence through focus group discussions of staff interest in service users' lives (beyond the presenting issues) and desire to use their engagement, even in small ways, to repair some of the harm many clients had and continued to experience in their everyday lives. For this service user group, it was also noted that building trust was central to effective engagement with staff patience and tolerance needed. As a result, effective workforce support strategies and reflective practice opportunities were required to help sustain the practitioner in light of the emotional demands of the work.

Finally, there was a plea for policy makers to become more interested in understanding the lives of service users whose needs do not always fit neatly 'into a box'. By doing so, BIHS staff members envisaged **the creation of more flexible and accessible services** that could meet the needs of the most vulnerable:

"[There is a] clash of cultures between policy and policy makers and people and practitioners... So you know, who listens in terms of, from grassroots up from the healthcare professionals that help shape perceptions of proper policies, because the services..., they just don't exist, you know, they just aren't there for the people that we meet here. You know, where do people go in our world if they've got a drug debt and they're under a life threat, you know, and statutory services are great when things are, you know, fit in a box. But there's so many other variations. Or young people out of care? So when they're 18, they're suddenly an adult and you've got young women on the street here who are very, very vulnerable, you know. And so, if the policies don't meet their needs first, the most vulnerable, then it's just a piece of paper and... we deal with people, not paper."
(Staff Focus Group)

Figure 2.2: Belfast Inclusion Health Service Trauma Informed Implementation

References

Bunting, L., Montgomery, L., Mooney, S., MacDonald, M., Coulter, S., Hayes, D., & Davidson, G. (2019a). *Evidence Review: Developing trauma informed practice in Northern Ireland.* Belfast: SBNI & QUB.

Cole, S. F., Eisner, A., Gregory, M., & Ristuccia, J. (2013). *Helping traumatized children learn: Creating and advocating for trauma sensitive schools.* Boston: Massachusetts Advocates for Children

Hanson, R. F., & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. *Child maltreatment, 21*(2), 95-100.

Maisa A, Semple S, Griffiths A, et al; on behalf of the Outbreak Control Team. Risk behaviours of homeless people who inject drugs during an outbreak of hepatitis C, Northern Ireland, 2016-2017. *J Viral Hepat.* 2019; 26: 1377–1387. https://doi.org/10.1111/jvh.13184

Mooney, S., Fargas Malet, M., MacDonald, M., O'Neill, D., Walsh, C., Hayes, D. & Montgomery, M. (2024a). *'We are on a journey': Implementing Trauma Informed Approaches in Northern Ireland.* Belfast: Queen's University Belfast, Safeguarding Board for Northern Ireland

Mooney, S., Fargas Malet, M., MacDonald, M., O'Neill, D., Walsh, C., Hayes, D. & Montgomery, M. (2024b). *'We are on a journey': Implementing Trauma Informed Approaches in Northern Ireland.* Executive Summary. Belfast: Queen's University Belfast, Safeguarding Board for Northern Ireland

SAMHSA (2014) SAMHSA's Concept of Trauma and Guidance for Trauma-Informed Approach. Available at https://store.samhsa.gov/sites/default/files/sma14-4884.pdf [Date accessed 12.1.24]

For further information, please contact:
Dr Suzanne Mooney,
Senior Lecturer Social Work,
Systemic Practice & Family Therapy Programme Director
s.mooney@qub.ac.uk

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