opportunity
NOTTINGHAM
Believing in people. Inspiring change.

Telling the whole story

Summaries of ten psychologist-led research projects in homelessness services in Nottingham

Author: Anna Tickle, Clinical Psychologist, Opportunity Nottingham and Framework

September 2020

www.opportunitynottingham.co.uk
0115 850 4128
@OppNottingham
Search for Opportunity Nottingham

COMMUNITY FUND
Opportunity Nottingham is made possible by funding from the National Lottery Community Fund.

> “Social, environmental and system factors all affect how and whether a person can make changes, even if they want change.”

Contents

Acknowledgements

No research is possible without people who are willing to take part. A special thanks goes to all the people who volunteered for the projects summarised here. Some use homelessness services, others work in them. They all gave time and thought to research and evaluation projects, without any promise that they would personally benefit.

Nearly all of the projects have been carried out by trainee Clinical Psychologists studying for a doctorate in clinical psychology, or students studying for psychology master's degrees. They have all gained knowledge and skills but have also put in a huge amount of time and effort to make sense of and document people's experiences. It is hoped their efforts can support wider development of psychologically informed approaches within services for people facing multiple disadvantage.

Trainees and students have also been supervised by Clinical Psychologists who work as staff at the University of Nottingham, University of Lincoln, and Nottingham Trent University. Those staff have offered expertise in both psychology and research methods to support the development of the projects and we are very grateful for their input behind the scenes.

All of the projects have been supported by senior managers within Opportunity Nottingham and Framework. Their openness to research and evaluation is very much appreciated.

What is a Clinical Psychologist and why do they do research?

Psychology is the study of brain and behaviour. Clinical Psychologists specialise in emotional and mental health difficulties, behaviours, or physical health problems that impact mental wellbeing. They work in lots of different settings, with people with a wide range of abilities and needs. Clinical Psychologists do lots of work with individuals, including assessments and therapy. However, they are also trained to work indirectly with family members, support staff, teams, and wider organisations to develop environments that promote wellbeing for everybody in them. In recent years, there has been a real growth in the number of Clinical Psychologists working in homelessness services.

Clinical Psychologists are all trained to understand and carry out research, so that what they do is based on evidence about what works for who. They also understand the limits of evidence. Unfortunately, people facing multiple disadvantage have often been excluded by researchers and their needs have not been well understood. Thankfully, this is starting to change and researchers from a range of backgrounds are beginning to pay attention to people who face multiple disadvantage and social exclusion. Clinical Psychologists are well placed to contribute to research that can build the evidence about what works and what needs more consideration. Sometimes they work in universities running really big studies, at other times they might evaluate their routine work, such as therapy.

This document summarises smaller-scale projects undertaken within services from 2018-2020.

Researchers involved in the projects and their affiliations

Dr Anna Buckell
Clinical Psychologist and Senior Lecturer, Psychology Department, Nottingham Trent University.

Sophie Buckley
Trainee Clinical Psychologist, University of Nottingham, and Nottinghamshire Healthcare NHS Foundation Trust. Sophie completed one of the research projects for her master's at Nottingham Trent University.

Rupert Burge
Trainee Clinical Psychologist, University of Nottingham, and Nottinghamshire Healthcare NHS Foundation Trust.

Dr Danielle De Boos
Clinical Psychologist and Programme Co-Director, Trent Doctorate of Clinical Psychology, University of Nottingham.

Dr Sarah McDonald
Clinical Psychologist. Sarah supervised this project while working at Nottingham Trent University.

Dr Nima Moghaddam
Clinical Psychologist, Trent Doctorate of Clinical Psychology, University of Lincoln

Alex Lord
Master's of Psychology in Clinical Practice student, Nottingham Trent University.

Dr Kristy Potter
Clinical Psychologist. Kristy was employed for this research as a research assistant by the University of Lincoln.

Beth Pritty
Clinical Psychologist, Nottinghamshire Healthcare NHS Foundation Trust.

Dr Andy Reeve
Clinical Psychologist, Derbyshire Healthcare NHS Foundation Trust. Andy completed the project as a Trainee Clinical Psychologist at the University of Nottingham.

Hayley Sapsford
Trainee Clinical Psychologist, University of Nottingham, and Nottinghamshire Healthcare NHS Foundation Trust.

Professor Thomas Schröder
Clinical Psychologist, Trent Doctorate of Clinical Psychology, University of Nottingham.

Kate Shepherd
Trainee Clinical Psychologist, University of Lincoln, and Lincolnshire Partnership NHS Foundation Trust.

Dr Anna Tickle
Clinical Psychologist, Opportunity Nottingham and Framework.

Jen Wells
Trainee Clinical Psychologist, University of Nottingham, and Nottinghamshire Healthcare NHS Foundation Trust.

Research summary: Developing Psychologically Informed Environments in homelessness services

Sophie Buckley & Anna Tickle

What was this research about?

‘Psychologically Informed Environments’ (PIEs) are services that work to improve the support they offer to service users. They do this through:

1) Developing psychological awareness of service users
2) Valuing staff training and support
3) Creating a culture of learning and enquiry about what works
4) Creating ‘spaces of opportunity’ in which people can positively engage
5) The three Rs – Rules, roles, and responsiveness of the service.

Relationships are seen as important to all five areas – relationships between service users, volunteers, staff, and people and organisations who are from outside the service but come into contact with people from the service.

There is evidence that developing homelessness services in line with PIEs increases positive outcomes for staff and service users (e.g. more confident staff, planned move ons and better access to health care for service users) and reduces negative outcomes (e.g. less incidents, less contact with criminal justice). This research is about three complex needs hostels and one community team (Opportunity Nottingham) working to develop through PIE training and support from a Clinical Psychologist in service.

What did we do?

Each service completed a ‘PIEs Assessment and Self-Development for Services’ (‘PIZAZZ’), which is a tool used by a team to evaluate themselves against the five PIE areas. This was done in late March 2019. Nearly all staff from the services then completed four days of training focused on the five areas of PIE and the impact of trauma. The services also had regular meetings with the Clinical Psychologist, to discuss specific service users from a psychological perspective. The teams then completed a follow-up PIZAZZ six months after the first one, around September / October 2019.

The PIZAZZ looks at 16 areas of practice within the five PIE domains and allows ratings of ‘Poor’, ‘Basic’, ‘Progressing’ or ‘Advanced’. It also looks at ‘helpful’ and ‘hindering’ factors and includes an action plan that teams would want to take to further develop.

What did we find?

Opportunity Nottingham staff scored themselves as ‘progressing’ or ‘advanced’ against most of the criteria on the first PIZAZZ, whereas the three hostel teams rated the service as ‘poor’ or ‘basic’ against most areas on the first PIZAZZ. This is likely to be because Opportunity Nottingham is a well-funded project that had principles of PIE built into the design. As a community team there is also greater flexibility in ways of working than accommodation service teams may have, e.g. being able to meet individuals when and where they prefer and not having authority over individuals’ tenancies.

All of the teams showed higher scores on the follow-up PIZAZZ compared to the first PIZAZZ.

For Opportunity Nottingham, most ratings moved from 'progressing' to 'advanced'. The two scores that did not change were for 'Staff support' and 'Three Rs – rules', which were both rated as advanced on the first and second PIZAZZ measures.

For the three hostels the change was from a score of 'poor' or 'basic' to a score of 'progressing' and sometimes 'advanced'.

There were four ratings by the hostel teams that did not change. One hostel rated 'Staff support' and 'Evidence generating practice' as 'poor' on both PIZAZZ measures. Another rated staff support as 'progressing' on both PIZAZZ measures and 'Three Rs – Roles' as 'basic' on both occasions.

Opportunity Nottingham identified **helpful factors** to be:

- *the ethos and set-up of the service* (e.g. not being a housing service; low caseloads; established training, supervision and reflection; no time constraints on service provision)
- *the staff team* (being supportive and skilled)
- *access to psychology provision.*

Hindering factors were seen as:

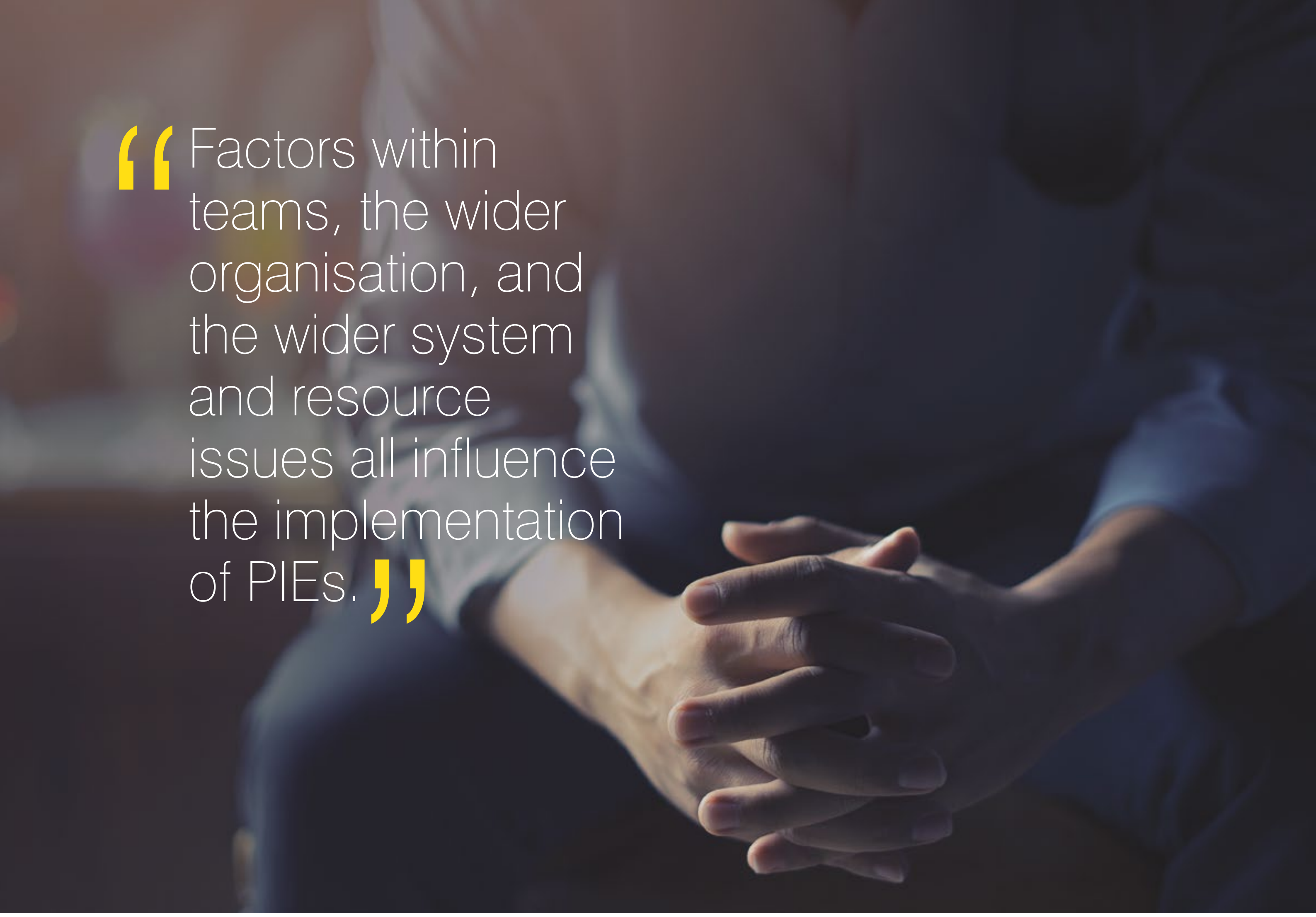
- *staff factors* (e.g. burnout and some staff being less open to reflection);
- *beneficiary factors* (e.g. change being too difficult for some individuals to achieve)
- *lack of training*
- *resistance from other organisations* to provide flexible support to beneficiaries.

Across the three hostels, **helping factors** were identified as:

- *strengths of staff* (caring, kind, responsive etc.)
- *implementation of PIEs* through training and meetings in service
- *service culture* (e.g. informal and formal support; flexibility in the application of rules; and a 'no-blame' culture)
- *external services* (e.g. good connections with relevant agencies); location / buildings (e.g. nice garden space; local amenities and transport connections).

Hindering factors included:

- *lack of / limited training* (e.g. breadth rather than depth; long waiting times)
- *organisational / wider systems culture* (e.g. lack of move on options for residents)
- *lack of organisational clarity or direction* (e.g. changing priorities)
- *a sense that hostel staff are not valued*
- *lack of understanding / clarity from senior management* (e.g. about day-to-day work in hostels or a lack of communication from higher levels of the organisation)
- *lack of resources* (finances for activities; staffing shortages and turnover; no Wi-Fi)
- *limitations of staff teams* (e.g. anxiety about upsetting each other or getting things wrong; sometimes passively waiting for service users to approach staff)
- *service users' limited engagement* (e.g. not being interested in consultation or other activities, spending little time in the service).



> "Factors within teams, the wider organisation, and the wider system and resource issues all influence the implementation of PIEs."

What does this mean?

All four services clearly rated their practice as having improved in line with the principles of Psychologically Informed Environments within just six months, following the training and provision of psychology input. However, there remains room for further development in all services.

Factors within teams, the wider organisation, and the wider system and resource issues all influence the implementation of PIEs. This means that training staff and providing psychology support within services is necessary but not sufficient to develop PIEs.

Commissioning and contracting of services are seen as fundamental in supporting or limiting the extent to which services can develop as PIEs.

What future research might be needed?

- Service user perspectives of how they rate the services against the five areas of PIE.
- Specific interventions to support teams to overcome hindering factors at team, wider organisation, and systems levels.

Research summary: Developing Trauma Informed Care in homelessness services

Rupert Burge, Anna Tickle & Nima Moghaddam

What was this research about?

Psychological trauma is known to make it more likely that people experience homelessness and mental health problems, misuse substances, and engage in offending behaviour (together these things are known as multiple disadvantage). Trauma can also lead to: difficulties in relationships with others; doing things that are harmful to yourself or others; and difficulties asking for or making use of support. Homelessness also increases the chances of experiencing further trauma.

> “Training about trauma is necessary for staff in organisations wanting to provide TIC but will not on its own lead to the highest standards of TIC provision.”

Trauma Informed Care (TIC) is an approach to care or support based on an understanding of how common psychological trauma is and how trauma effects people. Based on this understanding, TIC aims to offer people care or support that can help them feel safe, build trust, and move towards recovery from the effects of trauma. TIC also recognises that services and systems can further traumatise people and tries to prevent this. TIC has become commonly talked about in educational, healthcare, social care and homelessness settings. However, very few organisations have measured how successful they are at developing TIC. There is a risk that organisations say they are trauma-informed without any evidence.

This research evaluated a training programme about TIC for staff working in seven homelessness services (temporary accommodation and community services) in one organisation, to see if it made any difference to the way staff rated the organisation’s level of TIC.

What did we do?

We used a questionnaire called the TICometer. This was developed in the United States of America and is designed to measure an organisation against five domains of practice that relate to TIC: 1) Knowledge and skills (about trauma); 2) Relationships; 3) Respect; 4) Service Delivery and 5) Policies and Procedures. All staff in services (support workers up to the most senior staff in the organisation) anonymously complete the questionnaire online and one overall score is given for each of the five domains. The scores are categorised as ‘insufficient’, ‘fair / needs improvement’, ‘good’ or ‘excellent’.

Staff from the seven services (three accommodation services for adults; three accommodation services for young adults; and one community service) and their senior managers within the organisation were invited to complete the TICometer. All staff were then given four days of training, two days on developing psychologically informed environments generally, and two days that focused on trauma informed care. They were then asked to complete the TICometer six months and one year after the first time they completed it.

What did we find?

- There were some limitations of the TICometer, e.g. there were technical hitches for some people accessing it at the six-month and one-year follow up. It did not ask people for their job roles, which is to protect people's identity but makes it difficult to know whether people in some roles showed more change than others.
- 80 people completed the TICometer the first time. Only 18 people completed it at the 6-month follow-up and 26 people completed it at the 12-month follow up. This could be due to technical hitches, changes in staff (leaving or joining services), or a lack of interest. This means results must be interpreted with some caution.
- Across all participants, the first time the TICometer was completed, the scores were categorised as 'Insufficient' for four domains: Knowledge and Skills, Relationships, Service Delivery, and Policies and Procedures. The score for Respect was 'fair'.
- Across all participants, at the one-year follow-up, the scores for the four domains that were rated as 'insufficient' were rated as 'fair / needs improvement'. However, they were not statistically significant changes, except for the score for Knowledge and Skills, which showed significant change. The score for Respect remained categorised as 'fair'.
- We then compared changes for the people who completed the TICometer more than once each: the first time and six months later (9 people), those who completed it the first time and one year later (a different 9 people) and those who completed it all three times (a different 9). This showed significant improvements on the scores for Knowledge and Skills, Relationships, and Policies and Procedures.
- Those who completed the TICometer all three times showed changes were made by the six-month follow up (sooner after training) and were still evident at the one-year follow up.
- People who gave lower scores on the TICometer the first time, showed more change in the scores they gave at six-months and one-year.

What does this mean?

- Overall it appears training led to some development of the provision of trauma informed care in four domains, but with a need for further improvement on these four and the fifth, Respect, which was rated as 'fair' before and after training.
- Changes made following training can be maintained.
- Training about trauma is necessary for staff in organisations wanting to provide TIC but will not on its own lead to the highest standards of TIC provision.
- Evidence from other studies suggests that organisational factors impact TIC scores more than individual worker factors: resources and the culture within the organisation make a difference to whether TIC can be delivered. Wider organisational work is taking place to support further development of TIC in this organisation.
- It is possible that the changes were not down to the training alone, but this was not measured.
- Organisations cannot say that they are providing TIC just because they have delivered training about trauma to staff.

What future research might be needed?

- Studies of ways other than training to develop TIC in organisations.
- Studies of interventions in specific domains of TIC, e.g. how to support the development of respect across an organisation.
- Service user perspectives of TIC.

Research summary: Developing Psychologically Informed Environments in the Wellbeing Hub

Hayley Sapsford, Beth Pritty & Anna Tickle

What was this research about?

'Psychologically Informed Environments' (PIEs) are services that pay attention to:

1) Developing psychological awareness of service users
2) Valuing staff training and support
3) Creating a culture of learning and enquiry about what works
4) Creating 'spaces of opportunity' in which people can positively engage
5) The three Rs – Rules, roles,and responsiveness of the service.

Relationships are seen as important to all five areas.

Wellbeing Hubs bring together lots of services under one roof to make it easier to access them. This is especially important for people who need help with different things around the same time, e.g. mental health, substance misuse, housing, learning or employment opportunities, and sexual health.

This research is about measuring how psychologically informed both staff and service users see the Nottingham Wellbeing Hub to be.

What did we do?

All staff teams in the Wellbeing Hub were asked to complete a 'PIEs Assessment and Self-Development for Services' ('PIZAZZ') to evaluate themselves against the five PIE areas. Three of the teams did this. For one week, everybody who visited the Wellbeing Hub to use a service in it was invited to fill out a questionnaire about their experience of the Hub in relation to the PIE areas and 28 people did. They were offered support to do this by a volunteer with experience of using services.

Nearly all staff from all the services based at the Wellbeing Hub then had four weekly training sessions of three hours, which focused on the five areas of PIE and the impact of trauma. They were divided into three groups for this, to manage the numbers.

Unfortunately, the Covid-19 restrictions meant that the last group to get the training could not have the last session. The restrictions also stopped us repeating the PIZAZZ measures and questionnaires with service users, to see if there had been any changes after the training to staff. This means we only have the ratings for before the training.

What did we find?

Service user views:

- The majority of service users found staff to be understanding, with occasional exceptions.
- Some service users saw staff as overstretched and not always able to meet needs. This means results must be interpreted with some caution.

- Some service users said they wanted to be more involved in active roles in the service. They were aware of some opportunities, such as Service User Forums, but wanted these to be better advertised.
- Having services under one roof was valued; over half of service users said they had been provided support to access other relevant services. However, 21% said this had not been the case.
- Most people said they felt very or mostly safe when using the Hub.
- There were mixed views about whether the Hub met any gender-specific needs – 32% said they had no gender-specific needs; 39% thought gender specific needs were met very much so or mostly. 15% thought gender-specific needs were not at all met.

Staff views:

- The PIZAZZ scale rates each area of PIE as ‘Poor’, ‘Early’, ‘Progressing’ or ‘Advanced’. The three teams that responded rated themselves as ‘progressing’ or ‘advanced’ in relation to Psychological Awareness, Staff Training and Support, and The Three Rs – Rules, Roles and Responsiveness.
- Learning and Enquiry was rated as early, or early / progressing by two teams and progressing / advanced by another.
- Spaces of Opportunity was rated as ‘early’ by one team and ‘progressing’ by two.
- Staff highlighted the following as evidence of psychologically informed practice:
  - Training, supervision, and support.
  - Knowledge of different psychological models across team members.
  - Discussing expectations with service users.
  - Taking a person-centred approach and working to empower people to access other opportunities.
- Areas for improvement included:
  - Protected time for regular support and supervision (by one team).
  - Opportunities to take part in wider learning / enquiry / communities of practice.
  - Making better use of personal and professional reflections.
  - The physical environment, e.g. “stained carpets, bare white walls”, a noisy environment and difficulties in maintaining confidentiality for service users.
  - More opportunities and roles for service users, e.g. consultation.

What does this mean?

There are examples of good practice, but there remains room for improvement.

Teams within the same building might be at different stages in relation to PIE. Teams and service users together might be able to share ideas to further develop PIE practice.

What future research might be needed?

Specific projects to further develop PIE approaches within the Hub, perhaps particularly focusing on the development of service user roles and consultation.

Research summary: Implementing psychological formulation meetings in complex needs homeless hostels to develop Psychologically Informed Environments

Sophie Buckley, Anna Tickle & Sarah McDonald

What was this research about?

Clinical Psychologists often use ‘psychological formulation meetings’ to help teams think about the people they support. In these meetings, the team talk together about an individual’s difficulties, strengths, and how the team can tailor support to best meet their needs. These meetings are not common in homelessness services. However, they can support services to become ‘Psychologically Informed Environments’ (PIEs) by: raising staff members’ psychological awareness; being a form of staff support; encouraging staff reflectiveness, learning and enquiry about individual service users; considering opportunities and roles for the service user; and thinking about how the team can best apply the rules of the service in response to the person’s needs. We introduced formulation meetings to two ‘complex needs’ hostels. This research is about what staff thought of the meetings.

What did we do?

We interviewed four staff from a hostel for men and five staff from a hostel for women, before the formulation meetings began and after weekly meetings for eight weeks. We recorded their interviews, wrote them out, and then looked for themes in what they said.

> “Staff also had better awareness of how service users might view staff behaviour and the need to manage issues of power.”

What did we find?

‘Increasing psychological awareness and understanding of service users’: After the meetings, staff all said they had a better understanding of the people they support and their behaviour. Staff also had better awareness of how service users might view staff behaviour and the need to manage issues of power. The meetings helped staff feel more empathy towards individuals and better understand the impact of trauma.

‘Stopping, thinking, and doing something different’: Half the staff said the meetings changed the way they worked – they were more likely to stop and think about an individual’s needs and be more creative, flexible and person-centred in offering support. This included better working with other agencies. The teams began to work more consistently too.

‘A constraining context’: The meetings really made staff aware of the lack of resources available in the system to support people. They felt frustrated to only have six months to meet service users’ needs. At times, this awareness left staff with feelings of despondency, hopelessness and powerlessness to make meaningful changes.

'Recognising and reinforcing good practice': The meetings were a chance for staff to receive positive feedback and recognise that they were doing good things, despite the limits of the systems they work in. This positive feedback may encourage staff to continue good work.

What does this mean?

- Psychological formulation meetings fit well with the principles of Psychologically Informed Environments and can promote good practice.
- It is important to set realistic expectations of what can be achieved through the meetings, to strike a balance between pushing the boundaries of systems to achieve the best possible outcomes for individuals and reaching for outcomes that may simply not be possible within existing systems.
- Understanding more about how early experiences and trauma have impacted an individual can increase empathy towards them. .
- Staff can develop awareness of how their own behaviour impacts service users and change their approach for the benefit for service users.
- Even within limited systems, staff can be flexible in how they provide support and tailor this to the needs of individuals.
- There is a risk that discussing limited resources and service provision can leave staff with feelings such as frustration and powerlessness, which might impact morale. However, this can be balanced to some extent by recognising good practice.
- Staff benefit from positive feedback about their work, which can increase positive emotions towards work.
- The limitations of short-term hostel provision and the pressure on staff to 'resettle' people must not be underestimated – they can impact on staff morale as well as the people they support.
- While formulation meetings can lead to changes in day-to-day practice within hostels, broader service work is needed to promote greater flexibility in commissioning and service deliver that might better meet the needs of individuals in the long-term.

What future research might be needed?

Information from service users about whether they notice changes in the way staff work with them after formulation meetings, or more generally in the service. This would be challenging to achieve given the difficulties that bring individuals to the service and the power difference between staff and residents but is important to consider.

It would be useful to research whether formulation meetings lead to changes in support plans.

Research into staff feelings such as hopelessness and ways to support staff in managing these feelings would be helpful.

This research has been published in the Journal of Social Distress and Homelessness: https://www.tandfonline.com/doi/abs/10.1080/10530789.2020.1786922

Research summary: Staff views of change readiness in individuals experiencing homelessness and multiple complex needs

Alex Lord, Anna Tickle & Anna Buckell

What was this research about?

Staff in homelessness services play a big role in supporting individuals experiencing multiple complex needs to make changes. There are psychological theories about behaviour change and the stages people go through as they decide whether to make change and then take action to do so. These theories tend to look at one change at a time, not complex needs. There was also no research about how staff think about the people they support in terms of how ready they are to make changes. This is important because staff might only help people to make changes (for example through practical support or making referrals) if they see them as ‘ready’, and could block opportunities for change if they think somebody is not ready.

What did we do?

Ten staff members were interviewed about how they think about ‘readiness to change’ in the people they support. We recorded their interviews, wrote them out, and then looked for themes in what they said.

What did we find?

‘Multiple complex needs mean multiple complex changes’: Services need to be flexible to accommodate this. It should not be assumed that because somebody is not ready for one type of change that they cannot make other changes.

> “It should not be assumed that because somebody is not ready for one type of change that they cannot make other change.”

‘Talk versus behaviour’: People will start to say that they want change but sometimes might be scared of change, which can stop them making the changes they say they want. People might keep using ‘unhealthy’ ways of coping because they feel safer than new ways of being.

‘Change is not a linear trajectory’: Change is slow and not always steady – it can take years to make changes and they are not always maintained. Sometimes, success is avoiding negative outcomes, rather than big ‘positive’ changes.

‘The role of consistent boundaried relationships’: Workers need to build consistent long-term relationships. They need to manage their own and services’ views about what somebody ‘should’ be changing. Workers need to balance delivering person-centred care, meeting service demands, and maintaining a relationship that has helpful boundaries. Endings must be carefully managed.

‘Change is not solely within the individual’s control’: Social, environmental and system factors all affect how and whether a person can make changes, even if they want change. For example, personal relationships, housing availability, and lack of access to mental health support can all limit change.

What does this mean?

- Traditional models of ‘readiness to change’ based on individual thoughts, feelings and behaviours do not address the complexity of change for people facing multiple disadvantage.
- Change cannot be forced by agencies and agendas to make people change are unlikely to succeed.
- Services should not focus on how ready somebody appears to be to make changes – services should also focus on how the system can actively help the person to feel hopeful that support will be given to make changes and maintain it.
- Time-limited services that only focus on one problem are unlikely to provide the support needed. Services need to be long-term, address multiple difficulties, and focus on building relationships with the individual to support change.
- Behaviours that may be ‘unhealthy’ may be important ways of coping for an individual and should be understood as such.
- Workers should be supported through training about ‘readiness to change’ (and its limitations) and ongoing supervision and support to recognise both barriers to and opportunities for promoting change.

What future research might be needed?

This study only asked staff their views – research is needed into the views of individuals facing multiple disadvantage about readiness to change.

There is a need to develop theory about readiness to change that can capture the complexity of individuals facing multiple disadvantage – this needs to include social, environmental and systems factors as well as an individual’s ‘readiness’. Detailed case studies of individuals with a focus on processes of change could help with this.

Research summary: Acceptance and Commitment Therapy for homelessness services staff

Andy Reeve, Anna Tickle & Nima Moghaddam

What was this research about?

Workers in homelessness services are known to face demands that can lead to work-related stress and 'burnout'. Burnout can involve exhaustion and not feeling engaged with the work. It can impact personal wellbeing. This can affect both the workers and the people they support – workers may feel less able to give good quality support and might avoid supporting people. It might also lead to long-term sickness and / or staff leaving, meaning people using services get less consistent support. There has not been much research into ways to support homelessness staff affected by burnout.

It is important to say that homelessness services often lack resources. The level of resources and the culture of the organisation are important in protecting staff against burnout. However, it is also appropriate to give some staff individual support when they experience burnout.

> “It is important that organisations and commissioners take action to limit the likelihood of burnout for their staff.”

Acceptance and Commitment Therapy (ACT) aims to help people increase 'psychological flexibility' – this means the ability to be in the present moment (not caught up in the past or future), be open to difficult feelings without them getting in the way of what you do, and doing the things that are in line with what is important to you. This research looked at whether just three sessions of ACT could support staff in homelessness services who were experiencing work-related burnout.

What did we do?

We invited a small number of staff in homelessness hostels and a community team to have three one-to-one 'workshop' style sessions of ACT and regularly complete questionnaires. We measured their level of burnout (exhaustion and engagement with work), personal wellbeing, psychological flexibility, and the two values most important to them. Four people took part. We looked at whether the things we measured changed after the ACT sessions, and whether any changes were still there four weeks after the sessions ended.

What did we find?

- All participants reported lower levels of exhaustion after ACT.
- Three of the four participants reported being more engaged with their work.
- Personal wellbeing improved for all of the participants, but not significantly

- All four reported changing their behaviour in line with what they considered important.
- All four showed a significant increase in their psychological flexibility.
- One participant's improvements did not last four weeks after ACT.

What does this mean?

- Offering ACT sessions for work-related stress could be beneficial for homelessness workers who are experiencing burnout.
- It is possible that longer interventions would be helpful – the findings of this study are based on just three sessions.
- It is important that organisations and commissioners also take action to limit the likelihood of burnout for their staff. Individual interventions are just one way of supporting staff.

What future research might be needed?

- Whether longer sessions or group sessions might be as or more effective than the sessions in this research.
- Whether teaching staff ACT skills might protect against burnout longer-term.
- How acceptable ACT sessions are for staff – this research looked in detail at four people, but it would be useful to know if others would be interested and willing to try ACT.

This research has been submitted to the journal Clinical Psychology & Psychotherapy.

Research summary: Acceptance and Commitment Therapy to support people struggling to reduce low-dose buprenorphine use

Kate Shepherd, Beth Pritty, Anna Tickle, & Nima Moghaddam

What was this research about?

Difficulties managing (regulating) emotions can keep both drug use and mental health problems going – people can use substances to block out or avoid difficult emotions. The recommended treatment for people dependant on opioids is prescription of an opioid substitution drug, such as buprenorphine. These are not a long-term solution and do not help the person learn skills to manage their emotions. This means when prescriptions are reduced, people are more likely to begin using other substances. People may be prescribed very low doses for a long time because they worry about the effects of stopping.

Acceptance and Commitment Therapy (ACT) is a type of talking therapy, which helps people learn to manage emotions and not block them out. It tries to improve what is called ‘psychological flexibility’ – the ability to be open to difficult emotions, aware of your own behaviour, and do things that are important to you. ACT focuses on the individual’s personal goals, and personal barriers to achieving goals. ACT could help people to reduce buprenorphine prescriptions without going back to other substances. However, ACT is not routinely offered to people who are prescribed buprenorphine. This research is about offering ACT to people prescribed low doses of buprenorphine. It focuses on one person’s experience of it.

What did we do?

Eight people prescribed low doses of buprenorphine were offered up to 12 sessions of ACT. Three declined on invitation, three only took part in one, two, or three sessions, respectively. Two others completed ACT and completed questionnaires each session to see if it had any effect on mental wellbeing, psychological flexibility, and personal goals. Unfortunately, due to Covid-19, data for only one of them was available for this report. He also took part in an interview after therapy had finished and has given consent for us to write about him.

What did we find?

The client, who we have called ‘Bruce’, had 12 weekly sessions. He was 40 years of age and referred to the drug treatment service two years prior to therapy for support because of misusing opiate-based prescription medication originally prescribed for chronic pain. Bruce began misusing opiates three years before therapy after his long-term relationship broke down and he lost his home and regular contact with his children. He had begun to use alcohol and self-harm (cutting) to cope. When therapy started, Bruce was living in a hostel and avoiding spending time with friends and family due to social anxiety. Bruce’s goals were to improve his: 1) poor motivation “to do anything”; 2) housing situation; 3) anxiety.

Mental wellbeing – Bruce’s overall mental wellbeing increased very slightly after therapy. However, despite his anxiety and difficulties, he rated his well-being as higher than average in individuals in a ‘non-clinical’ population who do not have mental health difficulties.

Psychological flexibility – The questionnaire has a total score of 48 (a higher score is better). Bruce showed significantly higher levels of psychological flexibility at the end of therapy (33 out of 48), compared with the start of therapy (14 out of 48). He was much more able to do things that were important to him: keeping himself busy with cooking, bike rides, shopping, contacting friends and family, and spending time with his children. He began aiming to return to work and seeking learning opportunities. He reduced his alcohol consumption. He said in the final session that he was trying to live the life he wants to live even though he still had practical difficulties (such as housing). He stopped self-harming.

Personal goals – Bruce showed a significant improvement in his motivation and a significant reduction in his social anxiety by the end of therapy. There was not a significant change in his housing situation, but he was more actively seeking alternative accommodation at the end of therapy than he had been at the start.

Relationship with the therapist – Bruce rated the relationship with the therapist at the maximum possible every session.

The client's view of therapy – Bruce said he enjoyed therapy and found it useful to have someone to talk to and learn strategies to manage his distress. He found it useful to have concrete goals set between sessions and have something to achieve. Bruce said he had made the following changes as a result of therapy: 1) Learned better ways to deal with difficult or painful things; 2) Learned to socialise more; 3) Seeing his children much more often; 4) Drinking less; 5) Not self-harming; 6) Not being 'stressed out' as much and not crying as much. He viewed all of these changes as moderately to extremely important and saw most of them as unlikely without therapy.

It is important to note that Bruce's prescription of buprenorphine was increased from 0.4mg to 0.8mg between the third and fourth session of therapy.

What does this mean?

- Therapy was either not taken up or not completed by six of the eight people it was offered to.
- The individual who this report focuses on built a good relationship with the therapist and benefitted from therapy.
- It was not an aim (for the client or therapist) to reduce buprenorphine use.
- Although therapy did not lead to a reduction in buprenorphine use, it did lead to better motivation, better ability to cope with difficulties, and more engagement with positive activity and relationships in day-to-day life
- Therapy cannot resolve practical systems issues of housing availability or feelings towards inadequate housing. However, therapy supported the individual to begin actively seeking alternative housing.
- Some people accessing substance misuse services can make use of and benefit from psychological therapy, specially ACT.

What future research might be needed?

More research would be needed to know why people decline talking therapies and whether anything could increase access.

Research in progress summary: Acceptance and Commitment Therapy for individuals with multiple complex needs

Anna Tickle, Nima Moghaddam & Kristy Potter

What is this research about?

It is known that many people facing the challenges of homelessness, mental health difficulties, substance misuse and offending struggle to access mainstream mental health services and psychological therapy. Services often exclude them for a wide range of reasons, including lack of stable address or G.P. registration, levels of risk to self or others, and myths that people need to stop using substances before they can make use of therapy. People might also be excluded because of practical difficulties such as getting to set appointments or having periods in prison. For those who are offered therapy, strict rules (such as about attendance) might make it difficult to stay in therapy. There is also little, if any, evidence that traditional therapy approaches can be helpful for people facing multiple disadvantage (also known as multiple complex needs).

> “Some people who had been turned down by mental health services were very keen to have therapy and made good use of it.”

This research is about using Acceptance and Commitment Therapy (ACT) with people with multiple complex needs. ACT does not focus on challenging people’s thoughts (like traditional Cognitive Behavioural Therapy), instead it helps people step back from their thoughts (memories, fears, traumas), focus on what is important to them in life, and help them take steps towards living the life they want to. It has been shown to be helpful for people facing a wide range of mental and physical health problems, as well as addiction. However, even ACT would usually be done in regular weekly one-hour appointments, often in a therapy room. This research also looks at what changes to therapy might be helpful for people.

What are we doing?

We offered people in hostels and a community team the chance to take part in the research – this involves having up to 12 sessions of therapy, filling in some questionnaires before, during and after therapy, and being interviewed by an independent researcher after therapy finishes. Therapy sessions are recorded to check the therapist is doing ACT right.

We are looking at all the questionnaires and interviews to find out if therapy helps people to stay focused on the present moment, step back from difficult thoughts, and do things that are important to them. These abilities together are known as ‘psychological flexibility’. We are also looking at whether therapy helps people to meet personal goals and improve their wellbeing. We will look at what changes people needed to therapy compared to how it is usually delivered, e.g. when, where and how long sessions were and what support people needed to attend.

One person has completed therapy so far. Unfortunately, Covid-19 has affected the research. One person decided to put therapy on hold during lockdown until face-to-face sessions were possible again. Another person had sessions over the phone, but found it hard to have these weekly.

What have we found so far?

- Not everybody who was offered the chance to take part wanted to – this might be because of the research, rather than the therapy.
- Some people who had been turned down by mental health services were very keen to have therapy and made good use of it.
- Some people who wanted to take part have not been able to start or keep going with it, for a range of reasons, including long periods in prison, moving away, and changes in relationships.
- People do not attend every week – they might miss sessions, sometimes for weeks or even months, but then want to start again and appreciate being able to.
- It is important to change the length of sessions to suit people – some people can only manage 30 minutes; some people cannot manage with under an hour and a half.
- People can make good use of therapy even if they are under the influence of alcohol and drugs within sessions (up to a point). Drinking alcohol within a session can help somebody feel able to attend – reducing drinking within sessions and managing the emotional challenges of doing so can then be something they work on with the therapist. It is also possible for a client to attend under the influence of mamba and still make good use of a therapy session.
- For the one client who has completed therapy, it there was evidence that they were significantly less bothered by six problems they wanted to work on in therapy, including difficult thoughts, self-care, anxiety, managing money, and physical health. Two other problems also reduced, although not significantly. One problem remained the same. They developed skills to be more ‘psychologically flexible’ – to stay in the present moment, focus on what was important to them, and take action towards the life they wanted. Their overall wellbeing also increased significantly. They also reported that they found ACT helpful because it gave them practical skills to manage difficulties.

When will the research be completed?

It is intended that therapy sessions and any interviews will be completed by the end of 2020 and the research report finished in 2021.

Research in progress summary: Designing and evaluating a psychological intervention for individuals with multiple complex needs

Hayley Sapsford, Thomas Schröder, Danielle De Boos & Anna Tickle

What is this research about?

This study aims to explore a new psychological 'intervention' for people experiencing multiple complex needs (i.e. homelessness, mental health problems, substance misuse, offending). This involves 6 – 8 sessions with a Clinical Psychologist, which are based on a document called 'The Power Threat Meaning Framework' (PTMF). The PTMF aims to help people understand their experience of psychological distress. It focuses on how power and threat can lead to somebody thinking, feeling and doing things that are distressing, but also how personal strengths can be protective (see more here if interested: https://www.bps.org.uk/power-threat-meaning-framework/introduction-ptmf). However, the document is very long and has a lot of jargon: we have taken key ideas from it into a workbook to be completed over 6 – 8 sessions with support from a Clinical Psychologist. This research is to find out if going through these sessions is helpful for individuals and whether it makes any difference to their sense of agency (sense of control), sense of empowerment, and their wellbeing.

What are we doing?

- Hayley wrote the workbook and then consulted with Opportunity Nottingham Expert Citizens about the contents. She made some changes based on the consultation.
- We invited people to take part in the research. The sessions were supposed to be face-to-face. Unfortunately, Covid-19 meant that they had to be held over the phone. People are paid £5 per session that they complete, to thank them for their time.
- So far, one person has completed the research – they had all of their sessions over the phone with Anna. They filled in questionnaires (with support from Anna) before they began sessions, during each session and after the sessions finished. They were also interviewed after the sessions by Hayley, to find out what it had been like for them.
- We are currently looking to recruit more people to take part before the end of 2020.
- All of the completed questionnaires and the interview data will be looked at in detail to see if taking part in the sessions is helpful.

What have we found so far?

- It is too early to say much at this stage about the findings. However, it does seem that the workbook can offer a useful structure to support somebody to think about how power and threats in their lives have affected them. With support, it can help somebody to tell their story, consider their strengths, and think about what they would like to build on in the future.

When will the research be completed?

The research is due to be completed in early 2021. We aim for it to be published later in 2021.

Research in progress summary: Good practice guidelines for Clinical Psychologists working in homelessness services

Jen Wells, Anna Tickle & Danielle De Boos

What is this research about?

Homelessness services are actively looking to develop Psychologically Informed Environments (PIE) and Trauma Informed Care (TIC). Clinical Psychologists are trained to work therapeutically with individuals and also support organisations and systems to develop. They are therefore well placed to help services develop PIE and / or TIC approaches. Until very recently, very few Clinical Psychologists worked in homelessness services, despite those services working with people with high levels of psychological need and the challenges of this for staff. Recently, many more Clinical Psychologists are being employed to work with people experiencing homelessness and multiple disadvantage. This research is aiming to produce good practice guidelines to support Clinical Psychologists working in these settings.

> “The ways of working that are seen as good practice challenge the way that mainstream mental health services provide support and measure ‘outcomes’.”

What are we doing?

Jen met with some Opportunity Nottingham Expert Citizens to ask them about their experiences of working with Clinical Psychologists and what they see as important to Clinical Psychologists to keep in mind. She then invited Clinical Psychologists experienced in working in homelessness services to take part in interviews. Jen gave them a summary of what the Expert Citizens had said. The Clinical Psychologists were asked what they consider good practice when working directly with individuals who use services and also when working indirectly with staff and services more widely to help them in delivering support. They were asked to make specific recommendations to other psychologists about good practice. These recommendations were collected into a set of guidelines, which have been sent back to the Clinical Psychologists who were interviewed, to finalise them based on agreement about which are most important and how to best word them. The guidelines will also include examples of good practice taken from the original interviews.

What have we found so far?

- Expert Citizens said:
    - Access to psychology early is important.
    - Psychologists need to understand the impact of the environment, e.g. access to substances, lack of consideration of diversity when placing people in shared accommodation; how victimised people can feel by housing systems.

  - Meeting psychologists can be helpful, but there can be worries about whether a psychologist can truly understand their situation. They want Clinical Psychologists to have training with people who are homeless and spend time shadowing outreach workers to understand what homelessness means, beyond not having a roof over your head. This includes the sense of community and solidarity that exist and the good reasons for being defensive.
  - Practical tools given in therapy might be more beneficial than just listening.
  - You can make use of clinical psychology even when you are using substances or drinking.
- The 12 Clinical Psychologists taking part work across different settings, e.g. some in the NHS, some in hostels, some in community teams etc.
- Despite the Clinical Psychologists working in different settings, there is a high level of agreement between them about what is important when working with individuals facing homelessness and multiple disadvantage and the staff / organisations who support them.
- The ways of working that are seen as good practice challenge the way that mainstream mental health services provide support and measure 'outcomes'.

When will the research be completed?

The research is due to be completed in early 2021. We aim for it to be published later in 2021 and the guidelines be made available to all Clinical Psychologists working in homelessness services, as well as homelessness organisations, mental health NHS Trusts, and commissioners of services.

A blog on consulting with Opportunity Nottingham’s Expert Citizens about research

Hayley Sapsford & Jen Wells, Trainee Clinical Psychologists

Hayley and Jen write about their experience of consulting Expert Citizens to help them in their clinical psychology doctorates.

What is your research about and how do you hope it will benefit people experiencing multiple disadvantage?

Hayley: My research is exploring the use of a psychological model called the “Power Threat Meaning Framework” (PTMF) as the basis of an intervention for individuals experiencing multiple disadvantage. The aim of the intervention is to help individuals understand their experiences of psychological distress over 6-8 sessions with a psychologist. It focuses on how power and threat can lead to somebody thinking, feeling, and doing things that are distressing, but also how personal strengths can be protective. It pays attention to strengths the person wants to build on.

Jen: My research has focused on creating good practice guidelines for Clinical Psychologists working with or in homelessness services. At the moment there are no guidelines for Clinical Psychologists working in this area. It’s my hope that speaking with experts to create guidelines will support Clinical Psychologists already working in the field and provide Clinical Psychologists new to the field with guidance on how best to work with and support those experiencing multiple disadvantage.

Why did you consult with the Expert Citizens to inform your research?

Hayley: I consulted with the group to get their opinion on the materials I was using for my research, such as the participant information sheet, to ensure the language was clear and jargon free. The group was also asked to look at the intervention booklet used throughout the sessions and gave their opinion on the language and its appearance.

Jen: I consulted several expert citizens in a focus group about their experiences of being homeless. I also asked them about their experiences of contact with Clinical Psychologists and discussed what support they would or may have found helpful. This was to provide the Clinical Psychologists taking part in the research with a broader insight into people’s lived experiences and views of how psychologists can support them.

What was it like to go and meet with the Expert Citizens?

Hayley: The group were extremely warm and welcoming. The members provided me with some really valuable insights into the design of my materials and how the language used could be potentially perceived as upsetting or confusing.

Jen: The group were fantastic. They answered all of the questions I asked and engaged in some really helpful discussion with each other - they even stayed later than originally planned to make sure I had all the information I needed.

How has it shaped or changed your research?

Hayley: I made changes to my materials to make them easier to understand and less provoking. This is hugely important, as without the advice of the group, my materials may have put people off from participating in the study.

Jen: The information provided by the Expert Citizens was collated, anonymised, and sent out to all the Clinical Psychologists involved in the research. When proposing guidelines, the Clinical Psychologists were encouraged to think about and, where possible, include the Expert Citizens' thoughts on what they find helpful.

Are there any recommendations you would make to other researchers in relation to involving people who have used services?

Hayley: People who have used services provide an invaluable perspective which is often lost in research. I believe it is of even more importance that those who have faced multiple disadvantage and exclusion are involved in the research process, as neglecting to involve them negates the research effort.

Jen: I would really encourage researchers, wherever possible, to include people who use services in their research. Speaking with the Expert Citizens provided me with a valuable insight into the lived experiences of those considered to face multiple disadvantage. Having an insight into what they have found and/or would find helpful from a Clinical Psychologist has helped to guide participants in their recommendations, making the guidelines useful in practice.

Any final thoughts?

Hayley: I'd really like to thank the Expert Citizens for their advice on my research and giving such a valuable experience. I'm looking forward to returning and sharing my findings with them.

Jen: The Expert Citizens helped increase my knowledge and understanding of the range of different experiences individual challenged by multiple disadvantage may face. I really want to thank them for the time they spent with me and would really encourage them to continue to take part in other research - their contribution is invaluable. It would be lovely to share and discuss my findings with them when the project is complete.

COMMUNITY
FUND
Opportunity Nottingham is made
possible by funding from the National
Lottery Community Fund.