Break The Cycle:

Understanding multiple unmet needs in Hull

Winter 2023/24

An in-depth discovery and report which explores multiple unmet needs and disadvantage across Hull, England

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Executive Summary:

People experiencing the impact and effects of multiple unmet needs in Hull

A summary of our research

In this report we look at the needs of people and groups who have faced and in many instances are still facing some of the highest levels of exclusion, hypermarginalisation and layers of disadvantage in society.

We have referred to these areas of compounded disadvantage as **'multiple unmet needs'** **(read more about Our Definitions from page 19)** and they are broadly understood to include the following groups:

- People who are experiencing homelessness, including forms of hidden homelessness;
- People who are experiencing harmful use of drugs and alcohol, such as dependence or addiction;
- People who are experiencing contact with the criminal justice system;
- People who are experiencing domestic abusive relationships;
- People who are experiencing the removal of a child or children from their legal care (this also includes children experiencing legal removal from their parents) *and/or*
- People who are experiencing poor mental health.

Generally, someone who is going through the impact and effects of multiple unmet needs has two or more of the above challenges and experiences. Oftentimes in the last few years, this has been referred to by services and health and care systems as ***"severe and multiple disadvantage"*** and we discuss the evolution of our language away from this terminology in our **Co-Creating Language and Labels** sub-section **(see page 21 onwards).**

When we began this work, we knew we wanted to carry out a holistic assessment into the needs of people across Hull who are experiencing these types of multi-layered disdvantages, and we are fortunate that funding from the **Changing Futures partnership programme** within Hull City Council has made this possible. We completed our research, which includes both quantitative and qualitative analyses, between February to November 2023, with parts of the project led by independent analysts to help to ensure a holistic and specialist overview and output. The work of our independent researchers was further complemented and supported by Hull City Council's Public Health team. From our combined efforts and the holistic approach taken to this Needs Assessment into multiple unmet needs, we have been able to produce the following outputs which are now detailed in this report:

- A quantitative assessment offering us a baseline estimation for the first time of the numbers of people who are experiencing multiple unmet needs in Hull;
- A quantitative analysis of what people's needs are, based on available datasets at the time of writing;
- A qualitative and holistic assessment of what multiple unmet needs look like and mean for the people who are experiencing them and the staff who are helping them;

The work of the independent researchers was complemented by support from Hull's Public Health team.

The experience of multiple unmet needs is often made more complex by the interplay of disparities and inequity.

- A set of co-produced and collaborative **Recommendations (see page 129)** to inform the next steps and future thinking around system and strategic responses to multiple unmet needs.

It is hoped that this report can shine a light on the difficult and distressing circumstances that so many of our citizens and communities are exposed to, many of which we found to be characterised by significant levels of inequality, trauma, abuse, stigma, loneliness and social isolation.

Although we have opted to talk about 'multiple unmet needs' throughout this report, we wish to echo what a member of staff said to us during our research: that this is about examining and describing ***"the cracks that people fall in to"*** and ***"a philosophy of service and care"*** and that it's not about homogenising a group of individuals under one umbrella term.

As we discovered during our quantitative research, people experiencing multiple unmet needs come from a range of age groups and locations – though we also found that many of them live in the most deprived areas of Hull. Later, during our qualitative assessment, we were able to further conclude with confidence that people with multiple unmet needs have a diverse range of needs and this is reflected in the ***25 evidenced and holistic needs*** that we discovered. Although there are common themes highlighted by the people we spoke to and running throughout our research – themes such as inequality, poverty, stigma, deprivation, trauma and loneliness – nevertheless we hope that we have been able to do justice to the holistic nature and circumstances of people's lives. These holistic circumstances are multifaceted and multi-layered, sometimes made more complex by the interplay of disparities and inequity, and it is in this way that the experience of having multiple unmet needs becomes compounded and interrelational. It is rare that an individual presents with only one need, nor even two, and it is rarer still that their needs can be addressed in a siloed and fragmentary approach. It became clear during our research that as a person's needs are joined-up and interconnected, so must be the services and the systems set up to meet them.

Coming back to the use of **language, labels and terminology,** during our research we took the opportunity to speak to staff and clients who work with or experience multiple unmet needs to find out more about how these can influence perceptions and responses on a daily basis. We wanted to work towards a "co-produced" definition of multiple unmet needs and ensure that people could see themselves reflected back in it.

Many people were happy to share their thoughts and experiences with us, and some of the key takeaways included pleas for the language we use to be as ***trauma-informed*** and ***strengths-based*** as possible, moving away from notions of "complexity" and "complex," seeing the wholeness of people, and taking the onus off individual responsibility or blame – particularly where trauma, adverse experiences and inequalities are present. This brings us back to the core finding that multiple unmet needs are inherently compounded and intersectional, yet we must not lose sight of the human beings beneath these so-called 'complex' layers.

A frontline worker reminded us that using terms like "disadvantage" and "severe" feel loaded and others said they miss the "grit" and "hope" of individuals, indeed our language often misses "how amazing these people are." We found a broad consensus to move towards much more holistic and inclusive language – meaning here to be inclusive of people's strengths, gifts, joys and generally maintaining much more positive and optimistic perspectives about the people we serve across our working and caring environments.

Using phrasing like ***people who are experiencing the impact and effects of multiple unmet needs*** was supported and preferred by people who have lived experience during our research.

Another key takeaway has been around reassessing our relationship to the concept of "choice-based" behaviours. This is when we think of experiences of multiple unmet need as being grounded in "choice" or even a "lifestyle choice," e.g. homelessness, or street sex working. Both staff and clients were keen that movement takes place toward a better understanding of the impact that trauma has on being able to make choices across a person's life course.

A frontline worker emphasised: "Behaviour that society would say is a choice made by a person, is not actually a choice, it's a coping mechanism, something people do to make their life a bit better, making the best of a bad situation."

You can read more about language and terminology around 'choice' and the power and influence this can inadvertently carry, across services and systems, from page 26.

From here we go onto providing a short overview of Hull as a city, its location and demographics, and our higher-than-average levels of deprivation in comparison to other English cities. It is here that we mention ***collective and intergenerational trauma*** for the first time, which later emerged across our qualitative research in interviews and conversations with staff and clients as a need area for consideration. **See page 28 onwards** for our **'This is Hull'** section.

We then reach our quantitative findings. Our report has taken some inspiration from existing best practice in the field of research into this area, namely Lankelly Chase Foundation's 2015 report: ***Hard Edges – Mapping severe and multiple disadvantage in England.***[1] This report considered the picture of multiple unmet needs across England and attempted to quantify the scale of the issue, considering "where [people] live, what their lives are like, how effectively they are supported by services, and the economic implications of the disadvantages they face." In our section on **Estimating multiple unmet needs in Hull (from page 33),** we have utilised that research and its methodology in order to produce baseline estimations for the city.

At a glance, our analysis estimated that there are ***almost 16,000 people in Hull*** who are experiencing the impact and effects of multiple unmet needs and that this is likely to be an underestimate because it does not include mental health, domestic abuse, or the removal of children. This is a baseline estimate of at least 8% of Hull's adult population.

It is important to note that this is not a count of actual individual people, but an estimate based on different datasets available to us during the time of writing this report, and should be used or cited with this in mind. This estimate is also unable to tell us definitively if people have more than one unmet need, but as our overall findings have been that people's needs are compounded, multi-layered and inherently interrelational, we can say that of this estimated 8% of people, there is a strong likelihood that they are experiencing two or more multiple unmet needs as defined in **Our Definitions (see page 19).**

[1] Lankelly Chase (2015)

Our research has found that there is no single source of data that is collected that can tell us about the landscape of multiple unmet needs in Hull. We therefore made use of additional datasets alongside the ***Hard Edges report*** to produce informed estimations for the population in Hull, and then mapped them across the different domain markers of multiple unmet needs to the best of our ability with the quantitative information available. This meant we were able to produce baseline estimates for the number of people in Hull facing different aspects of one or more multiple unmet needs and consider how many people may be experiencing more than two of these challenges at the time of writing **– please refer to the Venn diagram on page 46.**

Our resulting baseline estimates are felt to be valid for the period 2022-23 and, longitudinally, if this research is repeated in future years, they could be used for comparative analyses. At the same time, due to the challenges around data and information, we found that it is not actually currently possible to quantify multiple unmet needs in Hull beyond a shadow of a doubt. Not only is this because of the challenges or limitations in the available datasets, but it is also because there are likely to be many people with multiple unmet needs who are unknown to services or whose needs are not fully understood. This was anticipated when we set out to complete this Needs Assessment report as people facing the highest levels of exclusion, hypermarginalisation and layers of disadvantage in society are known to "fall through the cracks" and under datasets. Therefore, some people's needs or indications of need areas will be underrepresented or unseen within existing quantitative datasets, and within our estimates.

In terms of identifying need areas through quantitative data, we analysed information that various local services were able to provide to us, including substance treatment, probation services and hospital data. We found these to be largely consistent in their collective messaging, telling us that the prevalent need areas for people experiencing the impact and effect of multiple unmet needs are: ***housing and accommodation, support for substance use and dependence, support around domestic abusive relationships, physical healthcare needs, mental health treatment, disability and long-term illness support, contact with the criminal justice system or policing,*** and ***support around children.***

To read about our quantitative analysis – Estimating multiple unmet needs in Hull – please visit page 33.

Our qualitative analysis: **Giving voice to people with multiple unmet needs** found from **page 57,** was undertaken in two workstreams:

- An **in-community and outreach analysis** looking at people's needs when out in the community and going about their daily lives; and
- An **in-hospital analysis** looking at people's needs in hospital and secondary care settings, when they may be accessing A&E, Outpatients, Inpatients or Discharge services.

This was a much more holistic and story-driven piece of work, focusing on conversations, interviews and dialogue with frontline staff, key stakeholders, current and former clients, and people with lived experience (sometimes called **Experts-by-Experience).**

We drew our analysis, case studies and findings from these conversations and time spent out in the community with people who experience multiple unmet needs. The results of our findings were collated and summarised using verbatim language where possible, such as direct words and phrases used by people with lived experience or by the frontline staff supporting them.

This included words and phrases like **"All I want is a friend,"** and **"I know what 'Good Love' looks like," "Why has nobody told me this before,"** and **"Everybody needs a Pam."**

We successfully summarised our qualitative research findings into **25 evidenced areas of need,** their need descriptions, and the main challenges, issues and observations relating to them. We found good levels of consistency and symmetry with our quantitative analysis, and the most often cited needs by clients and staff were:

(In no particular order)

- *"Somewhere I can call home"* **– Safe and Reliable Housing**
- *"Someone's got my back"* **– Advocacy, 'Hand-Holding' and Floating Support**
- *"Somewhere I can go to at odd hours"* **– Walk-In Centres with Open Access**
- *"When I'm ready, support for my addiction is available"* **– Accessible Treatment for Substance Use and Dependence**
- *"People want to hear what I've got to say and learn from me"* **– Lived Experience Input and Co-Design is meaningfully valued by Services and Staff**
- *"Please give me back my dignity"* **– Authentic Dignity and Respect from Staff and Services**
- *"Everybody needs a Pam"* **– Trauma-Informed Key Workers and/or Single Points of Contact**
- *"I know where to go to get my teeth seen"* **– Dental and Physical Healthcare**

This was true and consistent regardless of the domain marker of primary unmet need being examined or discussed e.g. homelessness, harmful use of drugs and alcohol, contact with the criminal justice system, domestic abuse or the removal of children.

We encourage readers to view the full summary of our findings and all 25 evidenced needs from page 57 onwards of this report.

It's worth noting that we received interesting feedback from clients and staff around the difficulties that ***"complex" health and care systems*** pose for people who are experiencing multiple unmet needs, such as the challenges and obstacles that can often arise in attempting to navigate support services. Staff talked about 'de-mystifying' pathways and amending our expectations around what is reasonable and realistic for people who are usually living in "daily survival mode" i.e. spending a lot of time in activated trauma responses of fight/flight/freeze.

Staff also told us about ***"slow-burn suicide"*** **(see page 121)** and how this particularly affects women who are experiencing multiple unmet needs, and which is usually characterised by despondency, apathy, hopelessness and a process of inwardly and outwardly 'giving up.' We may think about where the points are in the system which could pick up and respond to this need, and if they are not there yet, we might think about how to create them.

There was also a plea during our research for the deaths of clients to be given more attention in the city, for there to be more time spent on death reviews, and learning from coroner reports and related investigations to ensure that we highlight patterns and missed points of prevention and intervention.

Several staff wanted us to think about ***how the whole system "holds" and "carries" people,*** particularly where healing or recovery from the impact and effects of multiple unmet needs is not a priority for someone or where an individual client does not wish to prioritise recovery or is not ready to.

Threaded into this is the tension between what "the system" views as recovery – which is often defined in clinical terms such as recovery from substance use or recovery from mental health symptoms – and what "recovery" (if we are to continue to use this word) means to people and clients themselves. Our research told us that it is important to understand 'recovery' and healing from the perspective of the individual in their own journey – towards a quality of life which is on their terms (not the terms of "the system," clinicians or professionals).

"The term 'recovery' is not helpful, you're telling someone they need to get better, to be better etc. They may not get better but their life is still worthy, this is what we should be teaching and reinforcing." **– A Frontline Worker**

Furthermore, as our research made clear to us, 'recovery' and healing of any kind depend upon the needs of individuals being met in an effective way, one that enables them to transition out of "survival mode" and into a place where they have the freedom and capacity to settle down, grieve the traumas they have experienced, and "rest."

We are fortunate that our research has produced such a wealth of wide-ranging and holistic understanding of multiple unmet needs in Hull.

A note on prevention

The bulk of our research has focused on adults and speaking to adults who are experiencing the impact and effects of multiple unmet needs, and the staff and services supporting them. That said, we recognise that children can and do experience multiple unmet needs and this may be considered as an area of further research. It is something we have thought about during the composition of the report's recommendations and how we may wish to work on prevention and resolution of multiple unmet needs in the future.

For preventative work, we may wish to draw attention to the intergenerational nature of multiple unmet needs and the problematic nature of drawing absolute lines between the needs of adults and the needs of children, something which can come up during ***"transitions"*** e.g. transition from childhood to adulthood. Many of the needs we have found during our research might be seen as applicable to children's lives as they are to adults' lives – needs around safe homes, safe attachment and safe environments **(e.g. "Somewhere I can call home," "I know what 'Good Love' looks like," or "I don't have to fit in and people embrace my differences")** but we know that children will also have additional needs not discovered in this report, such as those needs around parenting, nurturance, nourishment, education or early life and birth. By understanding and meeting the needs of adults facing multiple unmet needs, this may have a positive, knock-on effect to breaking the cycle of intergenerational trauma and preventing this from impacting on current and future children's lives in Hull.

This is an emergent issue that is beginning to draw the attention of services. As one staff member said to us: ***"every traumatised adult was once a traumatised child."*** In responding to multiple unmet needs going forwards, we might explore the "artificial" divides and processes that have grown up around pathways to create cultural and systemic fragmentation between children's and adults' services. Indeed, one voluntary sector staff member we spoke to agreed that the children they serve would continue to benefit from their services as adults if they were not moved on when they reach the age of 25. The good practice they have built up around responding holistically to children's and young people's needs means there is a ripple effect into adulthood, and this might be explored further in Hull to understand where there is already excellent practice taking place in the city which would benefit adults' services or more fluidity between services. All of this may give rise to best practice around transitions.

If multiple unmet needs are interrelational and multi-layered in nature, made often more complex by health inequalities (as our research has discovered), and impacted again by the ongoing inheritance of unresolved intergenerational trauma in families, communities and cities, then it makes sense that "binary" divisions between children's and adults' services might not always be supportive of prevention efforts. Some of this will be structural in nature – with the implications of health inequalities such as poverty and long-term austerity becoming impossible to ignore – but it's worth a go if we want to be the "cycle-breakers."

"Most of our service users are 16 plus, we cater up to 25 years old here. We have 'exit plans' for young people as they're about to turn 25. We are currently looking at how to keep engaging a young person for whom we know the Exit Plan won't be enough, thinking about how they can still use our service, still come to us… yes, I do think young people would continue coming here into adulthood and beyond 25 and for a long time… This artificial

distinction between children and adults is working against young people." **– A Voluntary Sector Worker**

Although we haven't been able to do the topic of prevention the justice it deserves during our research, in exploring greater links between children's and adults' needs, life stories and experiences there could be much richness, wisdom and innovative work to be discovered. This might inform future service design and delivery, by finding more holistic and trauma-responsive ways of addressing widescale traumatisation in our communities and meeting the needs that this traumatisation has generated across families and generations. We gave thought to this during the composition of the report's recommendations.

Recommendations

We have been able to successfully identify a broad range of ***practical, physical, emotional, cultural, and systemic needs*** that people are facing and need our support to manage and heal.

We now also, through our quantitative analysis, have an indication of the baseline numbers of people in Hull who need our help, attention, compassion, and trauma-informed approaches.

The ***"compounded"*** nature of the experience of multiple unmet needs that we have discussed in this report often means that it can be harder to interrupt patterns and interrupt the ***"spiral"*** of inequality. This can become more problematic when there is persistent intergenerational trauma at play, or chronic health inequalities and entrenched disparities. We are also still asking "traumatised people" to navigate "complex systems" and support services, even though many people are trapped in a constant cycle of "fire-fighting."

Many people feel a lack of "hope" and in turn they may be surrounded by a professional culture where they are seen as "difficult," "chaotic" or "aggressive" by frontline workers and the public, and generally they may feel misunderstood, "dismissed," and discriminated against. **(For a more detailed discussion of unconscious bias and stigma, please visit page 114).**

"…There's no ambition, no hope, just following in the footsteps of family members and peers… They're not interested in education because their parents weren't, it's not passed down. They need to be given some hope. The people of Hull need some hope… It's learnt behaviour, people are growing up with this as the norm." **– A Probation Services Worker**

So that we may consider how to foster cultures and communities that have the capacity to interrupt intergenerational patterns and "cycle-break," the holistic findings of our Needs Assessment require holistic recommendations.

To that end, we facilitated two collaborative workshops in Hull to share our research and explore our next steps with a range of frontline workers, stakeholders, and current and former clients **(sometimes called Experts-by-Experience).** Through this exercise we have wanted to ensure a sustainable legacy to this report, that it may go onto influence any necessary change and transformation across Hull, at the same time as give people who experience the impact and effects of multiple unmet needs a clear voice.

We also wanted to contribute towards offering that "hope" which people told us about, noting that with the right support at the right time, cycles and patterns can be interrupted and "slow-burn suicide" can become a thing of the past that no individual is exposed to again.

Together with those who attended the workshops, and others who have been a part of this journey from the beginning, we have created the following Recommendations for services and system leaders to reflect upon and implement.

Where these recommendations talk about ***trauma-informed care*** or ***trauma-informed approaches***, there are many emerging and evolving ways of defining what this means in modern health and care services – including across Hull – and we have not attempted to provide a full analysis of these here. In general, throughout this report, we have made the assumption that readers will have some familiarity with these terms and how they are being applied or beginning to be applied across statutory services. In trauma-informed practice, there is a strong and

central focus on the emphasis of safety and working actively and compassionately to avoid retraumatisation.[2]

It is commonly agreed by leaders in this area that relationships, trust, choice, collaboration, empowerment, cultural humility, and safety are key principles in this endeavour.[3]

To use the learning from this report to continually improve our understanding and enable us to better prevent and address multiple unmet needs in Hull, we offer these 12 Recommendations:

1) **Including People with Lived Experience**
   We recommend that the views and experiences of people with lived experience of multiple unmet needs are consistently embedded and included across all levels of service design, decision-making and delivery.

2) **Continuity of Care**
   We recommend committing to a model of continuity of care for clients and patients who are experiencing (or are at risk of) multiple unmet needs, which offers a single point of contact for individuals and frontline workers, and care navigation of an individual's co-designed care plan.

3) **Safe Homes and Housing**
   We recommend that this report contributes to ongoing discussions and summits taking place as a response to the current housing crisis in Hull. Our research found safe, reliable and secure housing to be a foundational need for people who are experiencing the impact and effects of multiple unmet needs, and that without this, many of the other needs of individuals cannot be met.

   As a leader in Probation Services told us: *"Accommodation is fundamental to the rehabilitation and resettlement of people on Probation. Often regarded as a 'less attractive tenant,' People on Probation are in the midst of a perfect storm. The cost-of-living crisis has hit hard in Hull and East Riding. More families are in need of accommodation from Local Councils than ever before, pushing people on probation lower down in the priority list. The loss of William Booth hostel has resulted in a huge gap in supported accommodation provision. Local Councils do not have properties available and many private landlords have withdrawn properties due to the Landlords bill and the cost-of-living crisis. For People on Probation having safe and secure accommodation is pivotal and conveys a message of value and worthiness that many have not experienced. It is the basis of building social capital and desistance. However, this is not as simple as having a roof over one's head. This requires strong partnership from all agencies, in order to ensure a holistic approach that is responsive to the needs of the individual, promoting and enabling access to community services and bringing together local partners with the required expertise and experience."*

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[2] Loomis, B, Epstein K, Dauria EF., Dolce L. (2019)
[3] Office for Health Improvement and Disparities (2022)

4) Holistic and Non-Clinical Care

We recommend increasing the access to holistic and non-clinical interventions in the city, including peer support, coaching, mentoring, and activities designed to tackle boredom, loneliness and isolation.

5) Inclusion Healthcare

We recommend:

a. bespoke long-term, holistic and personalised inclusion health primary care to meet the needs of people facing multiple unmet needs, utilising trauma-informed approaches and created in co-design with people who have lived experience and professionals who have expertise in this need area;
b. instilling best practice around access, experience and outcomes for people with multiple unmet needs across primary care in collaboration with people who have lived experience;
c. ensuring that pain relief prescribing in all health settings is person-centred, equitable and trauma-informed;
d. access to trauma-informed step-down (intermediate) care following hospital discharge, and improved care and attention to discharge processes for people who are experiencing multiple unmet needs.

6) Trauma Prevention Public Health

We recommend the development of a long-term and ambitious public health approach to trauma prevention which incorporates an all-age population-level lens to identify, mitigate, resolve and prevent trauma in the city.

7) Trauma-Informed Training, Education and Awareness

We recommend ongoing availability and access in Hull to trauma-informed training for people who live and work here, considering the existing provision and working to improve coverage and accessibility where needed.

8) Trauma-Informed Approaches to Data

We recommend services review how they collect, use and share information about their clients, to ensure people's needs are holistically understood and supported, and that we have more trauma-informed approaches to asking for and using this data.

9) Caring for our Workforce

We recommend improving support for staff around caseloads, recognising the impact of ongoing reduction in resources, and giving more attention to the currently high rates of workplace burnout, chronic stress, and compassion fatigue.

10) Transitions

We recommend greater consideration of the transitions across people's life courses – in particular those of childhood to adulthood, or prison to release – both furthering our understanding of and taking any action towards disconnect between services and the impact this may have on prevention or health inequalities.

11) Recognising and Celebrating Good Practice

We recommend more frequent recognition, celebration and sharing of good practice in the city, in particular that which enables improved responsiveness to the needs of people who are experiencing exclusion or risk of exclusion based upon a) speech and language skills, b) reading and comprehension / literacy, c) individual communication styles that may be linked to a trauma history, mental health or disability, and d) neurodiversity.

12) Acting Now with What We Do Know

We recommend acting now with the information we already have to reduce the inequalities faced by the following groups who are experiencing (or are at higher risk of) multiple unmet needs:

a. people with protected characteristics as per Equality Act 2010 (where the protected characteristic e.g. disability, religion, belief, gender, age, sex, marital status, sexual orientation, pregnancy or maternal status, etc. may increase the risk of or existence of systemic exclusion);

b. racially and ethnically minoritised groups, including (but not limited to) EU Nationals, Migrant Communities, Asylum Seekers, Refugees, unauthorised migrants or people who have been refused asylum, Gypsy, Roma and Traveller communities;

c. people who are currently sex working or who have previously sex worked;

d. Children who are currently Looked After, and those who have been in the children's social care system at any point in their lives.

Finally, we wish to thank everyone who was involved with and contributed to this report. From the staff working in busy hospital wards and discharge teams, to the specialist support workers based in hostels, and to the current and former clients and people with lived experience – everybody we met has been open, enthusiastic, supportive, and passionate about the work we have undertaken through this Needs Assessment report.

We thank you for coming along on this journey with us.

We hope that this report offers a clear insight to the lives of people in Hull facing multiple unmet needs, a glimpse of current and future ideas, and a beginning vision that can support us to unpick the patterns that may be keeping us in silos and separation.

Ultimately, we hope that this research may contribute to efforts to 'break the cycle' of trauma across families, communities, systems and society.

Thank you for reading.

Language and Definitions:

What we mean by multiple unmet needs

We are conscious that work is ongoing across services and sectors to improve our trauma-informed language.

What we mean by "multiple unmet needs" in this report

Throughout this Needs Assessment report we use particular language to refer to the people in our communities whose needs we are aiming to identify, understand, and paint a picture of for others to understand. This is explained in more detail below.

The topics we discuss in this report are multi-layered and oftentimes they traditional reporting and research methodologies because their causes are interacting and interrelational. Because of this, and the need to maintain dignity and respect when talking about people's unique and individual needs, we have used the following language:

- People with **multiple unmet needs** refers to those of us who are experiencing the impact and effects of ***homelessness, harmful drug and alcohol use, domestic abuse, poor mental health,*** *the* ***removal of children*** *from legal care,* or ***contact with the criminal justice system***. Generally someone with multiple unmet needs is living through two or more of these difficulties;

- **Multiple unmet needs** is used interchangeably throughout this report with ***multiple disadvantage* –** that is because the former phrasing is beginning to replace the latter when discussing hypermarginalised groups. We have dropped "severe" from 'multiple disadvantage' following feedback from frontline workers and people with lived experience that this leads to a strong "negativity bias" across services and helping settings.

This language is in line with current terminology used by services across England.

However, we are conscious that the language we use as professionals could be further developed in line with **trauma-informed transformation**, which is ongoing across health, care and voluntary sector settings, and we do anticipate that the above language is likely to be refined again in the coming years to reflect that evolution.

We also asked people with lived experience about language…

In the compilation of this report we also took the opportunity to speak to people directly on this topic – asking them ***how they would define themselves and talk about their life experiences***. We've summarised the feedback we received from page 21, in case it is helpful for organisations and systems as they move forward with services and pathway design.

Our Definitions

In order to define what is most commonly understood by services and systems as ***people who are experiencing the impact and effects of multiple unmet needs***, and to support our data analysis and research, we have used the following **Definitions** in this report:

Homelessness

People of any age group experiencing homelessness includes anyone who has current, former or threatened experience of one or more of the following scenarios: rough sleeping outdoors or on the streets, has no accommodation to occupy, is at risk of violence or domestic abuse, is reliant upon temporary accommodation such as a hostel or refuge, has accommodation but cannot secure entry to it, has no legal right to occupy their accommodation, has accommodation but it is not reasonable for them to continue to occupy it, is likely to become homeless or has received a valid Section 21 notice in respect of their only accommodation. Where accommodation is not reasonable for them to continue to occupy it, this could include reasons such as being unaffordable, insecure, overcrowded, unsafe or in poor condition, or a refuge / emergency hostel.

A person is also considered homeless if they live in a movable structure such as a caravan, mobile home or houseboat, and there is nowhere where they have permission to put it and live in it. This might include if someone is staying on a caravan site where the rules do not allow them to live there, or living on a barge but do not have a place to moor it.

A person does not need to be sleeping rough to be considered legally homeless. A local authority only needs reason to believe a person might be homeless to accept a homeless application. Therefore other forms of hidden and transitional homelessness are also included within this definition, such as sofa-surfing, relationship- and marriage-breakdown, staying with friends and family, sleeping in cars, reliance on bed and breakfasts or hotel rooms, exchange of sex, substances or goods in return for a bed for the night, bankruptcy and other forms of financial breakdown or insecurity, sudden unemployment, sudden injury or disability which renders current accommodation no longer fit for purpose, or other drastic and uncontrollable life changes.

Harmful Drug and Alcohol Use

Addiction to or harmful use of drugs and alcohol means a person of any age who is caught in a patterned use of a substance which they consume in amounts or with methods which are harmful in some way to themselves or to others and is considered a form of substance-related illness. Substance-related illnesses (sometimes called disorders or dependence) are defined as intoxication by, dependence on, or regular, excessive consumption of alcoholic and/or psychoactive substances leading to social, psychological, physical, economic or legal problems. Someone who is substance-dependent may persist in drinking and using drugs, despite harmful consequences. They will also give drugs and alcohol a higher priority than other activities and obligations in their lives.

Domestic Abuse

This means a person of any age group who has experienced or is experiencing any single incident or a course of conduct of physical or sexual abuse, violence or threatening behaviour, controlling or coercive behaviour, economic abuse, psychological, emotional or other abuse between two or more people who are or have been personally connected to each other.[4]

Removal of Children (into care)

This means a person who has experienced or is at risk of experiencing the removal of their children from their legal care and guardianship. We have focused on the needs of adults in this report but this definition also includes ***Children Looked After,*** which means a child or children removed from

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[4] Hull City Council (2023)

the legal care of their parent(s). The reasons for the removal of children from the care of their legal guardian(s) or biological parent(s) are varied and unique to each situation. Common issues include the presence or risk of emotional, physical or sexual abuse, neglect, abandonment, serious illness or death of parents, or incarceration of parents. The legal removal of children from care is carried out either with permission of the parents or through a court order. For a child to be permanently placed into care, care proceedings must have been completed and a court must have made a final judgement of the case.

Contact with the Criminal Justice System

A person of any age group who has experienced or is experiencing contact with the criminal justice system is a person that has had involvement with policing services in the role of alleged or actual committal of a crime. Contact with the criminal justice system may look like any one or more of the following: arrests or time spent in police custody, time spent on remand, prosecution for criminal offence by the courts, time served in prison or in community service for an offence, time spent in probation services, or time spent in youth justice or secure forensic settings.

Poor Mental Health

We have not sought to define poor mental health during our research as this was felt to be too wide-ranging and open to diverse interpretation. It is more likely to be self-defined by a person and would not necessarily require a clinical or statutory diagnosis to be included into a person's health and care planning or individual needs assessment.

We would like to ensure that the language we are using is always strengths-based and strengths-focused.

Co-creating language and 'labels'

When we started this Needs Assessment we were using the language of **"severe and multiple disadvantage,"** and the definition of this provided by the National Institute for Health and Care Excellence (NICE), which is:

> ***"Severe and multiple disadvantage – multiple and overlapping disadvantages that are often persistent and interrelated and affect a person's life. These disadvantages include the experience of homelessness, harmful drug or alcohol use, criminal justice involvement, poor mental health, and the experience of domestic violence and abuse. People experiencing severe and multiple disadvantage have often experienced underlying adverse childhood experiences, poverty, psychological trauma, stigma and discrimination. People with these experiences may have had sporadic and inconsistent contact with services or been serially excluded from services. People who experience severe and multiple disadvantage tend to have much poorer physical and mental health, have higher social care needs, and die at a much younger age than people without severe and multiple disadvantage."***[5]

In collecting our research there was widespread consensus that we would like to ensure that the language we are using to describe people is always **strengths-based** and **strengths-focused.** As one frontline professional described: *"We don't value the good in people, we focus on a presentation and a situation. We base their worth on what they do."*

There was agreement during our research that it is always difficult when labelling people, because when the label gets rolled out across services and cultures, it can start to "miss out the human being" underneath.

It is helpful to have something recognisable which staff and key workers understand as a kind of "short-hand" to quickly catch-up with a situation or to talk to regulators and funders – particularly if multi-disciplinary teams are involved – but there was consensus that it shouldn't be at the detriment of the individual sitting in front of you or whose life story (and often their trauma history) is on your computer screen.

How we frame people's lives matters…

So what language, labels and terminology do work when supporting people in a helping profession, particularly where a person may have a life story of traumatic experiences and distressing events? **How can we make sure that our language is co-created and approved by the very people we are talking about in our offices, in our meetings and across our professions? In our research, our funding bids, our reports?**

By moving away from using "severe and multiple disadvantage" to talking about the experience of multiple unmet needs, we might continually ask ourselves if the individual is at the heart of care and services?

[5] National Institute for Health and Care Excellence (NICE) Guideline (2022)

The Benefits of a Common Language and Labels

It was acknowledged by staff and also people using services that it feels helpful to have a “common language” that we all use, especially if that language is well-established and has been around for a long time. It’s human to use acronyms, short-hand and common phrases especially during busy work days and shifts.

One person with lived experience told us: *“We don’t like the [SMD] word, but everyone understands it. Multiple disadvantage has been around longer, severe was added on recently.*

“ ‘Disadvantage’ puts it onto the person with the disadvantage, but if we are talking to police for example, they understand what we’re talking about quickly.

“If we start using a new term, people won’t understand it, and we’d have to explain it all over again. It’s a bit like disabled people don’t like to be called disabled, so it’s similar to that, that’s the only way I can think of explaining it.”

Although it was found there is no agreed and set-upon standard definition of **severe and multiple disadvantage** across services and sectors in Hull, it is nevertheless reasonably well-used across settings, governance and structures.

“ ‘Disadvantage’ puts it onto the person with the disadvantage, but if we are talking to police for example, they understand what we’re talking about quickly.”

– A person with lived experience

The phrasing of **severe and multiple disadvantage** has the denotion of an individual facing many different setbacks in life and was understood by the majority of staff we spoke to. However, most people agreed that they did not feel comfortable using labels for the people they support throughout the week:

- *"SMD has to be something we use, we've got to have a name or you don't know what it means, the general public don't know, we've got to pick something for it, and there's NICE guidance for it."*
- *"It helps if we are all using the same language, organisations being on the same page for consistency."*
- *"Commissioners understand what you mean, and we have to use the language when we're writing reports for them. Some of this is when we are speaking to regulators too, the language comes down to us from higher up. I'm sitting in front of OFSTED with spreadsheets and percentages, not with people's stories."*
- *"It needs to be more like a communication tool that professionals use – because to service users we'd say 'you've had a hard paper round growing up, haven't you.' "*
- *"I didn't realise we are SMD until your email. We work with domestic abuse, substances and mental health, we call it the toxic trio. It has really broadened my horizon to understand this as SMD."*
- *"SMD is a convenient short-hand but a double-edged sword. We'd be remiss not to acknowledge its usefulness, to have a common language which crosses agencies. But staying aware of the detrimental effect language can have, especially once embedded in MDTs, it takes over. The person can get lost within that… We are in a hinterland where people don't really know what words to use. Even the term 'service user' is now being looked at."*
- *"SMD is like ACEs, it's all terminology, it's really hard labelling people, but they do face disadvantages. They can't get a bank account because no fixed address, or no ID. So even basic things they can't do. Every task is like a mountain to climb."*

The challenges when using labels and "short-hand" terminology

On the other hand, it was felt that using words like 'severe,' 'multiple' and 'disadvantage' weigh people down because they are such loaded terms, and the person who is having the label applied to their life rarely has a say in the matter. The labels help the workers and the services to understand themselves and their roles, but they do not support healing in the individual. It was felt that labels are "done to" the client and not something they would necessarily choose for themselves.

"We wouldn't use it with our clients," said one frontline worker, *"it implies they may as well keel over and give up."*

Another worker we spoke to told us: *"It suggests the odds are stacked against you. No consideration is given to grit, hope or how amazing these people are…*

"…People know they're not in a good place. They don't need it pointing out to them."

The role of language in statutory services

Current phrasing around 'severe and multiple disadvantage' offers us little in the way of **strengths-based language** – something we were told is key for working in a trauma-informed way with people who have experienced traumatic events throughout their lives. We found that the preference amongst workers and people with lived experience is for language grounded in compassion, patience, understanding, as well as non-blame and non-judgement.

One formerly homeless person in recovery from harmful substance use said: *"We prefer language such as 'people who are going through a crisis or a trauma.'"*

They explained: *"We use drugs to push down the trauma. This is about trauma. We detest any talk of complex needs. We need the humanity of the person, it's the system which is complex, not the person.*

"That's what I always say and keep reminding people."

Talking about people who are experiencing ***the impact and effects of multiple unmet needs*** was supported and preferred by people who have lived experience during our research.

We might also be aware of the power of words to positively disrupt cultures and paradigms.

There is the further issue of labels being difficult to measure, as we discovered during our quantitative research for this report and as staff highlighted to us. We received feedback that the phrasing of severe and multiple disadvantage feels "wafty," places too much emphasis on blaming people or on their "individual responsibility," and doesn't give enough credence to the "compounded nature" of trauma at play in a person's life. It was noted that instead of paying attention to the multitude and severity of disadvantages, it would be better to look at the layering of life experiences and the "force of this" when they happen at the same time.

By being aware of the power of language in our services and systems, we can positively disrupt unhelpful and outdated paradigms across cultures and embed strengths-based practice where before we may have found unconscious bias, stigma and judgement. We discuss issues around unconscious bias later on in this report.

Where talk of **'complex needs'** and **'severe and multiple disadvantage'** can be used to place blame and responsibility onto individuals, and overlook structural failings and imbalances of power in society, understanding actually that this is about meeting people's needs – something they might not have experienced before as a child, a baby nor even as an adult – returns a sense of shared humanity and shared responsibility and ownership to the picture.

In summary:

- ***Severe, multiple, disadvantage*** – these words can't be measured and quantified, and there is a question mark around "who" gets to defines them and how much power they have. The compounded nature of trauma is not taken into account and although useful as a professional phrase, it isn't strengths-based or trauma-informed in its approach;
- ***Complex needs*** – this is felt to immediately suggest complexity and invoke heavy stigma; too often it is associated with personality disorders and

> behaviours which are viewed through a lens of being difficult or aggressive. As one social worker we spoke to said: *"in the healthcare area you think 'this is not gonna be straightforward…' It means the same to everyone, you automatically think 'oh gosh it's a personality disorder.' This is what happens in your training, but everyone with "PD" has a poor attachment from an adverse childhood experience. 'Oh they're Emotionally Unstable Personality Disorder' or 'they're under [the] Complex Emotional Needs Service'…it's dismissive and flippant."*

Feedback we received told us that terms used professionally between staff and commissioners like severe and multiple disadvantage should be a **"philosophy of service and care,"** an approach to services and a way of understanding **"the cracks that people fall in to"** rather than a label for a group of people or a way of describing clustered and grouped behaviours in any one or more individual(s).

People wanted us to centre the unique strengths and gifts of individuals over any discussion of the ways that staff and commissioners may judge their behaviour or **"life choices"** to be something we disapprove of and cannot understand. We talk more about language around 'choice' on the next page.

In this report, we have made every effort to stay with language which takes any sort of judgemental onus off individuals and which doesn't imply any sort of flaw in character, being, or persona of people with multiple unmet needs.

"I realised by coming here today, that our service users demonstrate our organisation's values more than our staff do. Bold, open, and compassionate."

– Substances Key Worker

Language around trauma and 'choice'

We found that there is also an urgent desire amongst cultures and services to move away from equating the behaviours of people with being choice-based. Many of the people we spoke to talked about this – the problematic nature of only seeing behaviours or only seeing mental health – rather than seeing the person and their "human trauma responses" and "coping mechanisms."

Seeing things as a 'choice' leads to **unconscious bias** in the form of **stigma and judgement**, as well as **misunderstandings** across all levels of services. We found that this is happening in many areas of the system where there are people experiencing the impact of multiple unmet needs, whether that's in prison, probation settings, or out in community health and care settings.

People we spoke to asked us if anything is really a choice "when you have no choice." They said "what kind of choice is there? Where is your brain in making that choice?" and "you are often choosing between two bad choices" and it is traumatic life experiences that have brought these hard choices to your door.

For example, in sex work, very high percentages of women have experienced sexual abuse or neglect in childhood, with some studies listing it as over 90%.[6] But many people still see sex work as a choice women make.

Staff and frontline workers we interviewed felt that seeing people's behaviours as "choices," "choice-based" or "lifestyle choices" is an unhelpful way of looking at things. They said it can even feel like a "get-out-of-jail-free card" for statutory services, so that there is "less guilt" about not stepping in and making interventions into somebody's care or welfare.

People we spoke to with lived experience of homelessness, street sex working and harmful substance use also felt that trauma had taken away the possibility of having and making empowering choices in their lives. They felt that they were left with no choices at all and little to no personal power. This is an important distinction for systems and services to make when supporting people who are experiencing the impact and effects of multiple unmet needs.

"It's not a behaviour, it's not a 'lifestyle choice.' We need a recognition and understanding of trauma and all its tentacles. Anyone's behaviour is trauma. It's the relationships they have and haven't had in life. It's very dismissive to say it's their mental health or it's their behaviour."

– Mental Health Social Worker

[6] Framework (2005)

Key insights: Language and Labels

The following is a selection of further feedback, insights and wisdom shared with us during our research from both staff and people with lived experience:

"I wonder how it feels to be classed as someone with severe and multiple disadvantage. Yes there's a lot of struggle, people with more than one difficulty in their lives, multiple challenges. But how does it feel as a service user, we're talking like everything's wrong with you, nothing is right with you. It's a reductionist approach for human beings. We miss who they are. I don't like the word 'resilience' but we miss that they're still here, they're surviving it all, there's more to them. We don't talk about what their strength is, we don't talk about what their joys are."

"Saying 'service user' is old-fashioned now. 'Client' works everywhere, we prefer it, it makes you feel a bit posh. It works everywhere, in drug treatment and in probation, everywhere. We don't mind 'patient' in GP surgeries. 'Inmate' is OK in prisons. It's better than criminal or offender."

"Dehumanisation of people breeds dehumanisation in people… Labels can lead to the behaviour."

"Complex needs brings stigma, in the healthcare area you think 'this is not gonna be straightforward,' that stigma is still there yes."

"You're not mad or bad. Being able to help people articulate their nervous system response helps them to process what's happening. They realise they're not mad or bad."

"Bruce Perry says that the number and quality of relationships that children have is a better predictor of positive outcome than ACEs is of negative ones – it's a social buffer. Can we measure that instead?"

"Behaviour that society would say is a choice made by a person, is not actually a choice, it's a coping mechanism, something people do to make their life a bit better, making the best of a bad situation."

"Even if you're in recovery, there's always that label of 'oh she used to be a prostitute' following them."

"We find 'cohort' really offensive. It misses the humanity. You're lumped in with a load of other people. You're an individual, you need individual support."

"We know [police's] job is to stop crime, but it's also to keep the public safe, and that includes criminals."

"The term 'recovery' is not helpful, you're telling someone they need to get better, to be better etc. They may not get better but their life is still worthy, this is what we should be teaching and reinforcing."

"We used to call them offenders all the time. Now we've switched to 'people on probation' or 'people in probation services' in the organisation."
– Probation Services Worker

This Is Hull:

A short look at our city

This is Hull – A short look at our city

Hull is a vibrant and diverse city, with a rich heritage and a unique history. Its citizens and communities are the city's greatest assets.

It is a place with a long track record of welcoming and supporting the most vulnerable individuals, including those seeking refuge from other countries. William Wilberforce, the anti-slavery and abolitionist campaigner of the 18th and 19th Centuries, hailed from Hull and has left a strong mark on the city's identity and cultural imprint. This is seen to this day across architecture, buildings, arts, street names and Hull's Refugee Week.

Hull is also a registered City of Sanctuary, meaning it is a place of welcoming, safety and refuge, giving sanctuary to people who are fleeing persecution and violence from all over the world.

Hull is also a city of strong partnership working with a shared vision of what is required to improve the lives of residents and an appetite to find out where the gaps are and how to keep improving. It is a great place to be born, live, learn, work, have a family and grow older.

Hull is also a city with a long history of collective and intergenerational trauma, some of which is felt to still carry an impact and a legacy to this day.

Intergenerational trauma (sometimes called 'collective trauma,' 'ancestral trauma,' or 'societal trauma') is understood as trauma that is inherited from one generation to the next, as the effects of adverse and unresolved traumatic events are passed down from survivors to their descendents.[7] This could stem from any kind of event or chronic stressor which was traumatic to an individual, a family or a collective, e.g. domestic abuse, war/conflict, poverty, disease/illness, divorce, bereavement, racism, sexism, emigration, or natural disasters to name only a few possibilities.

Hull was devastated by the World War Two bombing campaigns, having been the second most bombed city in Britain after London. In the post-war years, Hull went on to feel the enormous loss of the thriving port and fishing industry, and the clearance of the established and close-knit 'slum' neighbourhoods that supported this economy. The impact of this dispersal of people, community and industry is still felt to this day **(please see our research findings on page 97).**

Hull has survived major flood events and is at the frontline of the climate crisis, with much of the city expected to flood this century if significant intervention and innovation does not arrive in time to prevent it. For this reason, Hull is frequently at the centre of national and international attention for research into flooding events and climate change.

Location

The city and port of Hull lies on the banks of the River Humber and is positioned at the gateway to Europe. It is linked to the national motorway networks from the West via the M62 and to the South across the Humber Bridge via the M180.

These ideal links mean that Hull has a thriving industrial and manufacturing sector, including off-shore wind development. That said, this is yet to translate across to general population wealth throughout the city and large disparities remain.

[7] Marschall, Amy, PsyD (2022)

It is worth noting that Hull is surrounded by the East Riding of Yorkshire, a largely rural and agricultural area containing a number of affluent suburbs immediately adjacent to the city, such as Beverley, Hessle and Cottingham. Unlike other cities, Hull's city boundaries are so tight that these "leafy suburbs" are excluded from its catchment area. This has placed major restrictions on Hull's ability to generate income from those suburbs and satellite developments via council tax and business rates.

A decade of major regeneration schemes and investment across Hull is beginning to have beneficial effects on business start-ups, job creation and people's aspirations, but the city still lags behind in health and social inequalities, accompanied by high levels of entrenched, intergenerational poverty.

The upside of Hull's tight geographical boundaries is that access to central services in Hull is relatively good for the majority of people, with good transport links. Links such as bus routes are often less good between communities around the edges of Hull, which may be physically near to one another but not have easy access. This can add an additional barrier to people with multiple unmet needs when they are considering how to travel to and from appointments with support workers, with many people dependent on public and community transport.

Deprivation

Hull is the fourth most deprived local authority (bottom 2%) in England, based on the Index of Multiple Deprivation 2019.

Overall, 45% of Hull's 166 geographical areas on which the Index of Multiple Deprivation is based fall within the most deprived 10% of areas of England, with 54% in the bottom 20% and 76% in the bottom 40%. This is illustrated in **Figure 1**.

Hull has only 4 of its 166 geographical areas that are in the top or least deprived fifth of areas of England.

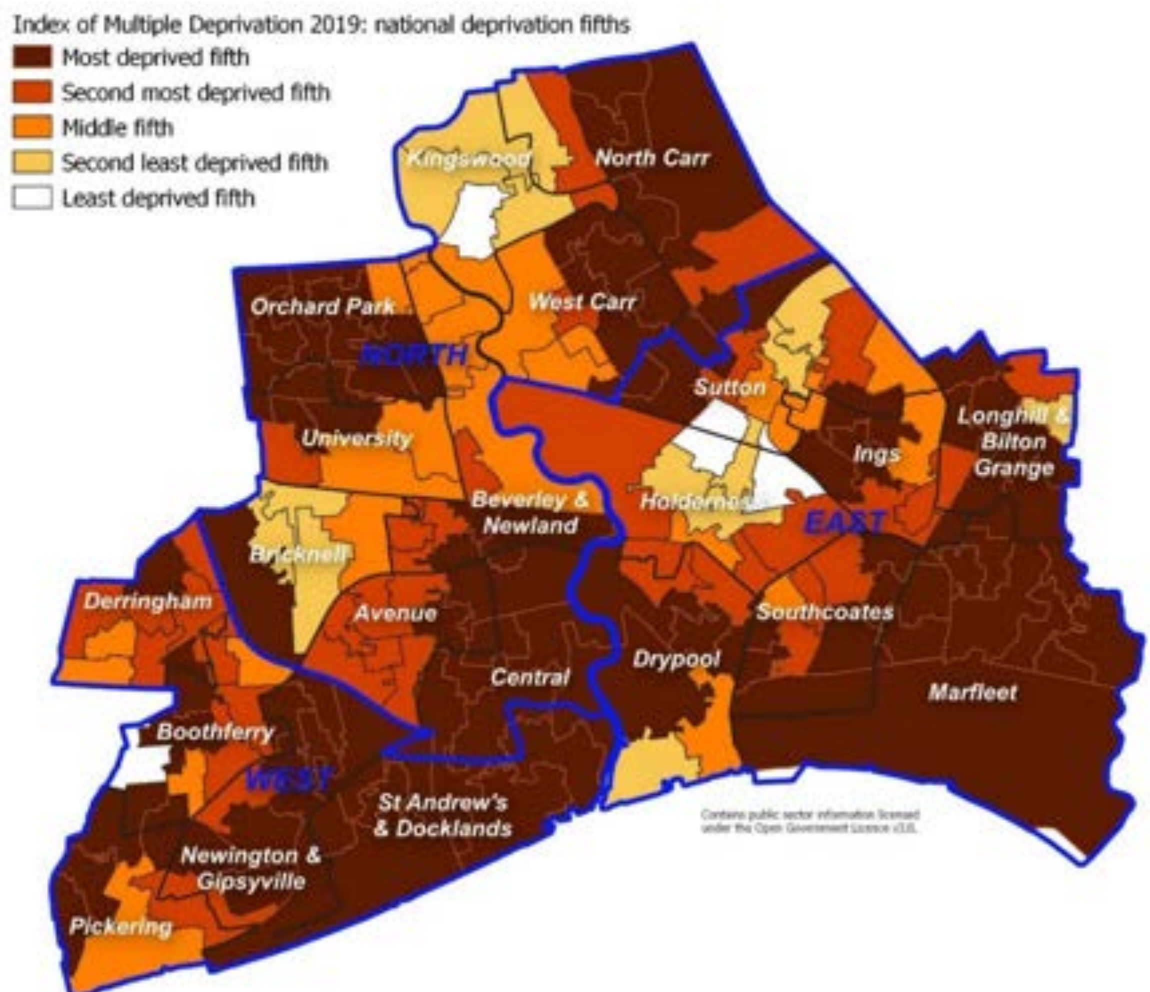


Figure 1: Index of Multiple Deprivation 2019, national fifths (Source: Ministry of Housing, Communities and Local Government, Index of Multiple Deprivation 2019)

Due to its high levels of deprivation, Hull has attracted a negative reputation regionally and nationally. This bad press has chronically overlooked the gifts and strengths which Hull has to offer and the people who make Hull what it is.

Some of the feedback we received during this report explored to what extent this reputation has led to a "negativity bias" within the city, leadership and commissioning, and if so, what could be done to reverse it. This becomes more complex when we acknowledge that we often reference our deprivation levels in order to attract and secure more funding for the city.

Compared to other cities across England, Hull has higher rates of poverty (including fuel and child poverty), homelessness, substance use, crime and offending, domestic abuse, lower educational attainment, pupil absences, lower quality employment opportunities and unemployment, use of welfare and benefits, smoking, obesity, long term illness and disability, hospital admissions, and premature mortality.

Hull often comes bottom or near-bottom in national league tables for deprivation, and we received lots of feedback related to this during the writing of this report.

The people we spoke to were also keen to highlight the individuals and communities who make up the beating heart of Hull, and the "unique" position the city is in to try its hand at solving difficult societal questions and issues.

One such of these issues is health inequalities.

Overall people are far healthier than they were in the past, but unfortunately health inequalities across Hull still exist. Poverty and deprivation play a huge role in this and their effects are mirrored across the inequalities we see in health and wellbeing.

With the strong partnership working structures we have in place across health, care and the voluntary sector, Hull is gradually changing for the better. There is also much more to do.

Demographics

From the 2021 Census, Hull's resident population is estimated to be 267,020 with an even split between males (133,231) and females (133,789).

As with many cities, Hull tends to have a younger population compared to the England average as young people tend to come into the city to live, work and study. There are particularly high number of students at the University of Hull and local colleges so the population of those aged 18-34 years is particularly high in comparison to England.

The population structure in Hull differs markedly across the city as does ethnicity. There are higher proportions of children and young people around the University Area and in Kingswood, North Carr and Orchard Park, with high percentages of people in their 20s and 30s living in these wards as well as around the city centre and in Marfleet. People in their 40s and 50s are more scattered throughout the city, and higher percentages of older people live in Longhill & Bilton Grange, Derringham, Boothferry and Pickering, as well as North Beverley & Newland.

From the 2021 Census, we can tell that 91.8% of Hull's population were classified as White (83.9% identify as White-British and 7.8% identify as White Irish, Gypsy and Irish Traveller, Roma or other white background). This should not be interpreted as meaning Hull isn't a diverse and multicultural city. Hull has a large population of White-Europeans, mainly Migrant Workers and EU Nationals hailing from areas of Eastern Europe, who have settled and made their lives in the city over the last 10-15 years in particular. They make up the largest ethnically minoritised group in Hull. Overall, of minoritised groups living in Hull and as per the 2021 Census, 7.8% are from other white backgrounds (thought to be predominantly White-European), 2.8% identify as Asian or British-Asian, 1.9% identify as Black or Black-British, and 1.8% as Other minoritised background.

Demographics is more diverse for children and young people than it is for adults in Hull. Among residents aged 30+ years, 13.5% are from minoritised groups, but this figure is 20.2% among residents aged under 30 years. Among state-funded mainstream schools for 2022/23, 23.6% of children are from minoritised groups (24.4% for primary, 23.0% for secondary, 12.4% for special schools and 14.4% for alternative provision schools). Across schools, 20.9% of pupils don't have English as their first language (23.1% for primary, 18.3% for secondary, 9.75% for special schools and 10% for alternative provision schools).

With the arrivals of Asylum Seekers hosted in Hull by the Home Office, it is possible that these figures are now changed, even if people are not permanent residents at this time. Staff feel that Asylum Seekers in particular are a hidden population who deserve to be seen and have their needs counted **– please see page 102 for further information.**

Post-Coronavirus and the Cost of Living Crisis

The coronavirus pandemic in 2020 immediately followed by the cost of living crisis and inflation have hit the city hard. Austerity measures and funding cuts from central government over the last 12 years have also continued to affect local finances and combined together these are having knock-on effects across all areas of public and statutory life, including housing, social care and health.

It is important to keep working together so that we can tackle these health, social and economic challenges as we meet them. A better understanding of any systemic "negativity bias" at play may support this process.

Estimating multiple unmet needs in Hull:

Quantitative Data Insights

Scope of our Quantitative Analysis

This section of the report explores what the ***quantitative data*** can tell us about people in Hull.

Our aim has been to establish an ***estimated baseline*** of the total numbers of people who are likely to be experiencing multiple unmet needs, working with what datasets are available to us, and identifying any gaps and limitations to this data.

It is difficult to ascertain the total numbers of people in Hull who are experiencing multiple unmet needs. That is because there is no single source of data which collects this information and which meets all the definitions of 'multiple unmet needs' that we are using for this report. Despite many services working closely together and as a partnership, the needs of individuals are not always captured in the same detail or in a similar manner nor for the same purposes. This is because each service has its own objectives and modus operandi.

National and local datasets have been used to estimate and baseline the number of people in Hull likely to be experiencing unmet needs such as homelessness, harmful drug and alcohol use, and contact with the criminal justice system. These datasets only cover individuals who are known to services and other information sources are needed to estimate any 'hidden need' within the city. This is because hidden need is not currently captured and is missing from datasets.

We have made some assumptions in relation to producing estimates of the numbers of people who have multiple unmet needs, and have been able to provide 'ballpark' figures. These should be used with the note that they are not an actual count of individuals and are likely to be an underestimate as some people remain unknown to services.

Where local data is available, it has been possible to analyse this in more detail. This is particularly the case for the data we obtained from the charity ReNew, which is Hull's local drug and alcohol treatment service. Whilst it is recognised that ReNew's data only covers a subset of the population (people who are actively in treatment), it nevertheless allows a valuable insight into their needs and has been summarised at a high level for this report **(see page 47).**

Owing to the aforementioned limitations in our national and local datasets, some modelling has been undertaken using information within the ***Hard Edges (2015) report***[8] from Lankelly Chase. This national report is the closest there is to a national baseline of multiple unmet needs in England, but it has its limitations. The resulting modelling used to estimate the numbers of people affected in Hull is dependent on the definitions used in this report and on the quality of its data. As a result, our modelling cannot provide a full or complete picture for Hull.

Our aim has been to establish a baseline estimate of the number of people likely to be experiencing multiple unmet needs.

[8] Lankelly Chase (2015)

We have combined the Hard Edges modelling with locally available datasets to improve estimates.

For example, the Hard Edges (2015) report only included harmful substance use, offending and homelessness within its definition of multiple unmet needs, and so it does not portray a full view of the layers of disadvantage we are highlighting in this report.

As mentioned, we are also dependent on the definitions and quality of data used within the Hard Edges report. Whilst we increased ratios and percentages to try to account for the higher rates of deprivation in Hull, these are still based on assumptions and are dependent on the accuracy of these assumptions and the quality of Hull's local data.

The Hard Edges modelling adopted for Hull provides us with a 'ballpark' figure based on substance use, offending and homelessness. This is an improvement on what went before, when we had no modelling or estimates available to us for multiple unmet needs.

We have tried to further enhance the legitimacy of our estimates by also looking at local data to produce revised estimates for Hull in relation to substance use, offending and homelessness. Where it was possible to do so, we have also offered an overview of estimated figures for ***Domestic Abuse*** and the ***Removal of Children*** into care.

Approach to our analysis

As most estimates are not a true and actual count of individuals locally with the specific need, numbers are generally rounded to the nearest 25 individuals.

Homelessness – national datasets were used which give the number of households assessed for statutory homelessness including information on household composition from which the number of adults affected was estimated. The Homelessness Monitor: Great Britain 2022 report[9] was used to provide an estimate of the number of 'hidden' homeless households which are not included in the official figures as they do not seek help or are not eligible for statutory help;

Contact with the Criminal Justice System – there is no single source of data available for offending and involvement with the criminal justice system. Information was combined from a number of different national datasets including sentencing information from the Crown and Magistrates Courts, incidents of crime and anti-social behaviour including

[9] Crisis (2022)

outcome data from policing sources, and information from the Office for Health Improvement and Disparities' Fingertips tool which provides information rates of violent crime, first time offenders and re-offending. National and local information relating to prison populations and probation services was also examined;

Harmful Drug and Alcohol Use – on the Office for Health Improvement and Disparities' Fingertips tool, the estimated prevalence of people who use opiate and/or crack cocaine has been estimated for each local authority, and a dataset was provided by the local substance treatment service ReNew to give an estimate of the number of people currently in treatment in September 2023. The ReNew dataset included those in treatment for opiates, alcohol, substances other than opiate or crack, and substances other than opiate or crack combined with alcohol. The numbers of hospital admissions related to drugs and due to alcohol-specific conditions were also examined. Hull's Adult Health and Wellbeing Survey 2019 was used to estimate the number of individuals who were dependent or had a high risk of dependency on alcohol and/or drugs in that they were using drugs ('other than those for medical reasons') daily and/or had drunk 70 or more units of alcohol the week before and/or 'daily or almost daily' failed to do what was expected of them due to alcohol and/or 'daily or almost daily' could not remember what happened the night before due to alcohol. The prevalence from the survey was applied to the total estimated number of residents aged 16+ years to obtain a figure for the total adult population of Hull. However, it is recognised that people with these high levels of alcohol consumption and daily use of drugs may be less likely to participate in local surveys, so any resulting numbers using the prevalence from this survey will represent an underestimate of the overall levels of need in the population;

Domestic Abuse – the number of adults affected by domestic abuse was estimated for Hull by applying the age-gender specific prevalence estimates of domestic abuse from the Crime Survey for England and Wales 2021/22 to Hull's population structure. An adjustment was made to account for Hull's increased levels of reported domestic abuse, however it is recognised that even with an adjustment it may not fully reflect the true levels of domestic abuse as many incidents and crimes go unreported;

Many domestic abuse incidents and crimes remain unreported and they will not show up in our estimates.

Removal of Children (into care) – a local dataset was provided containing anonymised information relating to children who had started to be looked after during 2022/23 in Hull and this included the factors influential in the removal of the children into care. National datasets were also used. The local and national datasets relate to children only, so it is not possible to examine the number of families or adults affected. Nevertheless it gives an indication to the extent of possible need across Hull.

Poor Mental Health – please note that we do not attempt to quantify mental health prevalence within our analysis of multiple unmet needs, but we acknowledge that the experience of homelessness, contact with the criminal justice system, substance use, domestic abuse or the removal of children will all carry or are very likely to carry mental health implications or a relationship of some kind due to their traumatic nature.

Analysis and results based on ‘Hard Edges’

We used the information found in the national Hard Edges (2015) report to model the picture in Hull and produce an estimated baseline of the population who are experiencing multiple unmet needs.

As noted, the Hard Edges report examined three main domains only as signifiers of multiple unmet needs: ***homelessness, substance use*** and ***offending.**** Importantly it also examined combinations of these domains in the seven groups as illustrated in the Venn diagram shown in **Figure 2.**

It is recognised that rates of multiple unmet needs are higher in Hull due to our increased levels of deprivation. Within the Hard Edges report, indices were given for some local authorities including Hull, to illustrate the increased levels of multiple unmet needs. The indices for Hull show that the prevalence estimates were just over twice as high in comparison to the England average. We have adjusted estimates for Hull by taking these indices into account during our modelling.

The prevalence of the overlap between needs based on this modelling was then applied to local data to produce estimate figures for Hull using broader definitions of homelessness, harmful substance use and contact with the criminal justice system relative to the definitions used within the Hard Edges report.

Please note that the Hard Edges report uses the terminology of ‘severe and multiple disadvantage’ where we use ‘multiple unmet needs.’

Figure 2: Venn diagram showing the seven 'groups' within the Hard Edges report (Source: Hard Edges)

From the Hard Edges report for England published in 2015, there were 586,000 people experiencing homelessness, harmful substance use and/or offending. With a population of 53,012,456 adults in England at the time (2011 Census), this equates to a prevalence of 1.1%.

If Hull had the same prevalence as England (which it doesn't) then this would mean there would be an estimated 2,952 people in Hull who are currently experiencing multiple unmet needs.

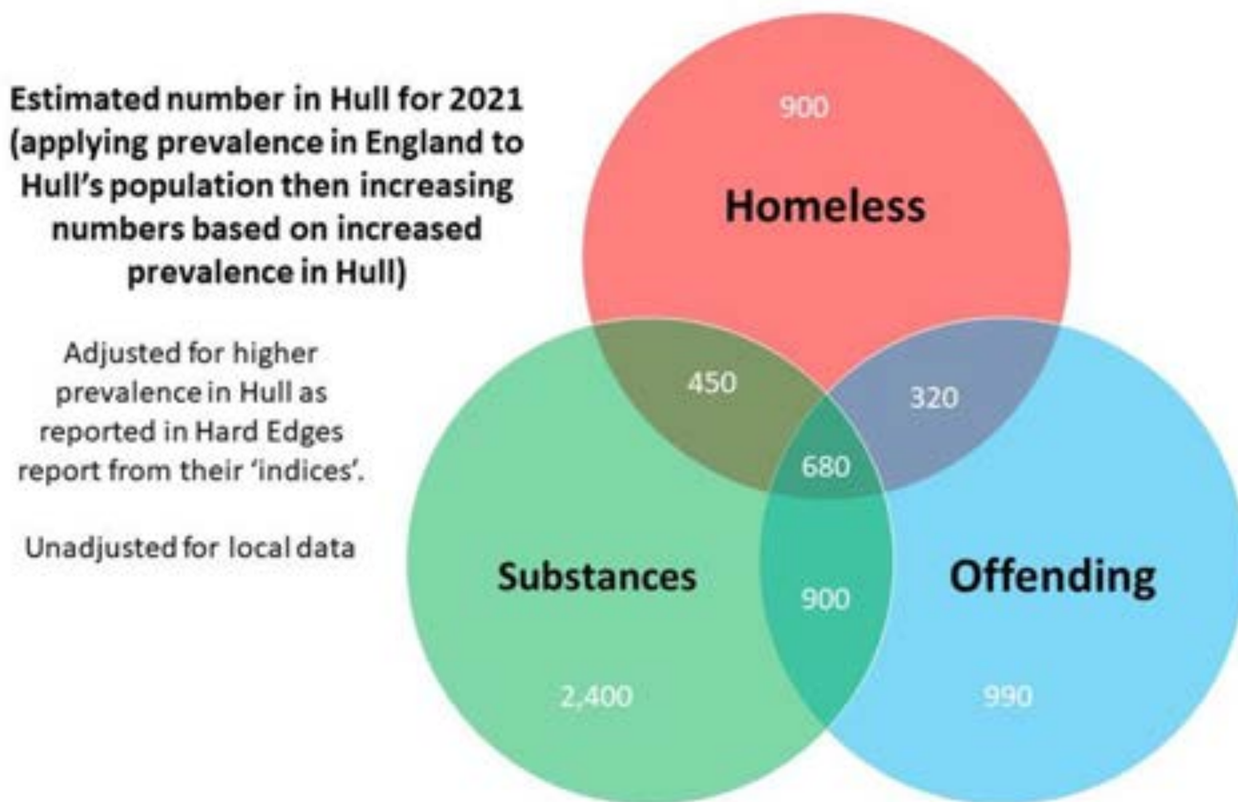
Within the Hard Edges report, indices were given for some of the local authorities with the highest and lowest prevalence estimates of multiple unmet needs to indicate the degree by which the local authority was higher or lower than England averages. Hull was one such local authority with indices of 251 for homelessness, 232 for problematic substance use and 191 for offending, and 224 for all measures combined for Hull.

An index of 224 means that the overall prevalence in Hull, across all three indices, was 2.24 times higher than England.

After adjusting for these indices, it would suggest that around 6,640 residents in Hull are experiencing the impact and effects of multiple unmet needs **(Figure 3).** This would include 4,430 individuals experiencing harmful substance use, 2,350 individuals experiencing homelessness, and 2,890 individuals who are in contact with the criminal justice system.

Overall, 4,290 people experience one domain only, 1,670 people experience two domains and 680 people experience all three Hard Edges domains of unmet need (homelessness, harmful substance use, and offending).

Figure 3: Estimated number of people in Hull experiencing multiple unmet needs (Source: Hard Edges 2015, and 2011, 2021 Censuses for population)



Following feedback during the compilation of this Needs Assessment, it quickly became clear that this estimated figure of 6,640 people is felt to be too low and unrealistic for Hull.

We have therefore supplemented the Hard Edges information with local and national datasets to inform and revise our baseline estimates and include our wider definitions.

Further analysis and results using local data

Please note that, in most instances, it is not always possible to remove duplicated individuals from the figures we have used in our analysis. It is likely that the results of our analysis involve individuals who have been double-counted locally by more than one service, particularly if they have more than one area of need.

Homelessness

From nationally available information, for the 2021/22 financial year, a total of 3,530 households in Hull were assessed for homelessness with 3,299 (93.5%) found to meet the criteria for statutory homelessness. Based on the household composition, it was estimated that these households involved around 3,700 adults.

Estimated number of adults officially homeless (as per statutory definition only) in the last year in Hull – 3,700

However, not everybody who is homeless fulfils the statutory definition nor is included in the official figures as these only include people and households known to services, and do not necessarily include 'hidden homelessness' such as sofa-surfing, people sleeping rough or people

staying in temporary and/or unsuitable accommodation. They also do not include all people at risk of homelessness or people living in insecure accommodation.

The Homelessness Monitor: Great Britain 2022 report gives the estimated prevalence of hidden homeless who are not included the official homeless figures. These prevalence estimates were adjusted slightly to take into consideration the deprivation levels in Hull, before being applied to Hull's population estimates. This gave an overall estimate (including those officially homeless) of 8,900 adults who are experiencing homelessness.

Estimated number of adults who are experiencing homelessness in Hull – 8,900 (including those adults who are officially homeless by the statutory definition)

There are an estimated 8,900 adults in Hull who are facing homelessness, as per the broader definition of homelessness we have used for this report, which includes forms of hidden homelessness e.g. sofa-surfing.

Contact with the Criminal Justice System

From the Office for Health Improvement and Disparities' Fingertips tool, the percentage of offenders that re-offend in Hull was 36% higher than the England average for 2020/21. The number of re-offences per re-offender was also 22% higher in Hull compared to England.

Rates of violent crime were 69% higher in Hull for 2021/22 compared to England, and the rate of sexual offences and hospital admissions for violence including sexual violence were both around 40% higher in Hull compared to England. The higher rates of deprivation in Hull could account for the higher rates of crime, although it is also possible that there are other factors present, such as better recording or more joined-up partnership working.

From Magistrate Court and Crown Court nationally available statistics from the Criminal Justice System Statistics for 2022, there were an average of 4,903 individuals per year who were convicted over the three year period 2020 to 2022 for non-motoring offences across the Humberside Police Area which included 1,530 who were immediately taken into custody and 2,417 who were otherwise dealt with (excluding fines and absolute discharges from the Magistrates Court). From the information accessed through Fingertips, across the Humberside Police Area, Hull residents account for around 28% of the population, and for four in ten of the first time offenders, and just over half of all re-offences. It is likely that violent crime is over-represented in the Hull cohort.

If it is assumed that Hull residents account for around 45% of the 2,417 who have conditional discharges, community sentences, suspended sentences or are dealt with through compensation orders, then this equates to around 1,088 individuals.

Estimated number of people involved in a Crown or Magistrates Court case in the last year (non-custodial sentences) – 1,090

From Police Data, during 2022/23, there were 37,640 reported incidents of crime with 739 cases where action was taken by another organisation, 98 cases where the suspect was charged with another crime, 1,976 cases had no status update with respect to the outcome, and 2,928 cases that went to court. Of the remaining 31,899 crime incidents, 1,329 resulted in outcomes that did not involve the courts, such as community resolutions or police cautions, a drugs possession

warning or a penalty notice. Overall, 919 were given a community resolution and 322 individuals were given a caution.

Estimated number of people with community resolutions and police cautions in the last year (did not go to court) – 1,240

Based on the Offender Management Statistics Bulletin for March 2023, there were 239,518 offenders on probation at the end of March 2023 across England and Wales. A total of 167,887 individuals were supervised in the community including 111,038 on court orders and 59,772 on post-release supervision, and a further 73,538 individuals were on probation on pre-release supervision (numbers do not sum to the total as one person could be in more than one group). Proportionately applying the same prevalence to Hull's population gives an estimated 1,073 people on probation in Hull with 752 supervised in the community and 329 in custody (pre-release). However, the local probation service figures are considerably higher.

The local probation service had a caseload of 2,350 as at October 2023, which included 1,515 in the community and 875 in custody (some people appear in both counts). The community cohort includes those with community sentences and with suspended sentences (both subject to court orders), plus any prisoners released on licenced supervision. Prisoners on a determinate sentence spend half their time in prison and half out on licence supervised by probation so then move into the probation service's community cohort. The community cohort also includes those who have very short sentences (e.g. two weeks) who have a supervision order after release (for example, for a period of 12 months following release). The number of individuals involved with local probation services are those whose current or last known address is in Hull.

The number given non-custodial sentences through the courts or community resolutions and cautions that did not go to court was around 2,315 which is reasonably compatible with the numbers in the local probation services in the community (1,515 individuals). The probation cohort will not include those with cautions or those with conditional discharges, compensation orders or otherwise dealt with through the courts.

Number of people in local Hull Probation Services – 2,350

As at October 2023, there were 88,016 prisoners in England and Wales giving a rate of around 179 per 100,000 population. Applied to Hull's population, this equates to around 388 residents of Hull in prison.

From incidents of crime recorded in Police Data, violent crime accounts for around 43% of all incidents for the three year period 2020/21 to 2022/23, and if the violent crime rate is around 70% higher in Hull and re-offending and re-offences rates are around 30% higher in Hull, then it seems reasonable to assume that the prison population in Hull is around 30% higher which equates to a revised estimate of 500 Hull residents in prison (or around 565 if 45% higher than England).

However, from the Magistrate Court and Crown Court, there were an average of 1,530 individuals sentenced to immediate custody and if Hull residents account for around 45% of Humberside Police Area cases, then this equates to around 690 individuals in prison.

Based on the national prison population and probation datasets, around 87% of the prison population are on pre-release supervision. With 875 individuals currently in prison involved with local probation services, if the same proportion was applied to Hull, then this would equate to 1,000 Hull residents in prison.

Examining the different datasets and applying different assumptions has resulted in quite differing estimates of the number of people in prison who are Hull residents (or were prior to time spent in prison).

However, it seems reasonable to use the information from the local probation services as this does involve a real count of individuals rather than applying national-adjusted prevalence estimates to Hull's population. This figure is based on an assumption that around 87% of those in prison are involved with probation services, but there is no indication that the situation might be different in Hull.

Local probation services have stated they are not involved with all those in prison, so this does mean that the estimated number of Hull residents in prisons throughout the country will be at least 875 individuals.

Estimated number of Hull residents who are in prison – 1,000

Adding these figures together, the numbers of people involved with the criminal justice system in Hull (those estimated to be in prison, sentenced at court in the last year or who had community resolutions or cautions in the last year) is 3,330. With the exception of police cautions, the majority of these individuals will be in contact with local probation services.

Estimated number of people who have contact with the Criminal Justice System in Hull – 3,330

The analysis above does not include historical contact with the criminal justice system, as we have examined data from a single year. To our knowledge there is no research across England which considers historical contact and it has not been possible to consider this as part of our report. This means that there will be far more people in Hull who have past experience of the criminal justice system than we are able to include in our estimates.

An estimated 3,330 people in Hull have experienced recent contact with the criminal justice system.

Harmful Drug and Alcohol Use

From the Office for Health Improvement and Disparities' Fingertips tool, in 2020/21 there were an estimated 1,625 opiate and/or crack cocaine users who were not in treatment representing 48.4% of all opiate and/or crack cocaine users. This equates to an estimate of 3,357 opiate and/or crack cocaine users in Hull. Previous modelling between 2011/12 and 2016/17 also produced broadly similar figures.

More recent prevalence estimates released in October 2023[10] covering the period 2019/20 are higher with an estimated 3,800 opiate and/or crack cocaine users in Hull. Whilst this period predates the information given on Fingertips, the latter bases its estimations on the average of the last three prevalence numbers and is based on older prevalence estimates than 2019/20.

These figures do not include children and young people.

Estimated number of opiate and/or crack cocaine users in Hull – 3,800 adults

From hospital admission data, around 1,100 separate individuals were admitted to hospital each year between 2020/21 and 2022/23 for alcohol-specific conditions (including alcoholic liver disease and poisoning), and around 100 separate individuals were admitted for conditions relating to drug use.

There were also patients admitted for both alcohol and drug use, but the numbers varied each year (56 in 2020/21, 27 in 2021/22 and 19 in 2022/23). Overall there were around 1,200 separate individuals admitted each year for substance use, and they had on average 1.8 hospital admissions each year.

Individuals admitted to hospital for issues related to alcohol or drugs – 1,200 adults per year (1,100 alcohol and 100 drugs)

From Hull's adult Health and Wellbeing Survey conducted during 2019 involving over 4,000 residents aged 16+ years, the prevalence of dependent and/or having problematic substance use varied from 9.9% among men aged 16-24 years to less than 1% among women aged 65+ years.

If the age-specific prevalence estimates were applied to Hull's population, then there are an estimated 8,300 individuals who have problematic substance use in Hull. However, it is recognised that people with high levels of alcohol consumption and daily use of drugs would be less likely to participate in the local survey, and any resulting numbers using the prevalence from this survey will represent an underestimate of the overall level of need in the population.

Estimated number of people in Hull with potentially harmful use of substances – 8,300

From the local substance treatment service provider (ReNew), in September 2023 there were 1,858 current 'open cases' for clients who lived in Hull.

There are also approximately 180 patients treated by Humber Teaching NHS Foundation Trust each year in their addiction services.

Estimated number of people currently in substance treatment services – around 2,040 adults

Once again, it is not possible to avoid the potential for double-counting across these figures, in providing an estimated picture of harmful drug and alcohol use across Hull.

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[10] Office for Health Improvement and Disparities (2023)

Domestic Abuse

According to the Crime Survey for England and Wales, it is estimated that 5.0% of adults (6.9% of women and 3.0% of men) aged 16+ years experienced domestic abuse in 2021/22. The age-specific prevalence estimates were increased to account for the higher rates of domestic abuse in Hull and then applied to Hull's population. This gave an estimate of around ***20,000 adults affected by domestic abuse***. It is possible that this still represents an underestimate, as local domestic abuse services have reported a 100% increase in demand in the last couple of years, in particular since the coronavirus pandemic.

In the last four years, local domestic abuse services have received 3,600 referrals into their service each year equating to 14,400 people affected. Some people may be referred more than once into the service, but there will be many more people who are unknown to services.

Please note that this estimate does not include children and young people under 16 years old. If we include children this figure will be higher.

It is commonly noted by experts in the domestic abuse voluntary sector that Hull has one of the highest prevalences of domestic abuse in England.

Estimated number of people experiencing domestic abuse in Hull – 20,000 adults

An estimated 20,000 adults over 16 years old have been affected by domestic abuse in Hull. This is one of the highest rates in England. Local services have recently seen a 100% increase in demand.

Removal of Children into care (also called 'Children Looked After')

The latest Fingertips data tells us there were 886 children in care in Hull in 2022. This is a rate of 150 children per 10,000 population which was more than double that of England (70 children per 10,000 population). ***The rate in Hull was sixth highest in England out of the 152 upper-tier local authorities.*** In 2021, the total number of children looked after in Hull was 948 giving a rate of 165 per 10,000 population so the number has decreased in the last year by 9%.

It is not known how many families are affected or how many adults are affected as national and local datasets only relate to individual children.

We would like to note here that children in Hull who have experienced legal removal from the care of their parents have asked that we do not say "Looked After Child" because the acronym of 'LAC' implies they are lacking, which they are not. This is why services in Hull use "Children Looked After" as a more sensitive and trauma-informed alternative.

From an adult client perspective, we found during conversations with people who have lived experience of the removal of their children that "Children Looked After" feels invalidating and renders the parent invisible in the process. They preferred that the grief and trauma caused by this experience is clearly named and acknowledged by services and staff.

More work with children and adults might be needed to understand if the language and terminology we use in Hull can be further improved.

Number of Children Removed into Care (Children Looked After) in Hull – around 900 in total

Recap of local results (excluding 'Hard Edges' figures)

Marker / Group (denoting experience of)	Estimated Numbers in Hull*
Homelessness	**8,900**
Contact with the Criminal Justice System	**3,330**
Harmful Drug and Alcohol Use	**8,300**
Domestic Abuse	**20,000**
Removal of Children into care	**900**

**Based upon most recent national and local datasets available to us*

In contrast to the earlier Hard Edges analysis, the local data available to us estimates that there are around 8,300 individuals who experience harmful levels of alcohol and drug consumption, around 3,330 people involved in the criminal justice system and around 8,900 people who are experiencing homelessness including forms of hidden homelessness. This is significantly higher than the Hard Edges estimates we considered **(see page 39)**.

Using percentages of people in each of the overlapping categories from the Hard Edges modelling (illustrated in **Figure 3**) as a guide, the estimates can also be adjusted for the local figures. This resulted in revised estimates which are shown below in **Figure 4.** Please note that the 2021 date here refers to the 2021 Population Census.

Figure 4: Estimated number of people in Hull experiencing multiple unmet needs based on local analyses and estimating the overlap between groups based on the Hard Edges modelling (Source: local analyses and Hard Edges 2015 report)

The sum of each 'circle' within the Venn diagram equates to 8,300 individuals experiencing harmful substance use, 8,900 individuals experiencing homelessness, and 3,330 individuals involved with the criminal justice system.

The total estimated number of individuals with one or more need is 15,900.

Based on these estimates, 12,300 (77%) individuals experience one of these domains, 2,570 (16%) experience two domains and 1,030 (6.5%) experience all three domains. Multiple unmet needs is generally understood as the experience of two or more of the needs as identified in **Our Definitions** **(see page 19)** but here we have focused on the three domains as used in the Hard Edges report – seen as the benchmark for estimating multiple unmet needs in England. We are conscious that, although quantitative data cannot show this clearly, the likelihood of experiencing only one unmet need is very low due to the interrelational and "compounded" nature of multiple unmet needs at play in a person's life.

In-depth quantitative analysis of people in substance treatment services (ReNew)

As well as offering an estimated analysis of the numbers of people experiencing multiple unmet needs in Hull, locally available datasets also give us an insight into the practical or emotional needs that people are experiencing when they access services.

We were able to complete an in-depth analysis of the needs of clients when they accessed local substances treatment service, ReNew, based at Trafalgar House. This data gives us a detailed picture of the additional needs which people have when they seek out support for harmful drug and alcohol use.

This is a quantitative analysis and it cannot take into account the holistic or person-centred view of people's needs, nor offer commentary on the root causes of needs to support system and service responses. For a qualitative, holistic assessment of needs, please see the following section of this report – ***Giving voice to people with multiple unmet needs.***

Clients accessing ReNew services:

Age and Gender

One-quarter of all ReNew's clients were men aged 45-54 years (25.2%) and a further fifth (21.9%) were men aged 35-44 years with the next highest percentage among women aged 35-44 years (12.5%).

These three groups accounted for six in ten of all clients **(see Figure 5).**

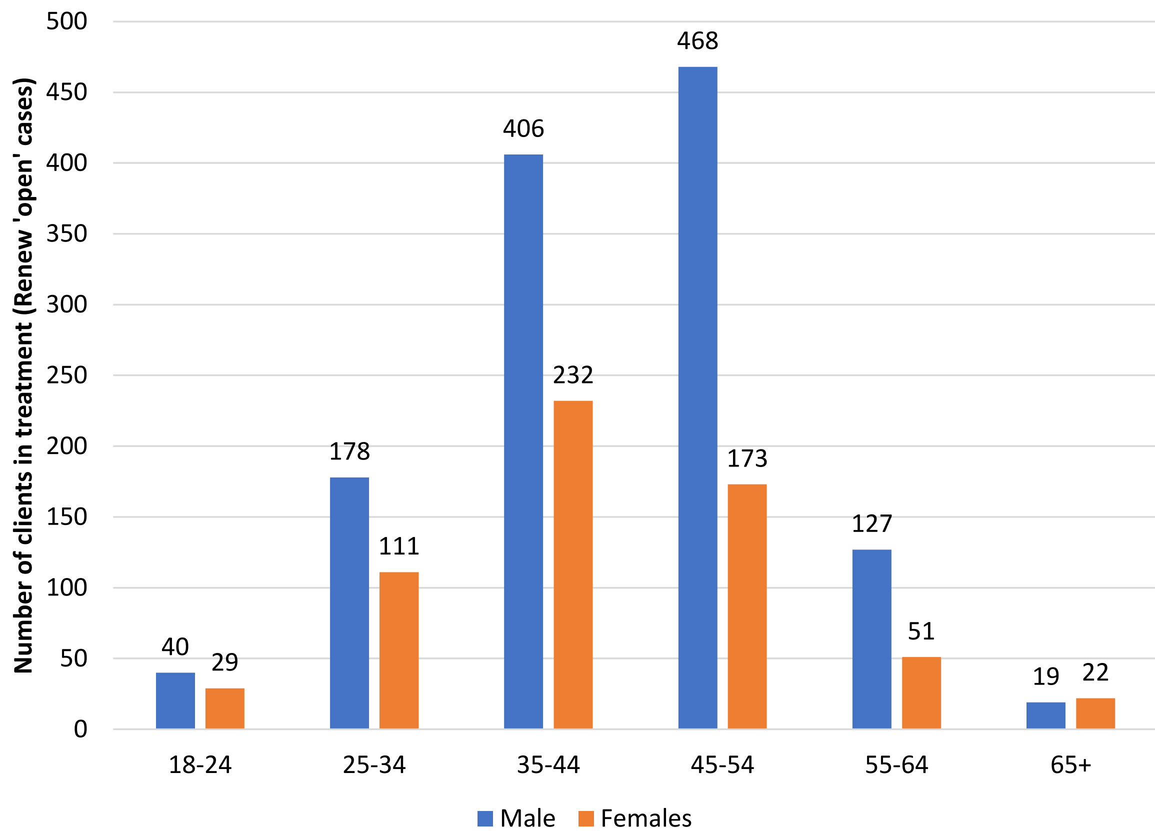


Figure 5: Number of Hull residents currently in substance treatment services (Source: ReNew, September 2023)

Types of Substance Use

Overall, 357 (19.2%) were being treated for alcohol dependence, 169 (9.1%) for non-OCU (opiate and/or crack cocaine use) combined with alcohol, 126 (6.8%) for non-OCU, and 1,206 (64.9%) for opiate use.

Between 11% and 16% of men aged 18-54 years were being treated for alcohol, but it was much higher among men aged 55-64 years (28%) and 65+ years (68%). For women, the percentages increased with age from 14% among those aged 18-24 years to 26% for those aged 45-54 years, with around half (51%) of those aged 55-64 years in treatment for alcohol and almost three-quarters (73%) of those aged 65+ years.

Around one-third of clients aged 18-24 years were in treatment for non-OCU and 38% of men and 45% of women in this age group were in treatment for non-OCU combined with alcohol, but both these percentage decreased with age to 22% for men and 16% for women aged 25-34 years for non-OCU and around 15% for men and women aged 25-34 years for non-OCU combined with alcohol. Those aged 35+ years had around 10% or less in treatment for both non-OCU only and non-OCU combined with alcohol combined.

Around one in ten of those aged 18-24 years were in treatment for opiates, but this increased to around 45% for those aged 25-34 years and to around three-quarters of those aged 35-44 years. Eight in ten men and two-thirds of women aged 45-54 years were in treatment for opiates as were around six in ten men and four in ten women aged 55-64 years. The percentage was lower among those aged 65+ years with around one-quarter in treatment for opiates.

All 37 of the women who are currently sex working, or those who had sex worked within the last three months, were being treated for opiate use, as were 83% of the 54 clients who had previously sex worked.

Deprivation

Excluding the 74 individuals with no fixed abode, 34% lived in the most deprived fifth of areas of Hull, 27% in the second most deprived areas, 23% in the middle fifth, 11% in the second least deprived fifth and 6% in the least deprived fifth of areas of Hull based on the Index of Multiple Deprivation 2019.

20% of the overall population lives in each fifth, so there is a clear skew to living in the most deprived areas.

Some of the homelessness hostels are also located in the most deprived areas of Hull. This may influence the prevalence presented by local deprivation fifths.

Recorded Areas of Need

One-fifth had information on their accommodation missing as there is a current data recording change happening with regard to the accommodation information. Of the remainder, one-fifth (20.7%) had unstable accommodation in that they had no fixed abode (4.8%), or had no home of their own and were living with friends or family short-term (5.5%), were in supported accommodation (4.6%), hostels (3.3%), bed and breakfast accommodation or other temporary accommodation (0.3%), sofa surfing (1.5%), or were squatting or sleeping rough (0.7%).

Younger people, particularly men, were more likely to have unstable accommodation (around 40%) compared to around 9% among people aged 55+ years.

Overall, 17% were involved in the criminal justice system (316 out of 1,858) but this was highest among men compared to females, and higher among those aged 25-54 years. One in eight men aged 18-24 years was involved with the criminal justice system, but this increased to around one-quarter of men aged 25-44 years before decreasing to 16%, 13% and 5% for men aged 45-54, 55-64 and 65+ years respectively.

No women or hardly any women aged 18-24, 55-64 or 65+ years were involved with the criminal justice system, but between one in ten and one in eight women were involved among those aged 25-54 years.

Around one-quarter of younger men were currently or had previously been affected by domestic abuse but this decreased with age to 12% for men aged 55-64 years with none of the men aged 65+ years having stated they were affected. The percentages also decreased with increasing age among women, but were much higher with around 70% of younger women affected which decreased to just over one-third of women aged 65+ years.

Almost two-thirds of those in substance treatment services had a physical health condition or disability (63.7%) with the most common condition recorded as “behaviour and emotional” issues (18.3%) as illustrated in **Table 1.** The numbers were too small to present separately for people with Autistic Spectrum Disorders, dyslexia, manual dexterity, perception of physical danger, personal self-care and continence, and speech, and in total there were 14 individuals with these conditions.

Table 1: Physical health condition or disability (Source: ReNew, September 2023)

Physical health condition or disability	Number	Percentage (%)
None	674	36.3
Acquired brain injury	8	0.4
Behaviour and emotional	340	18.3
Hearing	11	0.6
Learning disability	35	1.9
Mobility and gross motor	162	8.7
Physical disability	17	0.9
Progressive conditions and physical health	82	4.4
Sight / Vision	9	0.5
Other condition	14	0.8
At least one physical health condition or disability	**1,184**	**63.7**

We would like to note that the figures for Acquired Brain Injury and for possible neurodivergence or diagnosis of neurodiverse conditions (listed in **Table 1** against 'Acquired brain injury,' 'Learning disability' and 'Other condition') are believed to significantly underestimate prevalence.

Over one in four had also been diagnosed with a serious health condition with around 2% having a serious heart condition and almost one-quarter had current or previously diagnosed respiratory issues.

There were 321 (17.3%) people in substance treatment without identified mental health treatment needs and a further 1,122 (60.5%) individuals with identified mental health treatment needs who were receiving treatment for their mental health needs.

This meant that there were 412 people in substance treatment with identified mental health treatment needs who were not receiving treatment for their mental health needs representing 22.2% of all those in substance treatment services. Based on what we know from our qualitative research, it is likely this figure underestimates prevalence of mental health treatment need.

Of those with an identified need for treatment who were also receiving treatment, 81% were receiving mental health treatment from their GP, 13.6% were engaged with the community mental health team, 1.7% were receiving National Institute of Health and Clinical Excellence (NICE) interventions, 1.8% were engaged with the NHS Talking Therapies for anxiety and depression, and 0.6% had an identified space in a health-based place of safety.

Overall, 476 (26%) of people in substance treatment services were a parent and a further nine individuals lived with children. At least 361 children lived with people in substance treatment services, although the number may be slightly higher due to some discrepancies in the data. Overall, among the 421 people with information recorded on the status of their child(ren), in terms of the highest level of help received, 46 (10.9%) had child(ren) removed into local authority care, 38 (9.0%) had child(ren) on Child Protection Plans, 31 (7.4%) had child(ren) in need, 33 (7.8%) were accessing the Early Help family support service and 14 (3.3%) were receiving help from other

relevant child or family support services. For the majority (61.5%) of people, they were not receiving support relating to their children.

Safeguarding assessments had not yet completed on 50 individuals in substance use treatment services. Of the remaining 1,808 individuals, 1,260 (70%) had no live safeguarding issues, 281 (16%) were deemed to be a risk to children or young people, 146 (8%) were deemed to be a risk to adults, 120 (7%) were deemed to be a risk to themselves, and 124 (7%) were deemed to be at risk of harm from others.

The numbers in substance treatment services were relatively small among those aged 18-24 years and 65+ years, but they had the highest percentages of risk to themselves (13% for men and 23% for women aged 18-24 years and 22% for men and 18% for women aged 65+ years). Between 3% and 6% of men and between 9% and 14% of women were at risk from others with the figures differing slightly across the age groups.

To examine combination areas of need, a count of the number of areas of need was undertaken with one point assigned for each of the following:

- Receiving treatment for substance use (all scoring for this one)
- Previously or currently sex working
- Any disability
- Unstable accommodation
- Mental health treatment need
- Involvement with criminal justice system
- Previous or current domestic abuse
- Safeguarding issues - risk to self
- Safeguarding issues - risk to others
- Has child(ren) in need, on a child protection plan or a child looked after
- Previous or current serious diagnosed health condition
- Previous or current serious heart condition
- Previous or current respiratory problems

The overall scores ranged from 1 (no other areas of need noted other than problematic substance use) to 10 (nine additional areas of need), although the maximum possible score was 13.

Around 10% of men had a score of 1 or 2, although it was slightly higher at 14% among men aged 55+ years **(Figure 6).**

Fewer women had a score of 1 or 2, although this increased with age from 2.9% for those aged 18-34 years to 11% for those aged 55+ years.

Around half of men aged 18-54 years scored 3 or 4, although this was lower among men aged 55+ years who tended to have a higher percentage with higher scores.

Women tended to have higher scores with around half of women scoring 4 or 5, and over 20% scoring 6 or more (so with five or more areas of need additional to their harmful substance use).

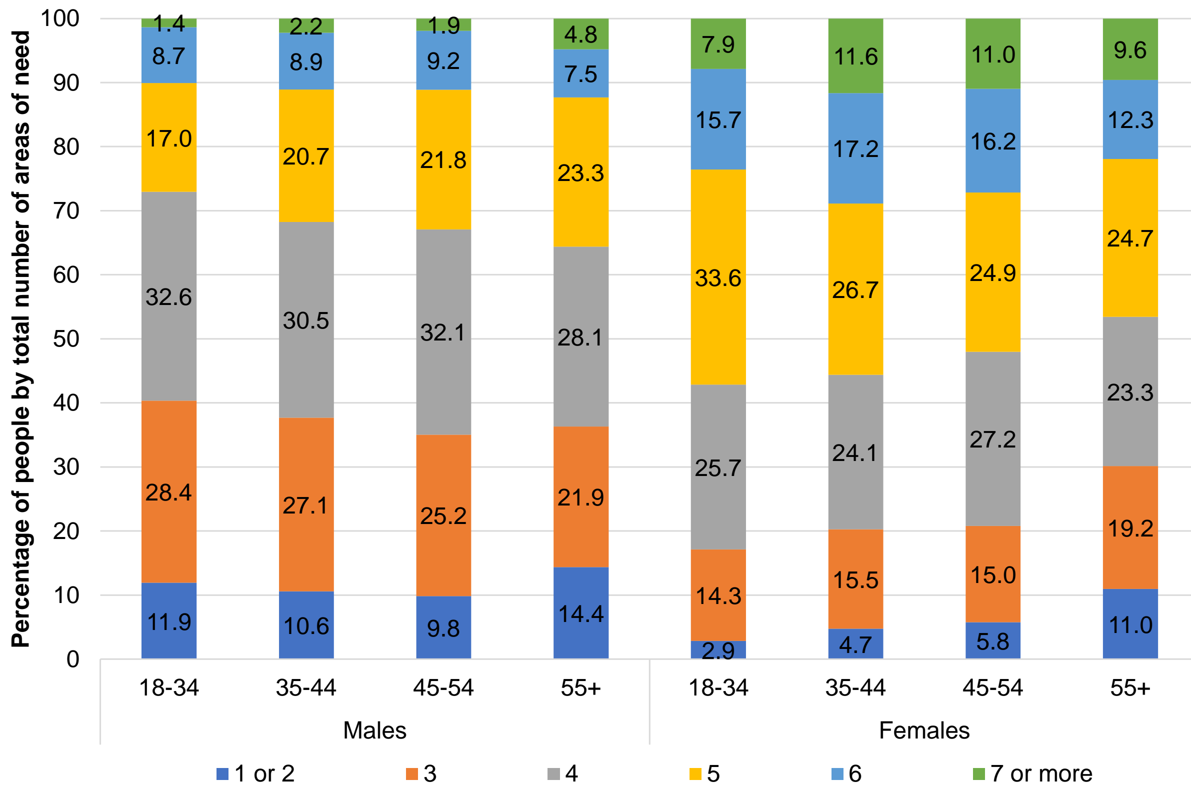


Figure 6: Percentage of people by count of the number of areas of need combining younger and older age groups (Source: ReNew, September 2023)

There were too many different permutations of the 13 areas of need to examine separately with 453 different combinations of areas of need noted among the 1,858 individuals. It was necessary to focus on the specific combination areas of need with a relatively high number of individuals with that combination.

There were 16 different combination areas of need where there were 20 or more individuals with that specific combination of needs, and 673 (36.2%) of the 1,858 people in treatment fell into these 16 combinations of need.

All 16 combinations without exception noted disability or mental health as an area of need, and many noted both disability and mental health. A relatively high number of these 673 individuals also had serious health conditions with some also having respiratory problems, and there were also individuals noted as having areas of need that included domestic abuse, children in need or unstable accommodation.

When the different combination areas of need were examined specifically for those in treatment for opiate use, the same factors of disability and mental health dominated with mentions of domestic abuse, children in need, or unstable accommodation. There was also a higher percentage with offending noted.

Analysis of needs within local probation services

We also received recent information relating to Hull's local probation services and were able to ascertain a 'snapshot' picture of the needs of clients who have contact with the criminal justice system.

During the three-month period May to June 2023, there were 713 assessments completed within local probation services for individuals identified as Hull residents or whose last known address was a Hull address. These included both new assessments and updates to assessments completed as part of an existing series of assessments (including 18 individuals who had more than one assessment within the three-month period).

More than four in ten (309 people; 43%) had accommodation identified as an area of need. Of those 309 people, 114 identified support for alcohol use as a need, 188 people identified drug use and 67 people identified both alcohol and drug use as additional areas of need. Overall, 210 people (29%) listed alcohol as an issue that they needed supporting with, and 295 people (41%) had listed drug use as an area that they needed supporting with.

Of the subset of 309 individuals who were released from prison and had an assessment within this three-month period, 82 people (27%) had accommodation identified as an area of need.

Of the 82 people with accommodation identified as an area of need, 11 people (13%) were released to temporary or transient accommodation or to family/friends on a temporary basis, and a further 19 people (23%) were homeless on release. These two percentages for temporary accommodation and homelessness were 5% and 28% for those with alcohol as an additional area of need, 20% and 28% for those with drugs as an additional area of need, and 7% and 32% for those with both alcohol and drugs as additional areas of need.

This data from local probation services ***demonstrates high levels of need for accommodation as well as high levels of need for support with drug and alcohol use,*** either upon release from prison or during ongoing contact with probation services.

Analysis of needs within hospital settings

We also received some limited information from hospital settings that could be mapped to people who are experiencing the impact and effects of multiple unmet needs. A request was made to information analysts at Hull University Teaching Hospitals (HUTH) to extract data from systems for patients within the definitions of multiple unmet needs as found in this report. This is so that we could understand to what extent quantitative data across hospital settings could tell us about need areas of patients accessing health services. Overall, we found that hospital data around ***the monitoring and recording of multiple unmet needs is poor*** and both patients and services would benefit from improvement.

For the financial year of 2022/23, there were 1,662 Emergency Department attendances from patients that existing data could tell us were likely to be experiencing the impact and effects of multiple unmet needs. Data was not provided on the number of individual patients this related to:

- Of these, 323 (19.4%) were followed by another within 7 days from the same patients;
- Overall, 222 (13.4%) of the 1,662 resulted in a self-discharge ("left before being treated"). For these attendances, the 7-day reattendance rate was 35.1%. This arguably suggests that self-discharge is a key challenge in terms of treatment completion and health improvement;
- 250 (15%) attendances resulted in an inpatient admission;
- Fewer than 5 deaths were recorded in the department from these 1,662 attendances.

Chief medical complaints included: chest pain, abdominal pain, head injuries, substance use, self-inflicted injury, poisoning, seizure, asthenia, and dyspnea. Because data recorded relates to "chief complaint" only it is not possible to see additional patient needs within the data, such as mental health needs or substance dependence. However, it was possible to deduce from the data that some of the chief complaints were relatable to mental ill health or substance use. The data showed that 7.7% of attendances and 7.6% of attendances could be linked to substances and mental health and/or learning disability respectively. This equated to 254 attendances altogether (15.3%) for the given period.

A total of 705 inpatient admissions were identified. Of these, 370 (52.5%) were Emergency Admissions, 229 (32.5%) were planned (elective care), and 76 (11.2%) were in maternity. Again, only primary diagnosis or chief complaint was recorded in clinical notes and this makes it difficult to draw any conclusions around additional patient needs relating to substances, mental health, contact with the criminal justice system or domestic abuse.

Out of the inpatient admissions, 5.8% related to substances e.g. alcoholic cirrhosis of the liver, or poisoning relating to use of substances; 2.1% related to mental health e.g. unspecified anxiety disorder or depressive episode, or a specified disorder of the brain. This equated to 7.9% of inpatient admissions being linkable to substance use or mental health in some way.

Across the outpatient admissions, there were high levels of Did Not Attend (DNA) instances within the data. The overall DNA rate was 19.2%. The top clinical specialties affected by the DNA rate included: infectious diseases, haematology, gastroenterology, Ear Nose Throat (ENT), nursing episode, trauma and orthopaedics, ophthalmology, neurology and general medicine.

It is felt that current hospital data is inadequate for the purpose of understanding need for patients who are experiencing multiple unmet needs. There are also no indicators in the data system for 'domestic abuse/violence' or 'criminal justice contact' that were able to be searched meaning the potential data pool is further limited. The lack of systematic identification and recording of patients with multiple unmet needs is an important finding and may indicate a system failing. It may suggest that the wider needs of patients are not being recorded and therefore they are less likely to be addressed within patient pathways and treatment plans.

Summary

Based on our local assessment and quantitative analysis, it is estimated that almost ***16,000 individuals in Hull*** are experiencing homelessness, harmful drug or alcohol use, and/or contact with the criminal justice system. This is around 8% of Hull's total adult population.

At least ***20,000 individuals*** are also estimated to be experiencing domestic abuse and there are approximately ***900 children removed into local authority care***. These are both some of the highest numbers in England. We have not attempted to quantify the prevalence of mental health need in our analysis but we know it will be significant and further increase the baseline figure of 8%.

As previously noted, our figures are based on a number of assumptions and it is likely that they are an underestimate. It is also not currently possible to adjust estimates for double-counting and the duplication of individuals across datasets, particularly given the interacting nature of multiple unmet needs and the partnership-working between services. Nevertheless, our baseline estimates show that across Hull there are significant numbers of people experiencing the impact and effects of multiple unmet needs.

By way of comparison with other need areas, there are just over 10,000 patients registered with Hull GPs who have coronary heart disease (4% of all registered adults), and just over 20,000 patients registered with Hull GPs who have diabetes (around 8% of all registered adults). There is significant investment across the city in coronary heart disease and diabetes. The prevalence of coronary heart disease is lower and diabetes is similar to the estimated prevalence of multiple unmet needs (8%) – and we have stated this will be an underestimate as it does not include mental health, nor predictive analysis of future unmet need for the purpose of prevention efforts, and it relies upon the limited datasets at our disposal.

In conclusion the national and local datasets available to us, and the Hard Edges modelling, are not sufficient to definitively quantify multiple unmet needs in Hull. However, it is an improvement on what went before when we had no current attempts at measurement of the prevalence.

The substance treatment, probation services, and hospital patient data we have summarised give us a rough idea of what people's needs are, and how they often co-exist and interact. Importantly, few people have only one unmet need in the definitions we are using. This indicates that the impact of multiple unmet needs is highly interactive and overlapping across people's lives, and intelligent, sensitive and holistic service provision is arguably required to respond.

Our analysis is not intended to offer definitive figures used to plan service provision – but it does help us to understand where Hull may need to focus its resources. Our analysis also demonstrates that this is a difficult area to quantify and poses questions to funders and commissioners in terms of how we understand population need and interrogate local datasets.

For example, when trying to quantify need and levels of need, we can look at the numbers of people experiencing a particular issue or situation (e.g. domestic abuse, contact with the criminal justice system, homelessness, or substance use), where they might live and how old they are, such as a quantitative analysis provides. In a manner of speaking, we might view these needs as the symptoms of other unmet needs that in a prevention approach, need to be addressed in an equal measure.

To understand multiple unmet needs more fully, the people we spoke to also wanted us to consider the underlying structural disadvantages at play within a city, the local health inequalities which are driving poverty and deprivation, and how these impact on people's exposure to or accumulation of multiple unmet needs across their life course.

This will support us to understand why and how there is ongoing multiple unmet need across the city, as well as working to quantify it more reliably.

To truly affect root causes and apply a population-level approach in our response, it is vital to hear directly from people who are experiencing these moments in their lives. This enables us to draw out what's really happening in somebody's life – the hidden, underlying or overlooked needs that they may have – which may then lead on to experiences of homelessness, domestic abuse, contact with the criminal justice system, poor mental health, or substance use.

We have sought to accomplish this in the next section of this report, with input from people who have living, lived or learnt experience.

Giving voice to people with multiple unmet needs:

Qualitative Insight & Case Studies

Case Study: Marianne's Story

**Please note all names have been changed in this report in order to protect people's privacy and identities*

Marianne grew up on a farm just outside of Hull and recalls having a good childhood in the countryside. She's now in her 40s and lives in Hull in supported accommodation. Before this, she was married with a family, children and a stable life.

Ten years ago Marianne's husband died and she has faced many setbacks since this huge loss. She is currently alcohol-dependent and has turned to street sex work to bring in money to survive.

She has now been sex working for several years and this has led to many more traumatic experiences including multiple sexual assaults and a gang rape. Marianne talks openly about the way she has witnessed men treating women, and says it makes her angry sometimes, and even feel quite feminist.

A year ago Marianne developed sepsis and nearly died. She spent time in Castle Hill Hospital and because she was so poorly, during this time she was able to detox and get sober. She reconnected with estranged family members and her children, who had been removed from her custody.

The doctors put Marianne on some new trial treatments and in defiance of the odds, she went on to make a full enough recovery to be discharged from hospital.

Upon discharge, Marianne was sober and looking forward to a fresh start, but with no support networks in the community for her to go to, and a mix-up with her prescription, she began drinking and street sex working again.

Marianne has been through many traumas, but her sense of humour is strong, her voice is powerful and she knows her mind. She makes fun of the music playing on the radio, wondering why it sounds so bad, preferring the 80s and 90s tunes.

Marianne is alcohol-dependent again, and facing eviction from her accommodation for breaking house rules, but she remains open and excited about the idea of residential detox or rehab.

Marianne is currently struggling with the ending of a relationship, where her partner was abusive towards her, and is considering her options. Although she has a little bit of low self-esteem, she is proud and enjoys doing her makeup and hair, and sticks up for other women and sex workers. She enjoys KFC takeaways and visiting a local charity, where the female workers know her well, light up when they see her during our visit, and remember her upcoming birthday with a card and gifts.

How we completed our research

Our ***Qualitative Analysis*** – which means research carried out non-numerical in nature and which is focused upon real people's experiences, opinions, insights and stories – has been separated into two easy-reference strands for this report:

- **In-Community and Outreach research –** this focused on the Voluntary, Community and Social Enterprise (VCSE) sector, grassroots activities and groups, street outreach, hostels and temporary accommodation, shadowing of Peer Support Workers, group interviews, workshops and one-to-one conversations. 19 interviews took place with frontline professionals and volunteers who are working with people on a day-to-day basis, and 10 interviews/conversations were completed with people who have either current or former experience of the impact and effects of living with multiple unmet needs and disadvantage.

- **Hospital, Outpatient and Acute Settings research –** this focused on what's happening within hospitals and secondary care, be that A&E and urgent care settings, inpatient and outpatient pathways, discharge procedures, and existing in-hospital resourcing such as the Homeless Health and Inclusion Team at Hull University Teaching Hospitals (HUTH). 21 interviews with frontline workers were completed and 13 conversations with people who have lived experience.

Qualitative research when working with hypermarginalised and under-reached communities is key. Often the more traditional types of data and fact-gathering exercises can only take us so far in the discovery of people's needs. It becomes essential to get out into the community and into the streets to meet and talk to people face-to-face who are living through multiple disadvantage on a daily basis.

That's what we did, and our findings are summarised here.

All quotations and case studies are from the real people of Hull who have ***living, lived or learnt experience*** telling us about the impact and effects of living with multiple unmet needs. Their feedback and stories have been either pseudonymised or anonymised to protect their privacy and none of the stock photographs in this report show current or former clients.

All quotes and case studies in this report come from the real people of Hull, who have living, lived or learnt experience.

Summary version

An easy-read summary table of our research for people who are living with the impact and effects of multiple unmet needs is provided from page 61.

Feedback from people with lived experience on how we have presented the 25 needs we found is positive.

The needs of people who are experiencing multiple unmet needs

During our research we have been fortunate that everyone we spoke to shared their thoughts and experiences so generously with us. From the data and insights we have been able to collect, we have considered what a more effective and holistic way of providing this information back to you might look like. To that end we have chosen to present the needs of people who are experiencing the impact and effects of multiple unmet needs, where possible, in first-person present tense.

These **'need statements'** are in parts verbatim from the voices of those with lived experience ***(e.g. "All I want is a friend")*** and other times they are in alignment with the feedback and stories we heard, using the same language and words we were given ***(e.g. "I know where to go to get my teeth seen")*** and respectfully pulled together based on those stories to allow for the messages of this report to land and hopefully resonate with readers.

The first-person need statements have been approved by people who have lived experience to ensure that they agree with them and feel that they can see themselves in them. The feedback to this presentation of the 25 needs we found has been very positive.

Finally, we have also aimed to separate out the 25 needs we identified into practical/physical or emotional etc, and also the needs which people have of others, e.g. what's needed from staff, key workers, leaders and systems. You can find this commentary later on in the **Conclusions and Recommendations** section of this report **(see page 123)**.

A brief note on 'homogeneity'

It should be remembered that people are, of course, individuals. They cannot be ascribed to one homogenous group with a set of homogenous needs. People who are experiencing multiple unmet needs are not all alike and do not like or dislike the same things. Neither do they all have the same needs or perspectives of their needs.

The idea of 'people with multiple unmet needs' is, at the end of the day, a grouping and way of categorising many numbers of individual people that we have adopted for the purpose of writing this report.

Nevertheless, during our research we were surprised at the ***high levels of consistency*** and ***similarity in themes*** that we heard across services and individuals, no matter what the presenting issue was at hand – be that homelessness, harmful drug and alcohol use, domestic abuse, removal of children, or experience of the criminal justice system.

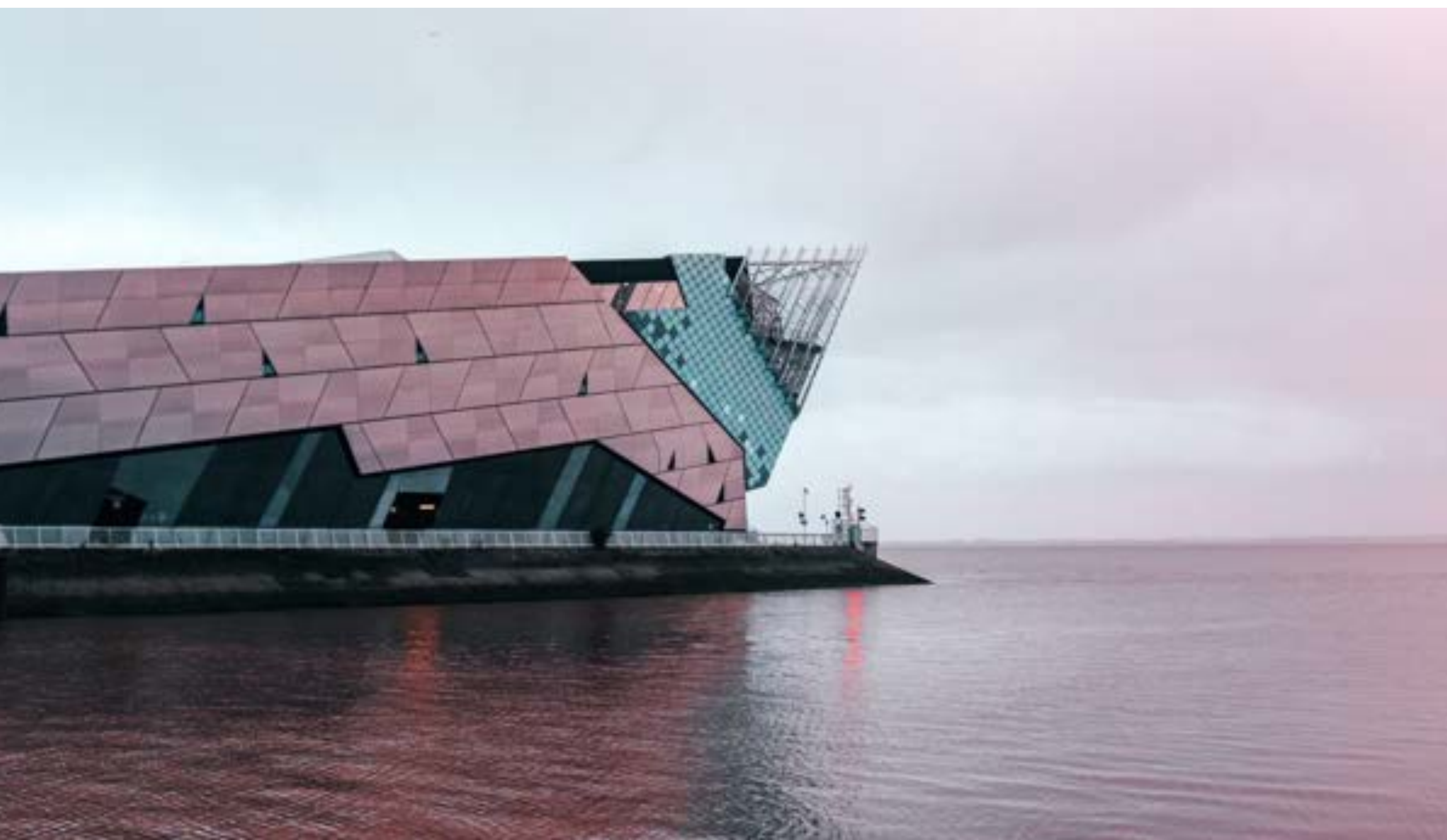
For this reason we feel confident in presenting the 25 needs as we have found them to be here and in this format.

A summary of the needs our research found in Hull:

(Please note these are not listed in any hierarchical order)

No.	Need Statement & Need Description	Research Category	See Page
1	***"Somewhere I can call home"* –** Safe and Reliable Housing	In-Community and Outreach; In-Hospital	63, 105
2	***"Someone's got my back"* –** Advocacy, 'Hand-Holding' and Floating Support	In-Community and Outreach; In-Hospital	67, 106
3	***"Somewhere I can go to at odd hours"* –** Walk-In Centres with Open Access	In-Community and Outreach; In-Hospital	68, 106
4	***"When I'm ready, support for my addiction is available"* –** Accessible Treatment for Substance Use and Dependence	In-Community and Outreach	70
5	***"Someone helps me with my bills and my benefits"* –** Long-Term Financial Support	In-Community and Outreach	74
6	***"People want to hear what I've got to say and learn from me"* –** Lived Experience Input and Co-Design is meaningfully valued by Services and Staff	In-Community and Outreach; In-Hospital	75, 107
7	***"People show me I have worth and value"* –** Confidence, Self-Worth and 'Unconditional Positive Regard'	In-Community and Outreach	77
8	***"Why has nobody told me this before?"* –** Tools, Skills and Psycho-Education	In-Community and Outreach	79
9	***"There's time and space for me to grieve"* –** Safe Spaces for Grief and Loss	In-Community and Outreach	80
10	***"All I want is a friend"* –** Loneliness and Isolation	In-Community and Outreach	81
11	***"Please give me back my dignity"* –** Authentic Dignity and Respect from Staff and Services	In-Community and Outreach; In-Hospital	83, 107
12	***"I don't have to fit in and people embrace my differences"* –** Neurodiversity, Speech, Language and Communication Styles	In-Community and Outreach	84
13	***"I know what 'Good Love' looks like"* –** Attachment, Boundaries, Trust and Trauma	In-Community and Outreach	86
14	***"I've got something to do"* –** Non-Clinical and Holistic Approaches and Interventions	In-Community and Outreach	87
15	***"I can feel safe as a woman"* –** Women's Specific Support	In-Community and Outreach	88
16	***"I can feel safe as a man"* –** Men's Specific Support	In-Community and Outreach	91
17	***"Everybody needs a Pam"* –** Trauma-Informed Key Workers and/or Single Points of Contact	In-Community and Outreach; In-Hospital	94, 109

18	***"I know where to go to get my teeth seen"* –** Dental and Physical Healthcare	In-Community and Outreach; In-Hospital	96, 111
19	***"I am shown that this isn't my fault"* –** Intergenerational Trauma, Health Inequalities and Breaking the Cycle	In-Community and Outreach	97
20	***"People understand that lasting change takes time, trust, courage and consistency"* –** Long-Term and Clear Commitment to Services, Funding and Innovation	In-Community and Outreach	100
21	***"It doesn't matter where I come from, how I got here or what language I speak"* –** EU Nationals, Migrants, Refugees, Asylum Seekers and People from Minoritised Groups	In-Community and Outreach	102
22	***"The physical pain I'm in is taken seriously"* –** Efficient, Equitable and Trauma-Informed Pain Relief and Prescribing	In-Hospital	112
23	***"I won't be discharged to the streets"* –** Options for Intermediate and Step-Down Care following Hospital Discharge	In-Hospital	113
24	***"Hospitals and staff feel safe and welcoming to me"* –** Ending Stigma and Unconscious Bias, Creating Psychologically-Informed Environments	In-Hospital	114
25	***"The people helping me aren't tired and burnt out"* –** Compassionate Workplaces and Trauma-Informed Organisational Development	In-Hospital	116



In-Community and Outreach findings:

"Somewhere I can call home" – Safe and Reliable Housing

"If we can adapt a building to accommodate a wheelchair, why can't we adapt buildings for sensory overwhelm, or trauma? What about aesthetical changes, like certain kinds of lighting, or circular, rounded doors?" **– VCSE Frontline Worker**

People with multiple unmet needs have a most urgent need of safe and secure accommodation – or as one social worker called it: "your own front door."

A ***tiered living system*** was suggested by clients currently living in hostels or in their own flats/houses, where they made the case for different types of housing for people who are on a spectrum of independent living. In this model the move onto independent living is a more staggered and gradual process:

"It needs a staged process, with different options going along. The first stage is getting settled in, at the hostel or supported housing. The second stage is those who want to move on with their life. The third stage is independent living but still with support, and if you get on with it, you're put on a list for housing." **– A formerly homeless man now living independently.**

"If we can adapt a building to accommodate a wheelchair, why can't we adapt buildings for sensory overwhelm, or trauma?"
– VCSE Frontline Worker

People need somewhere to base themselves and the opportunity to rebuild their lives. This can only be done when some level of stability has been found, which comes with the right type of accommodation. This "won't be a house and living alone for everybody." For some people it will be house-sharing or having a housemate, for others it will be remaining in a hostel which offers a more ***'sheltered-living' approach*** similar to that which is available for over-55s. Alternative housing models of this sort might be explored and piloted for people who are unable to for whatever reason or do not wish to live alone and manage their own housing. This may mean it is a slightly more residential-style of housing with additional hands-on support from staff and open-ended stays for residents, which was felt to be preferable.

There is a particular need for housing across the city of a type that can also be "personalised" and feel more like a proper home, where clients can "explore" their identity, take part in "home-making" activities to put their stamp on a place, and finally have the space, time and privacy to grieve and process the experiences they have been through:

"What does it mean to have a home? Most people I speak to say privacy and calm." **– A Frontline Worker**

Safe and reliable housing means having a place to settle, the chance to build a sense of connection to the community around you, and a place to call "home." It also means rest and relaxation becomes accessible, as people can begin to move out of "survival mode" and their nervous system can begin to calm. Staff told us that moving out of survival mode means a person starts to feel more emotionally resourced meaning they can start to look at other parts of their lives and begin the healing process. This can't happen when someone is stuck in survival mode:

"How do you build a sense of self when you're in survival mode? Your body is just trying to keep you alive, it's just firing cortisol. You can't process your trauma when you're in it, they've had no processing time. We are trying to fix people while they're in the thick of it, and it can't be done. Why are we expecting people to do stuff when they are in the thick of it?" **– Hull York Medical School colleague**

Our research told us that good housing means physical and mental safety, privacy, and permission to be who you are. The need for a safe and reliable home links directly with ongoing floating support in order to be able to maintain housing and the financial responsibilities that come with this (covered in the next section).

It was noted that a model of sheltered and supported accommodation also enables an atmosphere of "peer support" to grow up between residents, with a sense of "we're all in this together" able to form between them, which was evident within The Crossings hostel and valued by the residents we spoke to:

- *"We're like a team here, there is a good crowd here. I'm finding people here are more honest than my friends and family."*
- *"We have a fridge and microwave in our rooms, rooms are in clusters of 5 and we share a kitchen area."*
- *"We live here together so there is a level of peer support happening between us."*

It was noted that flats available through the Rough Sleepers Initiative come fully-furnished and that this is very helpful for clients, indeed it is felt to be best practice

by staff we spoke to as people often come from the streets and temporary accommodation with nothing to their names.

Our research findings also emphasised that everyone is at different stages of recovery and the types of accommodation available should reflect this. People who are in treatment for drug and alcohol use may not wish to be living in close proximity with those who are still using, and vice versa. We were asked that consideration to a "wet house" is given by commissioners and funders in Hull.

Clients noted it can be hard living in hostels where there is the presence of drugs, often accompanied by bullying and intimidation: *"People know your pay days and will come and knock on your door and stand outside your room. Everyone knows when paydays are. You just have to ignore them."* Some people observed that prisons have drug-free wings and this is seen as a positive as it offers the environment for safe and sustainable recovery.

Additional Key Feedback:

"All problems aren't solved when you get a house or a flat, sometimes it can be the start of problems. Bills can get bigger and bigger." ***– Peer Support Worker***

"I just want to move on to sheltered accommodation." **– A Hostel Resident**

"A woman we know, she comes out of prison, she's clean, she doesn't want to be in that hostel with people she knew. So she went back to her violent partner, it's been downhill since then." ***– VCSE Frontline Worker***

"What do you expect when you put 50 people together with drugs and alcohol?" – **A Hostel Resident**

"For everyone, [that hope] isn't a house. Some people can't live independently, they can't manage in a 1-bed flat. But society says 'why aren't you happy with that?' But it's not for everyone. Some people have been brought up in care their whole life, they just need places they can live, supported beds. So they can stay and settle and be happy and feel secure. That's basically what we are at the hostel, like the care homes they grew up in." ***– A Hostel Support Worker***

"We need like sheltered housing for the over-55s, but for the most vulnerable, it would stop the revolving doors. At the moment it's disheartening for staff too, it's like groundhog dog every day. We are trying to get a 1-bed flat, but they're already in arrears with the Council, or with their gas and electric. So they're setting up payment plans. It's just groundhog day. Our residents can't cope with all that. We are channelling people to fail." **– Specialist Support Worker**

"Accommodation is the biggest problem, there has to be accommodation in place, including flow-through. We have hostels and temporary accommodation, we need something where they're ready to move on from hostels. People are staying in SMD because there's no flow-out, they are in places surrounded by others in SMD, it makes recovery more difficult." ***– A Manager of Services***

"Big units will work for some people, it's not about a one size fits all though. More stuff is needed that is women-only in the city. More diverse types of housing like "pods" for the cold nights, where they can take their pet, because their pet is family. Something better than a shipping container, so society can keep people safe. Better than a cardboard box, and they can lock it up, leave their belongings there, basic

practical things like this are needed because they carry their life on their back." **– A Frontline Worker**

"No one is ready to work on their mental health or substance use if they've got no home or they're looking for somewhere to sleep every night. They're doing the basics just to survive day to day." ***– A Probation Services Worker***

"People who've changed their lives around are those who've had a safe, secure house. The in-and-out person hasn't had that."

– VCSE Support Worker

"It took him 3-4 times to come to Russell Street to see it before he agreed to stay. It was a slow process but now he loves it there. Everything is there, under one roof, all the services. It's the small wins that matter, the fact we've got him into the hostel, he's enjoying it, that's a tick. It's small steps. Why does he like it there? We've never asked him, but with bigger mainstream hostels there can be too many people around, it's noisy, a bit like prison, lots of people. He was against hostels before. I don't think it's because of the meals at Russell Street, but they do get meals cooked for them. The ratio of staff to residents is smaller, so they can get to know them better, spend more time building trust. There's usually a high turnover of staff at the bigger hostels. Russell Street is a 12-bed unit, key workers are more accessible. They still say it's noisy, but it doesn't feel as busy." **– A Homeless Support Worker**

"Someone's got my back" – Advocacy, 'Hand-Holding' and Floating Support

"I know this time it's my time, because I've got more support around me, help to set up my bills, to know what money I've got in the bank." **– A Client**

The ongoing provision of floating support and advocacy is a key need for people with multiple unmet needs. It was noted this may feel like "hand-holding" by key workers and staff, which gradually drops away over time and only when the client is ready. Removing the time-limitedness of this provision might be considered.

Floating support and metaphorical "hand-holding" is a need for people because we were told it can help them to ***maintain their housing, transition to new housing, manage their money and bills, and get to their appointments.***

With such high levels of trauma in their backgrounds, and often still in their day-to-day lives too, people may not have the same level of "life skills" that society expects. This may be compounded by difficulties around reading and writing literacy, and speech and language skills. Staff interviewed told us that neurodiversity is also becoming more prevalent in clients as awareness grows, and this can compound issues for clients who are trying to navigate complex, 'neurotypical' systems.

Our research findings demonstrated that services which are providing best practice are those which are persistent and patient in their attitudes towards clients, open-minded about the level of hands-on support needed, and those which do not give up easily on any individual:

- *"At the beginning of supporting someone, you've got to physically go and knock and pick them up. She wouldn't have left the house if we hadn't done that. Getting out the house to go there [to the appointment] is so important. Services would brand them non-engaging and discharge them. But if we don't pick them up, they won't go. You need someone in that with you. You haven't got motivation in you at that point. Getting on a bus terrifies people, at that stage of recovery."* **– VCSE Frontline Worker**
- *"If people don't turn up for appointments, we go looking for them. We are persistent."* **– Peer Support Worker**
- *"A lot of participants I spoke to admit they just don't have the skills. Mum wasn't around to show me, so I don't know how to use the washing machine to wash my clothes, etc."* **– Hull York Medical School colleague**

Time, planning and resource could be given to considering higher levels of advocacy across the city for people with unmet needs, longer term 'hand-holding' (a phrase we have kept in this report to normalise this type of vulnerability encountered in clients and workplaces), as well as ongoing, open-ended floating support, some of which may feel very holistic or "basic" in nature.

Additional Key Feedback:

"Continued floating support is what I need. I'd feel more confident about my future. I don't feel strong enough to leave the service, yes that's the word I'm looking for, I don't feel strong enough." ***– A Client***

"I picked him up with 2 bin liner bags and a small TV. It doesn't feel right to me and the team. We were able to secure grants for him through Emmaus. If it wasn't for our team he'd have none of that. We go above and beyond." **– Peer Support Worker**

"They've got no ID, no address, can't get registered with a GP, or a bank account, etc. So they will just plod along with illnesses instead, making do. Housing is a basic right but that's a mountain to climb." ***– A Probation Services Worker***

"Tenancy Sustainment Officers don't come in soon enough in a person's journey, but it's key. If it's not there then the housing shouldn't go ahead, it should be delayed, moving them should be delayed. The most important part is transition." **– NHS Frontline Worker**

"Through the support workers we have, there's an element of [advocacy] throughout what we do and the housing team, e.g. Citizens Advice, police interviews. In the main we support people in a language they understand, support with anxiety, ensuring they are hearing and understanding what is being said. When the meeting is finished, the worker can sit and have a coffee with them and go through what was said." – ***VCSE Frontline Worker***

"We need to stop mystifying it all, remove the mystifying, they keep it mystified so nobody can understand any part of the system or how to access help. You can see why people with additional needs won't engage with it. They're constantly fire-fighting, they simply haven't got the energy, to unpick it. I'm only repeating what I'm told." **– VCSE Frontline Worker**

"Somewhere I can go to at odd hours" – Walk-In Centres with Open Access

"We have no reception, no cameras, no registration process, totally open access. Even the counselling service is open access and you just turn up. Nowhere else is doing this." **– VCSE Frontline Worker**

People with multiple unmet needs need somewhere safe in the city they can go to at a time which suits them and be able to access the support they need there.

We were told that a 'Walk-In Centre' could provide co-location for services, a friendly face for people living on the streets, somewhere to keep warm and get food, emergency beds, counselling, and a host of other benefits if done right, done well and in co-design with clients.

"We need a big building where people can crash and access services," said one frontline worker, "a light building with big, open spaces."

Clients told us honestly that if such a building began to attract drug-dealers or people who are using substances, we would be able to learn from the likes of ReNew at Trafalgar House who manage similar issues. We would also be able to learn from other parts of the country which have a facility of this kind.

One client told us that he has been street homeless all over England and has seen much better support on offer in other cities:

“Hull needs improving, it’s a forgotten city, it’s more or less a third city. City of Culture was for people who had money. People born here are sat on their arse with no money. There’s not enough services to help people.

“In Sheffield and Leicester they have day centres, you can get a breakfast and lunch, it’s open all day. It helps homeless people to kill half the day, and then find somewhere to get their head down for the other half.”

Hub ideas have been tried before in Hull, most notably at The Crossings, therefore effective co-design of a walk-in centre would be required, working directly with clients and people with lived experience, to ensure such a project would be a success and offer a ***psychologically-safe*** and ***trauma-informed*** environment:

> *“Going to a day centre is a stepping stone to bettering yourself.”* ***– A Client***

Other clients were clear that they would need more convincing of the benefits and a reason to use it:

- “You’d have to vet people, like don’t put a raging crackhead in with us.”
- “Depends what it’s used for. Some people wouldn’t go ‘cause there’d be dealers there. Other people wouldn’t want to go there ‘cause there’s druggies and pissheads.”
- “Community centres are a waste of money. They just drizzle away. All centres are struggling. It would be better to split the funds up and give them to the soup kitchen.”

Key insights from staff and people:

“If soup kitchen staff were involved with the day centre, they’d know who’s using, they could help you stop dealers coming in. But you’d need to prevent others coming in like bullies, but they should still be entitled to food. If they cause trouble, they’re barred. Some places I’ve seen they have separate rooms for those who are using and those who are trying to stop.” ***– A Client***

“A day centre should have somewhere you can phone around to get your foot back on the ladder, phone housing, health, benefits, rooms with computers and help to use them.” **– A Client**

“When I was on the streets, yes I may have used it. It can’t do any harm. But it’s a bit like ReNew for me, I’ve stepped away because I see a lot of the old faces. I’m treading water, so I’ve moved away from using them [day centres].” ***– A Client***

“At the Wilson Centre you used to see a human being, now it’s all telephones and computers on the doors. Since Covid it’s never gone back to as it was. We had a deaf and homeless veteran who was told to use the telephone. One of the screening questions was ‘have you ever been abused as a child?’ and we were supposed to ask him this. We fed this back and they did change the screening questions after that.” **– NHS Frontline Worker**

“We tried to do drop-ins and it doesn’t work. So we are open access 9-5 Monday to Friday. There is a shower and washer available, food, clothes supplies…” ***– VCSE Frontline Worker***

“We had a hub here, it was meant to be a one-stop shop to see everyone in crisis, the most vulnerable ones, where they would stay for 72 hours. Get all their needs seen to, full assessment, housing, physical health, mental health. It never took off. It had great gusto at the start, on paper it was the best idea. But it never took off.” **– A Hostel Support Worker**

“When I’m ready, support for my addiction is available” – Accessible Treatment for Substance Use and Dependence

“There is support if you want it. I was injecting to my main artery. That was a turning point for me as I nearly lost my leg. It was a blessing in disguise.” **– A Hostel Resident**

People with multiple unmet needs, where harmful drug and alcohol use is present, need access to support and treatment on their own terms and in their own time.

Our research told us that recovery looks different for everybody and nobody will come to recovery until they are personally ready to try and give it their all. The people we spoke to also wanted us to know that relapse is normal and part of the healing journey, and that we need better planning and accommodation for relapse in services.

In order to make support and treatment as accessible as possible, the following ideas were offered to us by staff and clients:

- Housing and temporary accommodation which "exposes people to support";
- Lived experience input and peer mentors;
- The chance to see people at different stages of recovery, and be exposed to people at the different stages of recovery;
- Ceasing to expect people in "survival mode" to navigate services and "complex systems" or to engage in mental health work, when their focus that day is on their "next fix or finding a bed for the night."

This may mean that models of **dual diagnosis** (now becoming known as **'co-occurring conditions'**) need revisiting and perhaps combining with the advocacy, floating support and 'hand-holding' identified in this report. People strongly emphasised that it is unrealistic to expect traumatised people to navigate their own care until they are ready to do so.

Residential rehab and detox settings were favourable to the clients we spoke to, and many were honest and said that going to prison offered them a chance to get clean.

People told us that treatment and support should be open-access and less reliant on people keeping to appointment times, should be trauma-informed, and staff should be supported with morale and compassion fatigue where there are high levels of relapse or client deaths present.

Additional Key Feedback...

"We have one woman who is a tenant and she only comes in when she needs something. She drinks and is in an abusive relationship. We're not sure she can see a way out, it's entrenched for her. When she sees her problem has been dealt with she goes back to her life. We're there if she needs us, we try to talk to her about coming onto courses and our other activities, so she can meet other women at different stages of their journeys." **– VCSE Support Worker**

"Hostels don't accommodate for drug and alcohol use, they just get evicted, they're not getting specialist support. And people not using don't want to be in that environment with people who are using. We need hostel accommodation that exposes people to support." **– VCSE Frontline Worker**

*"By adulthood they're often an entrenched drug or alcohol user, I don't think mental health catches up with them till later, and more stuff starts coming out. They rarely talk about their pasts, but they're doing it [substance use] to try to forget. A lot see prison as rehab, because they've no access to drugs or alcohol there. They say they're turning their life around, but within 24 hours of being out they've disappeared…." **– A Probation Services Worker***

"When I get ill, I drop out of services. It's as simple as that." **– A Client**

*"A lot of people don't want to see the other side of society, like when they drive past here. But we know we are bottom of the rung. We don't hide what we are. The dog-walkers are nicer, they say hello to us." **– A Hostel Resident***

"I had false confidence before, going to places under the influence constantly. It numbs you, you don't have any nerves. It's a form of self-medicating. It wasn't about chasing a high for me, I was self-medicating. I have ADHD and drinking helped me to self-medicate. I used to have bad tics too, problems with Bs and Fs in words….and I wonder if I have Tourette's too." **– A Client**

*"ReNew groups are good, I go every Friday." **– A Hostel Resident***

"It's me got myself into this mess so it's me got to get myself out of it. I came off the meth on my own back." **– A Client**

*"It's got to come from the person, they've got to personally make the decision to change, to stop….It's self-revelation, epiphany, whatever. You've got to realise you've hit rock bottom." **– A Hostel Resident***

"When I get ill, I drop out of services. It's as simple as that."

Case Study: Peter's Story

Peter is in his 50s, lives in Hull, and has spent time living on the streets all over the UK as well as some time in prison.

He has battled with addiction issues including drugs and alcohol in the past. He is in recovery and has learned a great deal from his experiences which he is happy to share with others in case it can help them. He is looking forward to beginning trauma therapy soon with a psychologist and is keen to share his life story with others.

In particular he would like to share his story so that it is better understood within his own family, addressing the intergenerational trauma he sees at play:

Peter enjoys getting out for a coffee with his peer support worker.

Peter's Story (continued)

"I'd like to tell my story, write a book. I've been in and out of jail, had a bad time growing up. I'd like to get it off my chest and help other people. And so my children can find out why they're turned out as they have.

"I was sleeping on the streets, so I couldn't take my kids out. Social workers didn't send me photos or keep me up to date as they said they would… My son is in prison now, he's 19 and I've been supporting him…

"My son's grown up the way I've grown up. Mum's shouting, swearing at him. I remember seeing him when he was small and all I could see was me at his age. He was shaking. I told her to stop yelling at him, he's just a child."

Peter has found it easier to open up to women and female staff, due to the abuse and neglect he has experienced from other men throughout his life: "I'd like to be a good role model hopefully to my son. I didn't trust men 'cos they either beat me or tampered with me.

"When I was seven years old, my dad's mates taught me how to headbutt, and I'd go out fighting when I didn't want to…

"I find it easier to talk to women than men, 'cos of trauma with men in my life, it's easier to relax around women and be open."

Peter is up front about his prison time and what got him to those places in the past:

"For me committing crime was to survive. My mates would shoplift and I would sell it for them. Then I had to do it myself, getting by and surviving."

Peter has suffered with bad anxiety and this has affected his leaving the house sometimes, for fear of running into people he used to know from drug networks, but he is doing much better now with the support of key workers and his peer support worker. He last had a property in 2002 and is currently living in his own bungalow, which he is slowly personalising to make it feel like home.

He enjoys getting out for a coffee and shopping with his peer support worker, and spending time with his best friend who has been through similar experiences as him.

"Someone helps me with my bills and my benefits" – Long-Term Financial Support

"You shouldn't have to be somewhere at lunchtime to get seen. Their day may begin later in the afternoon, they might have been up most of the night, or the medication they're on might make them tired and affect their sleep." **– VCSE Frontline Worker**

People with multiple unmet needs need support with finances, money-management, budgeting, online banking, paying their bills, and keeping up with their post.

We have separated this out from *"Someone's got my back"* – **Advocacy, 'Hand-Holding' and Floating Support** because it is such a specific need around finances and benefits, particularly Universal Credit, rent and tenancy charges.

The right support is needed at the right time from the right service. Sometimes this support will need to be much more personalised, with more flexible access points and opening times, such as we've already discussed.

We were told that no assumptions should be made by staff and services around people's literacy and reading comprehension skills, including the ability to use computers or smart phones to manage online banking or correspondence with agencies such as Universal Credit. Financial Support should consider this and the increased support time that some clients might need to keep on top of their mail, their welfare benefits and their bills.

"It's still 'one strike and you're out' – I appreciate the pressure on waiting lists but when dealing with SMD it's not really giving equality of opportunity. Medication may make them drowsy – is that their fault?"
– VCSE Frontline Worker

Additional Key Feedback:

"The women we house and work with, practical things such as if they don't open their post, so they don't realise their housing benefit has been cancelled or they have sanctions, and so they risk losing their tenancy. Also depending on whether there is domestic violence present, they may not have managed their finances before. It all has a knock-on effect." ***– VCSE Support Worker***

"Not being able to get access in a way which works for them, like to a GP, it's not realistic for people experiencing SMD to use those routes. So they don't end up in hospital until they're critical which then costs more and uses more resource. A pod approach might work or the Health Inclusion buses which East Riding uses." **– A Support Worker**

"It can come down to making it to that appointment and clicking with that support worker, and not having to wait for that support. People are struggling and need that support now, even something as simple as applying for a small grant to buy a microwave or a fridge." ***– A Social Worker***

"People want to hear what I've got to say and learn from me" – Lived Experience Input and Co-Design is meaningfully valued by services and staff

"We need more people with lived experience working in the system, it has an impact, there's not enough of it. But the value placed on them is not good enough, it's outrageous and they're paid the lowest. We can't say we value that experience and not value it financially." **– NHS Psychologist**

People with multiple unmet needs need to be able to see themselves reflected back in the services and pathways they are accessing. These should be designed with the needs and voices in mind of the clients who will use them, and staff reminded us that there should be an ethical valuing and honouring of this across the system i.e. suitable financial recompense.

This might require a rethink and a repositioning of lived experience leadership and co-design as priorities across services and systems. Presently, people told us that there remains a "tokenistic" approach.

This might mean staff and professionals begin to see people with multiple unmet needs as being the experts in their own care and as the patient who knows best, instead of only being seen as a voiceless 'receiver-of-care' by default.

Throughout our research people have taught and showed us what they need, and this could be replicated across the design of services and pathways, and in the making of clinical decisions. One frontline executive said it could even be reflected in the way we commission, make funding and contracting decisions, and appoint staff to key roles and positions – particularly influential posts such as trustees, chief executives and non-executive directors. They told us that lived experience should be present.

Additional Key Feedback:

"Corporate staff and councillors are clueless, they have no idea. It's like trying to describe an elephant to a blind person. But the staff here are fantastic [at the Crossings]." ***– A Hostel Resident***

"25% of staff here have lived experience of domestic abuse, or learning difficulty, or mental health. And all of our volunteers have some kind of lived experience. We do this part well, but we don't necessarily tell our service users about it." **– A VCSE Frontline Worker**

"It doesn't matter if staff don't have lived experience, so long as they have had the training courses they need to do their job and be experts in it. We need compassion, understanding, empathy, no judgement, all those things that sound fluffy." ***– A Client***

"We need patient voice in the process. They need to be included in decisions about them.
My client was so distressed today because he felt all of this stuff had been decided without him."
– Hostel Social Worker

“People show me I have worth and value” – Confidence, Self-Worth and ‘Unconditional Positive Regard’

“It’s about being trusted and believed. People have said ‘thank you for believing me.’ This is their building. This is their space. We are only ever as good as our most vulnerable service user feels.”
– VCSE Frontline Worker

People with multiple unmet needs have a need to receive the worth and value that they may not have received as children or in their formative years, and later as adults. They also have a need for this to be modelled to them by services and staff, until they can develop the skills to also view themselves this way and embody it in their daily lives.

Learning confidence skills and learning about self-worth and self-esteem were themes throughout our time spent with clients and staff. At times in our research, lack of confidence and self-worth appeared to be exacerbating people’s experiences of harmful drug and alcohol use, dangerous situations such as street sex working and homelessness, domestic abuse, poor mental health and law-breaking.

For many people they have never received safe and secure, loving and caring attitudes mirrored back to them by adults at any time in their lives, and they may be stuck in patterns and relationships that – no matter what they do – keep confirming to them that they are deeply worthless and unloveable. It was noted that this is a vicious cycle that we should consider working to interrupt if we wish to see meaningful and positive changes in our clients.

‘Unconditional positive regard’ is a therapeutic concept coined by Carl Rogers, founder of person-centred and humanistic psychotherapy, and suggested to us by staff during our research. It means that we practise always seeing a person as “worthwhile” during our interactions with them. We put aside our personal opinions and judgements of a person and accept them as they are in that moment we find them, without any labels of good or bad. By accepting an individual as they are, instead of judging them by their actions, this encourages the individual to accept and value themselves: “we believe in them until they believe in themselves.”

‘Unconditional positive regard’ is a concept that might be integrated into trauma-informed settings across Hull with training and input from Experts-by-Experience.

“People are just as wonderful as sunsets if you let them be. When I look at a sunset, I don’t find myself saying, “Soften the orange a bit on the right hand corner.” I don’t try to control a sunset. I watch with awe as it unfolds.”

– Carl Rogers, in his book ‘Ways of Being’[11]

It is worth noting that where staff do not feel their own self-worth confidently or have good self-esteem, they may feel unable to provide this in turn to their clients. This might be normalised so that staff feel able to talk about it and it might be given open-minded consideration in workplace organisational development, staff appraisals and workforce training. However, more research might be needed to understand how a collective ‘ethos’ of unconditional positive regard towards clients may affect staff personally or the delivery of care.

[11] Jacobson, Sheri, Dr (2023)

Additional Key Feedback:

"We deliver Confidence and Self-Esteem work as separate groups, funded by DWP. This includes cooking, picnics in the parks, a trip to The Deep, crochet, it's a variety of things because we know something won't work for everyone." **– VCSE Frontline Worker**

"Don't expect them to control their emotions. This is a tough one, obviously professionals shouldn't feel afraid at work, but it often doesn't need to reach that point, if we have more awareness of how traumatised people may present. Just saying sorry can help such as: 'I'm sorry you've come all this way across town and your appointment isn't until tomorrow.' That sort of thing." **– A Frontline Worker**

"It's about doing what you say you'll do, being where you say you are. It shows the person they matter, they're important." ***– A Support Worker***

"They have got a sense of self and identity, we assume they don't. It's about finding what it is." **– A Frontline Worker**

"A turning point is things like getting a job, stuff that makes you feel valued. Having ownership, having a sense of safety, housing, or people who care about you, staff you feel connected to. Staff who are taking time to get to know you." ***– A Support Worker***

"I'm going out more to them. It's not about expecting them to show up for appointments. I see high risk ones on the street, I ask other services 'have you seen them' and we work collaboratively this way. I go to the hostel or where they're staying, I come back later if they're not there. It might mean early mornings and evenings, but I enjoy it, I get to see their lives. I see them at least weekly and have built good relationships, which leads to increased compliance. This reduces recall breaches. You get more out of them if you go to them, they feel we are making more of an effort and they comment on that. They might say 'you've took time out to come and see me' and its less formal too. It really works to go to them, building trust, it's all about relationship building." **– A Probation Services Worker**

"You can tell if you're welcome or not. We can read rooms well, we can tell if someone is being snotty. It kept us alive. Reading people kept us alive." ***– A Client***

"We believe in them until they believe in themselves."
– VCSE Support Worker

"Why has nobody told me this before?" – Tools, Skills and Psycho-Education

"I was teaching a client about fight/flight/freeze/submit etc. She said 'why has no one told me about this before?' It's about taking the time to truly explain it to them, not making assumptions of what people know. Also, just telling people 'you're not mad' and 'that's a normal human response to what you're going through' is helpful. Reinforcing that it's not their fault. Having time to identify what that person needs to hear." **– NHS Psychologist**

People with multiple unmet needs want to be the "cycle-breaker" in their generation of trauma if they are given the opportunities to learn how to do this and what it means. Clients told us numerous times that they need the skills to know how to deal with panic and anxiety, and how to cope when difficult memories or reactions arise during their healing journeys.

More ***empowerment and upskilling*** is required to meet this need, with "basic skills and tips" for coping with panic attacks and low moods, to more thorough "psycho-education" around trauma responses and the role of the Autonomic Nervous System. It was noted that instead of withholding this information from clients until they reach the top of an NHS waiting list, find an affordable therapist, or are assigned a trauma-informed social worker, ways could be sought to make it available now or sooner.

Additional Key Feedback:

"We do ACEs training and awareness sessions. The feedback we've got is very good. It's been a breakthrough. The main things we hear are 'For the first time I realise it's not my fault' and also 'I want the future of my children to be different. Now I understand why I am the way I am, I want to make the steps to change.' They want to become the cycle breaker." **– VCSE Frontline Worker**

"It feels shit to be on a waiting list." **– A Client**

"Tips and pointers help. 5-6 months ago I was a different person to what I am now. I've built good rapport with the staff here, with the mental health team." **– A Hostel Resident**

"Sometimes my inner safety tells me I need to leave. We haven't been given the skills and tools yet to deal with that, things like panic attacks. Work with a therapist would help us to have the tools and skills." **– A Client**

"Groups we run are about how they're coping and managing, not about their addictions. It really works, and a lot of the power is being in that group setting." **– VCSE Support Worker**

"Being able to tell their story in their words seems effective. But it takes a long time to get to that stage. Having a voice, it helps you think about it a bit differently, making sense of it. Nobody's ever listened to them, or believed them." **– NHS Psychologist**

“There’s time and space for me to grieve” – Safe Spaces for Grief and Loss (Therapy, Counselling, etc)

“Everyone needs time, space, and resources to figure out who you are and what matters.” **– A Frontline Worker**

People with multiple unmet needs need access to long-term and specific types of mental health support, be that grief and loss counselling or working with a trauma therapist.

When people have transitioned from a “daily survival mode” to having more time to “process” and be with their thoughts, memories and experiences, naturally grief and sadness begin to arise. People need spaces to explore this and receive support and feedback from trained, trauma-informed professionals such as mental health social workers, counsellors and psychologists.

Our research found that ***grief and bereavement are particularly overlooked***, with the majority of people experiencing multiple losses in their lives and this being relatively uncatered for by services and, at times, unrecognised by staff as a key need.

Much of the trauma people have been through is related to loss of some kind. This does not have to mean death (though we found most clients have been around death and serious injury in their lives) but can also mean ***the removal of children, loss of relationship, or loss of lifestyle*** – such as having once been a working person, or having been married, or owning a stable home.

Support with the grief and bereavement of having children removed into care was found to be a particular gap, for both men and women, and the impact not fully acknowledged by services.

Additional Key Feedback:

“You’re down on your luck and on your arse, you get yourself away from people but you’re on your own and you start to process stuff. It keeps going round and round your head, ‘cos you’ve got time on your own.” **– A Client**

“I came here as a hermit, self-harming, stayed in my room. I had support sessions with staff and the mental health team, it all helped. I’m more sociable with residents now, there’s a few like minds, a few bookworms like me. I like to read, a lot of crime thrillers, and I play chess at the Central Library sometimes.” **– A Hostel Resident**

“A lot of people just want to make sense of their own story.” **– A Support Worker**

“There is a pattern between offending and having your kids taken away, it’s well researched. There is a lack of support for women who’ve experienced this – there is labelling and judgement from services, there is no support with bereavement of having lost that child. Many women lose their reason to get up in the morning because the routine has been taken away that they had with their child, like getting ready for school.”

– VCSE Frontline Worker

“We need long term trauma work, everything else is sticking plasters. The deep, underlying reasons people are there in the first place. Reverse the trauma side of it, put you somewhere safe, and bring the addiction down. Trauma gets you there, addiction keeps you there.” ***– A Manager of Services***

“Much of the things people are stuck in is trauma. We have to be careful, we need specific trauma therapy for women and in our case female workers too. This has to be taken into account. It’s the basic standards, not the rocket science stuff.” **– VCSE Support Worker**

“They need the opportunity to reflect, to understand themselves as a product of their limiting experiences, what they’ve gone through etc. ‘It’s not their fault’ – and basic time to think about what’s happened to them. There’s a lot of shame. Compassionate Mind work is good, teaching self-compassion. The ideas people have around compassion means, even in the NHS, the word is often met with resistance or disgust, a “gross-out” feeling – we ignore compassion towards ourselves – so really learning what this is, and modelling it for clients.” ***– An NHS Psychologist***

“All I want is a friend” – Loneliness and Isolation

“A service user said to me ‘all I want is a friend’ so I said to them, ‘OK, for the time we are working together we are friends.’ We later got him an autism diagnosis and support for that. Now he’s going to an autism group and making friends there.” **– A Peer Support Worker**

People with multiple unmet needs experience high levels of loneliness and isolation, in particular when they begin a healing journey and begin to distance themselves from former social networks which may have been centred around drug and alcohol use, breaking the law, or spending time with abusive partners or abusive friendships based on exploitation.

When people are going through detox or rehabilitation, we were told that it can undo their steady progress to be around friends and familiar faces who were a part of their former lifestyles. That said, because of the loss of these friendships and social networks, and the need to create a healthy distance, ***people become lonely and isolated***. They may spend more time home alone. They may not see anyone during the week except their social worker or their probation officer. They may be afraid of making or trusting friends due to the way they’ve been mistreated by people in the past.

Our research informed us that loneliness and isolation is a top need and ***contributes to rates of relapse and eviction.*** Seeing familiar faces may drag a person back to using substances, or sheer loneliness in a new house/flat may tempt people to invite old friends and partners to live with them, leading them back into abusive relationships or to becoming what is called “cuckooed.” More chances, encouragement and opportunities to break this pattern are felt to be urgently needed.

Loneliness and isolation are commonly seen as issues facing older people and those who have experienced loss and bereavement. But these are universal issues facing many people during their lives and are particularly prominent for people with multiple unmet needs.

Additional Key Feedback:

“When you stop using you end up more alone. I spend most of my time on my own. You’ve got to take yourself away from it. I do feel lonely. I’m at a loose end Monday, Tuesday, Wednesday until my appointments and groups on Thursdays and Fridays. So I might take myself for a walk.” ***– A Hostel Resident***

“I’ve been on and off meth for 10 years. It can be tricky to see old faces from the street, ‘cos they might still be using, they might drag you back in.” **– A Client**

"They don't like seeing you do well, they want to tempt you back to drugs." ***– A Client***

"It's lonely. Every age group is isolated. Loneliness is a big cause for heavy drinking, for drug addiction etc. A hell of a lot of it is isolation. We used to pull each other up. There's a lack of community, if nobody knows you're using. We used to walk each other down the line, you don't have the threat of eyes on you like family, friends, neighbours, even police. The most place you get community now is the pub or the church, what does that say?" **– A Volunteer**

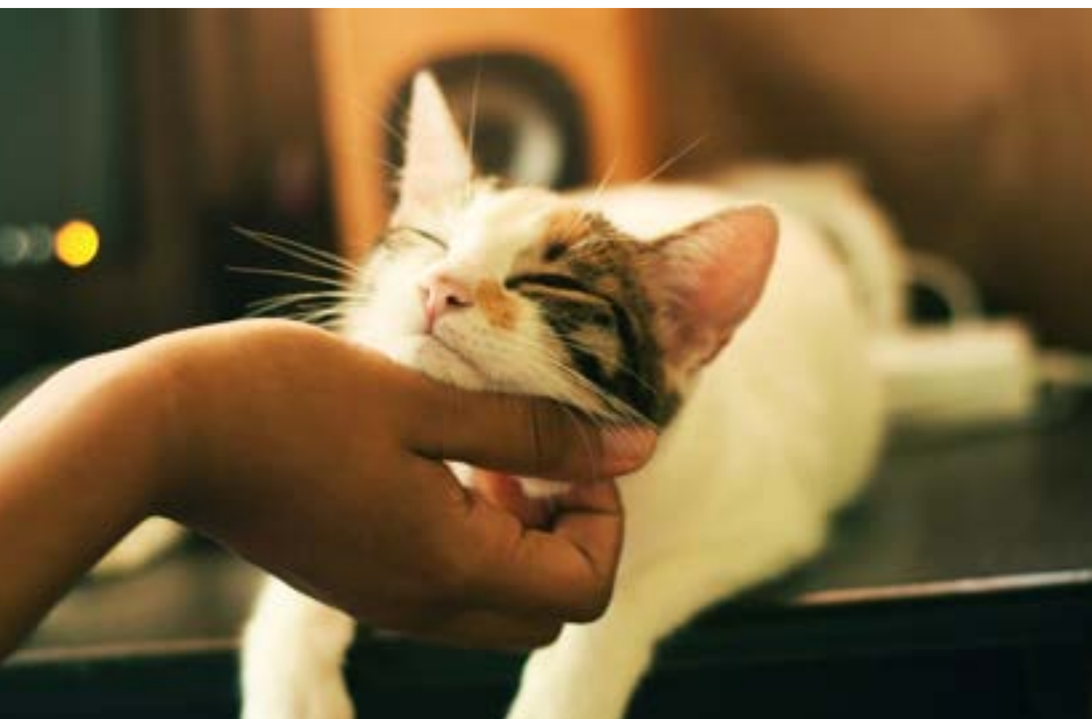
"If you take someone out of their community, put them in a house, they don't have any community. Being homeless you have a lot going on around you all the time." ***– A Frontline Worker***

"Social anxiety is big amongst the people I work with, they're the least likely to go to group activities but find the biggest benefit when they do, so working to reduce exclusion and anxiety is key." **– A Mental Health Social Worker**

"Seeing people who are not 'us' helps – engaging with the Vulcan Centre, boxing, bike maintenance, it gives confidence and a sense of belonging. Relationships, forming new ones, finding someone who is accepting and supportive of them. Someone interested in spending their time with them. Having human connection and a sense of worth, through volunteering, gaining skills, employment, an occupation." ***– Forensic Support Worker***

"Community and belonging, these are overlooked needs. These folk are the edges of society, we need community inclusion, be part of a community, this could be anything – caring for animals, dog-walking for rescue centres, walking with alpacas, art groups, theatre places, cinema, Barista training in Costa for work experience, bowling, bringing insects and tarantulas in to hold, African drumming, anything that says 'Life is beyond what you've got at the moment.' A reason to get out of bed on a Thursday. Make people feel like a human being again. I've taken clients out on days out, they're like giddy kids on a school trip."

– A Manager of Services



"Please give me back my dignity" – Authentic Dignity and Respect from Staff and Services

"We had a staff member here who was a former beautician, she'd do their nails or do their hair. It really boosted the girls. I remember one of them left saying 'I don't look homeless tonight.' They don't have self-esteem about anything. As soon as they set foot outside the door they know the world is against them." **– A Hostel Support Worker**

People with multiple unmet needs need staff and services to respond to them with authentic dignity and respect, in a similar vein to the emphasis that is put on maintaining a person's dignity in nursing, residential and care settings.

Our research told us that giving people dignity and respect will increase levels of trust between clients and professionals, and can transform the way that professionals view their clients. By centering dignity and respect in a care plan, an action plan, a GP appointment or a patient formulation it can inform the ethos of the service or pathway and can lead to improved client outcomes. We were told by staff that it encourages a more holistic and positive view of a person and helps to ***overcome unconscious bias and stigma*** found in services and systems.

Many of the people facing multiple disadvantages in their lives have not been afforded the dignity and respect that might have altered the course of their lives. Many people have faced stigma, discrimination and bias, including from health and care professionals. This does link to our earlier section *"People show me I have worth and value"* **– Confidence, Self-Worth and 'Unconditional Positive Regard'** but dignity and respect specifically came through our research as an area that would benefit from increased attention, awareness or exploration.

The staff we met who are delivering effective care and interventions across Hull shared a common philosophy of offering their clients the utmost dignity and respect throughout their interactions together, and they recognised that this is how they were different to other services.

Additional Key Feedback:

"Why shouldn't people have something in their life that makes them feel good, like a TV, pets, etc. We look down on these things as choices and judge them for making them, but they make them feel better, making the most of a bad situation." ***– A Frontline Worker***

"Take time to find out what people like and enjoy doing, where did people feel at their best, what was involved in that, who was involved in that? Taking time to explore what's important to people, get to know them, not basing things on 1-hour or 1.5-hour appointments. Asking the pink, woolly questions, because they matter, it's where you get the information, the narrative of a person, who that person is." **– A Mental Health Social Worker**

"We need less people sitting around talking about things at meetings, and more things been actually done. Sometimes I raise a service user at a meeting with 35 people there and everyone looks back at you blankly. You're hanging out their dirty washing and then nothing's been done. We're invited to meetings and then nothing's done, it feels like they've lost sight of what it's there for. I'm not sure how its happened, how its got lost or tokenistic." ***– VCSE Frontline Worker***

"It's about belonging and ownership. Make a space feel like yours, even something like a shoe-rack helps, because then your shoes have somewhere to belong, a home. This is about objects as identity, identity-making and home-making." **– A Frontline Worker**

"Over a cup of coffee, I found out so much about him that his worker doesn't know, his goals and aspirations, his history of abuse. That cup of coffee was a valuable intervention. Human nature is missing in our work. When he asked me if I was buying him a coffee out of my own pocket, or out of my work expenses, he was really asking me 'are you valuing me?'" **– A Manager of Services**

“They feel that staff in GP surgeries automatically treat them like lesser people. So it helps if services come to us at the hostel.”

– Hostel Support Worker

“The people who make decisions, there’s a misperception of their own citizens in Hull. Most of the City Council directors have never visited us. None of them live in Hull, they live in the outer villages, which we used to call the Scampi Belt back in the day, because there was a time when scampi was seen as posh. There’s a detachment. It’s not lack of will or compassion, but there’s a detachment. I walk to and from my work everyday, in the city centre, I pass through some rundown neighbourhoods… We are presiding over a widening gap, that at some point the leaders and councillors are going to start making decisions that don’t serve anyone.” **– VCSE Frontline Worker**

“I don’t have to fit in and people embrace my differences” – Neurodiversity, Speech, Language and Communication Styles

“We need to get out of these narrow frameworks about how we approach life, and how people are expected to fit in. The whole way we are structured. These are big philosophical questions about how we’re living as a society.” **– A Frontline Worker with Lived Experience**

People with multiple unmet needs are believed to have higher levels of neurodivergence that is in many instances undiagnosed or misdiagnosed, such as ADHD/ADD, Autism and Tourette Syndrome. However, although the majority of staff we spoke to agreed with and cited this, it remains an under-developed and under-researched area. It may also be that far fewer people are recognising their neurodiversity than we’d expect to see, as we saw in the quantitative data from **ReNew’s substance treatment service** on **page 50.**

Staff told us that neurodivergence is often misinterpreted by health and care services as mental ill health and it was felt this can lead to breakdowns in communication, loss of trust between client and professional, or even arrest, discharge or eviction. The symptoms, for example, of an “autistic burnout mimic those of Bipolar Disorder” and various Personality Disorders. People interviewed felt that more training and education is needed around neurodivergence and its presentation in the lives of people with unmet needs and histories of trauma.

Additionally, there arose a potential gap for greater attention afforded to the understanding of ***different and diverse communication styles*** and making safe space for these in services, as well as recognising the links between neurodivergence, speech, language and literacy.

No provision is formally made for the diversity of communication styles that people have and the uniqueness of how these may present in clients, despite Hull’s higher rates of lower literacy.

Rather than understanding an individual as someone with their own unique way of communicating, which may be related to trauma, and which may or may not be linked to a disability or to neurodivergence, staff noted that we are often labelling people as “aggressive,” “difficult,” “chaotic” or “complex.”

Our research suggested that people would benefit from their differences and diversity being embraced as positives, for staff to be "professionally curious" about their clients' unique needs or style of communicating (even if they are not aware of these themselves or in receipt of a clinical diagnosis) and for services to create more spaciousness and radical acceptance for this to play itself out without unconscious bias or unintended discrimination coming into the picture.

This is a topic which would benefit from further, targeted research with the input of Experts-by-Experience and specialist workers in neurodiversity, speech/language and health inclusion.

Additional Key Feedback:

"Autistic burnouts are happening relentlessly, it's not bipolar or mental health, it's a misdiagnosis. When it was eventually picked up and they got the right help or meds, it did help things improve." ***– A Frontline Worker***

"One of my clients had a diagnosis of schizophrenia for years, but it was eventually changed to an autism diagnosis." **– A Frontline Worker**

"We are coming across more women diagnosed with autism in our services. More people are being referred in for assessment, there is a shortage of funding and staff at the NHS to do the assessments." ***– VCSE Frontline Worker***

"Other services, they say to us 'get them to ring us' about our service users, they totally miss the point, they won't even have a phone." **– VCSE Frontline Worker**

"The system puts too much pressure on people in this situation. They can't manage anymore, they stop opening their mail, stop paying their bills, they're having to think about that stress everyday, so they just give up." ***– VCSE Support Worker***

"There is an issue with online provision. Some mental health services or appointments are still online, but service users can't afford the data or phone contracts for that, doing Zoom or video calls." **– VCSE Support Worker**

"I know what 'Good Love' looks like" – Attachment, Boundaries, Trust and Trauma

"I'm often asked by visitors 'what is the one thing that young people need?' I say love, but we don't give them love here. We give them unconditional positive regard, support, nurturance. Then they can tell the difference between what's good love and what's bad love."

– VCSE Frontline Worker

People with multiple unmet needs have a need for the presence of at least ***"one safe adult"*** who is reliable, consistent and who can model "secure attachment" and "healthy boundaries."

Our research taught us that the majority of people experiencing the impact and effects of multiple disadvantage have experienced high levels of ***adverse childhood experiences*** and have a history of complex trauma. They have not had the chance to experience secure attachment in their lives from caregivers and they may be more likely to have anxious or disorganised attachment styles.

There is little emphasis on attachment styles across services and how these show up in people's lives. This is likely to impact on client outcomes. Improved awareness of attachment styles would support both staff and clients to work together and build trusting, safe relationships.

Learning how to set healthy, safe and empowering boundaries is closely related to becoming a person with a secure attachment style. Women's services in particular demonstrated a need for this across their client base with staff telling us that "healthy boundaries" as well as recognising the signs of abuse and exploitation are key areas of need for their clients.

This is a topic which would benefit from further research and time spent with Experts-by-Experience to design training or learning groups that will support trauma-informed education around attachment styles, healthy boundary-setting and what 'good love' looks and feels like.

- "You need to build rapport. Rapport is so important. You can't do this stuff without rapport with people." **– Specialist Support Worker**
- "We ask ourselves what our service users ask. Do you look like someone I might strike up a relationship with? Does this look like the sort of place I would come into, would I come in here?" **– VCSE Frontline Worker**

"Saying 'I care about you' and 'I care what happens to you' really counts a lot. I had a male client who was in and out of prison his whole life. He cried when I told him I cared about him and it seemed to mark a turning point in the way we worked together. He trusted that I gave a shit. He told me "the only time I've met a psychologist is when they're doing a court report about me." We worked to help him understand himself as a vulnerable person, understand his life, accepting that somebody did care."

– An NHS Psychologist

"I've got something to do" – Non-Clinical and Holistic Approaches and Interventions

"Had I not have turned to gardening, art and music, I would not be here." **– A Former Client and now Volunteer**

People with multiple unmet needs are experiencing frequent "boredom" and a lack of purposeful activity in their lives, particularly during recovery. Staff believed that having this need met increases the success of recovery, improves connections to the local community, builds trust with staff and services, and increases people's confidence and self-esteem.

Our research found this gap in someone's life was generally due to the trauma they have experienced throughout childhood and growing up, such as a lack of role models and safe adults, and repeated exposure to abuse or neglect. This gap was often filled by drugs and alcohol or by unhealthy relationships as people strived to get their needs met. Staff told us that it meant when people reached adulthood and began to explore healing and recovery, they often didn't know or don't know what they enjoy doing or what their likes and interests are.

"We turn to drugs because of boredom. There's nothing to do."
– A Hostel Resident

The evidence for holistic interventions and non-clinical approaches such as social prescribing and mentoring is growing all the time. The best practice we saw during our research was from Peer Support Workers who were supporting their clients in a holistic fashion. This way of working is achieving great outcomes and nurturing trusting relationships with clients.

The need for increased holistic, creative and practical provision also links to the loneliness and isolation that clients are experiencing, which we mentioned earlier in this report.

The holistic support we saw on offer included things like:

- Taking clients out for coffee or lunch, particularly a cuisine they may have "never tried before" e.g. Chinese, Indian, Thai;
- Accompanying clients shopping for household goods such as vacuum cleaners and supporting communication with shop staff;
- Visiting clients at their volunteer bases to see how they're getting on;
- Chaperoning clients to activities in the community such as Men In Sheds or art groups, especially the first few times until they "build the confidence" to go alone;
- Driving clients to collect their prescriptions or complete their errands and to-do lists; supporting clients to write to-do lists and manage their commitments and tasks;
- Accompanying them to appointments and meetings, e.g. with housing staff;
- Arts and crafts groups; gardening; DIY and practical skills etc;
- Helping clients to rediscover (or discover for the first time in their lives) what brings them joy or what hobbies they might like to develop.

This is a topic which would benefit from co-design with Experts-by-Experience.

Additional Key Feedback:

"People warm to me because I'm not clinical." **– Peer Support Worker**

"There is a lot of boredom on the streets." ***– A Client***

"We need something to occupy our minds. If Rooted didn't exist I'd just be sat at home." **– A Client and Volunteer**

*"People don't know what they enjoy. They've haven't been fishing, they haven't played walking rugby, so it's exploring things. A lot of the work is helping people to find what they enjoy, a lot of the time they don't know what they like and we need to take time to find it out… People may have forgotten how to enjoy things, you're there to see them learn how to enjoy things again." **– Peer Support Worker***

"Sometimes it's as simple as 'come on, let's go for a coffee.' And we may not talk about anything at all except music or sports, which is equally as important. Some of these people spend a lot of time on their own and never get to talk about normal stuff, they only see people to talk about their mental health, and then they're back in the house all day." **– NHS Mental Health Worker**

*"Multiple complex needs…needs a holistic approach so we're not just constantly fixing someone's mental health. We've built a holistic service and plug gaps where we find them." **– VCSE Frontline Worker***

"I can feel safe as a woman" – Women's Specific Support

"Some women might be getting raped each month or exchanging a roof for sex."

– NHS Frontline Worker

There are nuances between the needs of women who are experiencing the impact and effects of multiple unmet needs and disadvantage, and the needs of men. In the following two sections we look at both of these which came through in our research.

We found that women need higher levels of trust, consistency, safety and time before they will engage with staff and services. Support needs to be compassionate, non-judgemental, trauma-informed and patient.

Our research has told us that women are generally much less trusting and slower to open up to support than men. Time needs to be factored in for what key workers called ***"rapport-building"*** in order to secure a woman's trust and willingness to be supported.

Staff describe distrust from women as being for a number of reasons, such as competition in sex work with other women, judgement from services, a fear of having their children taken away, or because they are being influenced by abusive partners in their lives.

"Usually the female service users say 'I don't like talking to other women.' Women feel threatening to them. In sex work there's competition with other girls, it's territorial. So other women might not feel safe to them. But when it's at the change stage it's not like that at all, they're so supportive of other women and each other."

– Peer Support Worker

Women who are street sex working in Hull are a group which are particularly under-reached by services, sometimes causing frustration or confusion amongst professionals. Services are reliant on networks of existing trust in order to reach female clients such as the **Lighthouse Project** or **trusted intermediaries** in community policing. In some cases this trust has taken years to build up, is under-recognised by statutory services, and would be at risk if key personnel moved away or retired. It is important to consider the sustainability of these trusted networks.

It was noted that many women have experienced sexual abuse in childhood and adulthood. This may include multiple rapes and assaults. One support worker we spoke to also emphasised that some women who street sex work are being raped every month.

We were told that services need to be mindful of the trauma that women have experienced and should provide female-only support workers and security guards at hostels. Exceptions are also needed to provide support in female-only settings and environments.

Lived experience leadership might be engaged to ensure that all outreach work with women, particularly street sex workers and surviviors of domestic and sexual abuse, is trauma-informed and personalised. In our research it became clear that there are few windows of opportunity to reach women in challenging circumstances and that we must take those opportunities when we find them.

Other specific needs we found for women experiencing multiple unmet needs:

- Grief and bereavement counselling for women who have experienced the removal of their children from their care or loss through miscarriage and abortion;
- Trauma-informed therapy for women who are survivors of rape, incest and sexual abuse;
- Confidence and self-worth work, such as coaching and mentoring. This could be delivered one-to-one or in group settings;
- Psycho-education around intergenerational trauma, attachment styles, and boundaries;
- Regular access to Female Peer Support Workers;
- Access to holistic provision such as social activities and groups with other women;

- Women-only temporary housing and accommodation, in particular a women-only bail hostel or a "halfway house;"
- Temporary accommodation suitable for "women who have children" e.g. crèche facilities;
- Housing, financial aid, and more intensive forms of specific intervention for women who are sex working; led by existing good practice in the city such as within the established women's and sex worker charities, open-ended and long-term;
- A ***"Female Mental Health Engagement Team"*** was specifically asked for – to work directly with women with complex trauma and who may have received a diagnosis of Borderline Personality Disorder. One woman we spoke to has been on a waiting list for 3 years because her needs are seen as being "complex emotional needs" by the health and care system, due to a diagnosis of a personality disorder. Staff told us that this was commonplace.

It wasn't possible to cover women's needs in detail during this Needs Assessment. This is a topic which would benefit from further, targeted research in co-design with Experts-by-Experience to identify best practice in working with women and the most effective interventions and healing routes for women.

Additional Key Feedback:

"We can tell if someone is not authentic, 100% that includes staff and key workers. Maybe women are more attuned to it because we had to be as working girls. I think men can do it too. But I don't know a single working girl who hasn't been attacked, so it's not 100% accurate." **– A Female Client**

"If I can see my ex outside the door, I'm not going in." ***– A Female Client***

"I would not be fully supportive of a Needs Assessment which lumps everything together, there are clear gaps. Different genders respond differently to SMD, this struck me when I came to work here. SMD impacts you by putting you at increased risk of losing your kids, increased risk of domestic violence, increased risk of poor housing, of contact with police or prison. All of this impacts on your mental health and physical health. If your mental health is not good then your physical health deteriorates, especially if using substances." **– VCSE Frontline Worker**

"We are wasting resource which doesn't work for women. Women offend for different reasons than men and so they need different approaches. I want to make this clear. We need separate services." ***– VCSE Frontline Worker***

"Women are more survivors than the men I think. Sofa surfing, they put themselves in such high risk situations. We always say to the working girls, we're not here to judge, but can we put a safety plan in place for you." **– Hostel Support Worker**

"Sex workers are one of the most trickiest client groups to navigate and support for our team. There is a hiddenness to the population, they're so difficult to pin down, to get yourself in front of them is really difficult. They don't want to talk to mental health teams, they think you are going to judge them, and the "choice" to sell their body. A lot have come out of domestic abuse or are in domestic abusive relationships. There's often a strong person they are scared of in their life, so it makes it harder too. Either a pimp, a frequent customer or an abusive partner. There is something around that gap. You don't just go onto Hessle Road and know what to do. It's really about grabbing that opportunity with them." ***– An NHS Psychologist***

"A woman we know, she comes out of prison, she's clean, she doesn't want to be in that hostel with people she knew. So she went back to her violent partner, it's been downhill since then." **– VCSE Frontline Worker**

"Women need more time for rapport building, and trust first, to open up. Sometimes it helps to do something small for them like book them an appointment." **– Specialist Support Worker**

"People may feel safer on the streets than in hostels. We know women who've left hostels because they've felt pressured to sex work or commit crime. Some accommodation just isn't suitable too, we had a woman with two little ones who had to share a kitchen and bathroom facilities. She was there 2-3 weeks but couldn't leave her kids alone in the room alone to go and cook. So they lived off pot noodles and things you can add hot water to for 3 weeks. I know it's probably the best the local authority can do, but it's not good enough." ***– VCSE Support Worker***

"We don't look at the offence, we look at the why's, we work in a very restorative way, we look at the emotional turmoil underlying the offending. We look at every aspect of a woman's life, that's what holistic means. Multiple complex needs are needs that impact on each other, so you can't do just one of them. We need systems in place to see the woman." **– VCSE Frontline Worker**

"I can feel safe as a man" – Men's Specific Support

"For me we have to have a value in life, not just how much money you make. I always wanted to be a father."

– A Male Hostel Resident

Men who are experiencing the impact and effects of multiple disadvantage and unmet needs have unique needs which are not yet fully understood by services or society.

Throughout our interviews and conversations, a theme began to appear around unheard men's voices and common issues men collectively face, which may be different to women's issues and going under-reported. This is an area which would benefit from more targeted research and collaboration with men's charities or specialist men's workers.

Some of the needs men face are also needs they share with women and they have been covered throughout this report, but we would like to draw attention to these ones in particular as they surfaced frequently in dialogue with male clients:

- ***"People show me I have worth and value" –*** low levels of self-worth and confidence amongst men with multiple unmet needs, sometimes leading to "extreme survival behaviours" such as social anxiety and not going out or fear of leaving the house. There is also a lack of male role models and safe adults; multiple men reported feeling safer with female support workers than around men, because men had abused them;
- ***"All I want is a friend" –*** high rates of loneliness and isolation among men with multiple unmet needs; lack of community connection and integration;
- ***"I don't have to fit in and people embrace my differences"*** – exploring neurodiversity and unique communication styles, reading, speech and literacy challenges facing men across Hull; identifying areas of "unconscious bias" towards men particularly where there is the presence of offending, violence, substance use and domestic abuse. Suspected significant levels of neurodivergence amongst male clients;
- ***"I've got something to do" –*** supporting men to find their purpose, vocation, employment, belonging, friends and likes/dislikes/interests etc.

We met men who have suffered in domestic abusive relationships as both perpetrator and victim, some who became street homeless after the breakdown of relationships, or the breakdown of finances. We met men who had been denied access to their children and had been disowned by their family members. We also met men who had spent most of their lives as working people and had never been homeless or used substances before nor needed to rely on governmental support.

It became evident during our interviews and conversations that men's specific needs are overlooked by services, misunderstood, or not yet properly researched. This could be due to gendered ways of looking at the world and society, and our standardised cultural norms, as one frontline worker suggested: *"Women and children first is a system-wide problem."*

It may be time for services and systems to take a brave look at men's issues and men's needs in Hull. Existing good work in the Voluntary Sector could support this such as Andy's Man Club or the Strength to Change programme.

Our research suggested that men with multiple unmet needs are more likely to:

- Be arrested by police officers during a mental health crisis and spend time in police custody, rather than receive an appropriate mental health intervention or attention from paramedics/medical professionals;
- Commit multiple offences, reoffend or spend time in prison;
- Leave the family home during a relationship breakdown and risk homelessness;
- Be street homeless / rough sleeping;
- Be associated with domestic abuse and violence.

It wasn't possible to cover men's needs in detail during this Needs Assessment. It is a topic which would benefit from targeted research in co-design with Experts-by-Experience to identify best practice in working with men and the most effective interventions and healing routes for men.

A note on people who are transgender or non-binary:

This Needs Assessment was unable to provide a deep-dive into the needs of transgender and non-binary people with multiple unmet needs, but we have received the following insights from staff and people with insight during our research:

- Staff reported a large population of homeless trans people in Hull yet their visibility across services is low;
- The needs of transgender and non-binary people with multiple unmet needs is not well understood by Statutory Services or health and care systems;
- There is a lack of input from people with lived experience taking place and no clear structures or platforms for their contributions to be seen and heard;
- Gendered responses are an issue across the city, such as in policing to give one example, as a Frontline Worker summarised: *"My clients were both unwell with psychosis when they were arrested. When identifying as women, they had more interactions with paramedics, when identifying as men, with police."*
- Gendered responses and unconscious bias or discrimination towards trans and non-binary clients may be affecting other services and pathways across the city and the nature of this deserves investigation and clarification;
- We were told that some women's charities and organisations in Hull have chosen not to work with trans women, leaving a gap;
- Trans people are more likely to leave home earlier as a teenager due to various reasons and may be at a higher risk of homelessness;
- Training, education and awareness of trans and non-binary issues particularly where they place clients at increased risk and exclusion on top of existing issues of homelessness, substance use and the other markers of unmet needs, could be explored – a Gap Analysis may be a worthwhile venture in collaboration with other health and care services in Hull who are working to improve trans and non-binary support outcomes.

We did not meet any transgender or non-binary clients during our research, to our knowledge. We did receive insights from colleagues with an expertise in trans and non-binary issues.

The report authors would recommend that specialised research is undertaken to understand the needs of transgender and non-binary people experiencing the impact of multiple disadvantage and unmet needs in Hull.

There is already fantastic and pioneering work happening in the city around this at Hull York Medical School which might inform any future projects or analyses.

“Everybody needs a Pam” – Trauma-Informed Key Workers and/or Single Points of Contact

“Pam was my key worker. Everybody should have a Pam. She listened. She let me cry. Without asking me to stop. She didn’t minimise my trauma. She let me have my trauma. She passed me the box of tissues. She let me talk myself into the methadone course, she let me think of possibilities of recovery as I walked out. There was never any judgement.” **– A Client**

People with multiple unmet needs have the need for a single, designated key worker who is trauma-informed and well-trained in the issues they are supporting on a day-to-day basis.

We found that the relationship between Key Worker and Client is of paramount importance and cannot be overstated nor overvalued. It is often the driving change and turning point in sustainable change and healing for an individual, particularly where a client has not found resonance, attunement or safety with support workers in the past.

With regular, at least weekly, access to consistent and safe relationships with Key Workers, it seemed the greater the client outcomes, progress and motivation for change.

Some staff described the work of the Key Worker as to be the equivalent of ***“a single point of contact”*** for clients, as well as for other frontline services, such that they become “the conductor of the orchestra” and know what is going on in their clients’ lives in terms of the other workers they are seeing and the support they are receiving.

Clients were clear that they benefitted from seeing the same person on a regular basis rather than any chop-and-change in staffing. They emphasised that they feel like the people they see consistently “really get me” and that the idea of trying to begin a new therapeutic relationship feels overwhelming.

In our findings, the presence and value of one positive, safe relationship in their lives is a priority need for people with multiple unmet needs.

Key assets and values of the “Trauma-Informed Key Worker” who can navigate care and support were described and demonstrated by clients and staff to us as:

Deep listening; non-judgement; compassion; warmth; trustworthiness; patience; empathy; willing to show vulnerability; openness; sense of shared humanity; generosity of spirit, attention and time; respect; dignity; appreciation of their client; consistency; persistence; no expectations put on client; presence; connection; courage; able to adapt behaviour and responses e.g. no intense eye contact; demonstrates “good love” and healthy boundaries.

Additional Key Feedback:

"A befriending service would be OK. As long as it wasn't swapping and changing all the time. It's not having to explain yourself from scratch. When I start getting ill, I start backing off from services." ***– A Client***

"I don't put lots of people in my work day, usually 3 at max, because I never know what I'll find when I go to see them and I want to give them the time they need." **– Peer Support Worker**

"The game-changer is the relationship. There isn't any 'one' intervention that works, it's slow and steady, it takes years. If you don't have the relationship, no intervention will work." ***– An NHS Psychologist***

"Part of the issue is they only look at mental health, and so a Community Mental Health Nurse isn't expected to sort out accommodation. We need more of a key worker mentality in mental health services, so they become like the conductor of the orchestra, joining the services together and knowing what is going on for that person." **– VCSE Support Worker**

"Are we overwhelming people with multiple workers? If you have one lead worker, everything should come through them, it should be done together but through the 'trusted worker.' That lead worker should coordinate the rest of the care, be aware of everything going on. Once the client is independent, they can back off on the wraparound care." ***– A Frontline Worker***

"The thought of losing [my key workers] scares me to death. They get me, they know how I think. You can't help but build a friendship up." **– A Client**

"I have a really low opinion of myself and confidence. I had a good relationship with my psychologist built up, they saw me at my lowest to where I am now." ***– A Client***

"Deep Listening, listening to us, so that you can even read back to us things we've said, because my memory is shit. But not the over-intense type, staring into our eyes, that's uncomfortable." **– A Client**

"You can tell if you're welcome or not. We can read rooms well, we can tell if someone is being snotty. It kept us alive. Reading people kept us alive." ***– A Client***

"When I was on the streets, you end up a bit on the scruffy side. Some people stop by and judge, but I never begged or shoplifted. But some will come over and give you a hot drink or a sandwich. It helps a lot, random acts of kindness. People aren't uniformly bad, it does restore your faith." **– A Hostel Resident**

"You get more out of them if you go to them, they feel we are making more of an effort and they comment on that. They might say 'you've took time out to come and see me' and its less formal too. It really works to go to them, building trust, it's all about relationship building." ***– Probation Services Officer***

"People want to be listened to. The NHS doesn't recognise recovery unless it is 'clinical recovery' and that's an issue. The step-care model doesn't work for SMD. It's not getting to the root causes of why, to the trauma. What you want is to listen to the person, find out what they need, and give them the right service the first time." **– VCSE Support Worker**

“I know where to go to get my teeth seen” – Dental and Physical Healthcare

“The first thing people ask me for is help with their teeth.”

– NHS Peer Support Worker

People with multiple unmet needs need open-access and convenient walk-in centres where dental and medical help is available to them.

Access to dentistry in particular is a key need. Staff told us there is only A&E as an option in a dental emergency, a lot of service users are missing teeth and have poor dental health, and people regularly have abscesses or chronic dental pain. They will then self-medicate further to alleviate the pain they are experiencing. There are few to no NHS spaces for anyone to get registered for dental care and treatment is inaccessible beyond an emergency when someone will present at hospital.

“Teeth gives it away, it's the first thing people say,” a frontline worker told us.

We spoke about authentic respect and dignity earlier in this report. We may extend this to issues around dental and physical healthcare for people who are living with painful issues that cause embarrassment, low confidence and self-consciousness: “I just wanted a nice smile,” a client told us.

Another key area of need is in wound care. People may be regularly injecting substances into their bodies and this can lead to severely painful ulcers and large, open wounds for which ***pain relief is not always readily available.*** We found that due to a worry amongst clinical services that pain relieving drugs may be misused or sold on the streets, there can be a reluctance amongst services to provide efficient and trauma-informed care for wounds. It could be argued that this is not good practice for trauma-informed care and needs a rethink to reach people in such difficult and distressing situations. We talk more about this later.

“I am shown that this isn’t my fault” – Intergenerational Trauma, Health Inequalities and Breaking the Cycle

“People feel hopeless, we have to address the hopelessness. What do you do to give them any light or hope, breaking the circle, because their days look all the same.”

– A Hostel Support Worker

People with multiple unmet needs can be trapped in cycles and patterns of trauma that did not start in their lifetimes but for which they are inheriting and shouldering the effects and symptoms.

Our research found, time and again, that people were born into families to parents and grandparents who carried their own traumatising experiences and childhoods, who in turn inherited trauma from their parents, and so on and so forth. In some cases this can go back several generations. To fully understand people’s needs and what they’re up against we need a much broader and braver perspective on trauma history and the way it continues to affect families, children and societies until it is addressed and healed.

To further compound this, the trauma that people with multiple unmet needs experience may not originate from their own family tree, but may come from the world and society that they live in. It was noted that they may be exposed to collective trauma like racism, sexism, homophobia, classism, or localised event traumas such as the closing down of mines, fishing industries, poor housing, flooding and environmental issues, climate change and war.

In supporting the needs of people facing multiple layers of disadvantage, we found that there is a need for us as professionals and decision-makers to understand that the difficulties being faced often did not start with one person or one family or one street.

There was a consensus amongst staff we spoke to that work around health inequalities and population health needs to consider the impact of family and intergenerational trauma on the people they are serving.

Education and awareness for clients is also important. Hearing that it "isn't my fault" is a powerful driving force in healing because it directly addresses shame. Shame was noted by some psychological staff we spoke to as an issue that their clients often needed support with.

People facing multiple layers of disadvantage need "hope" and positive validation from services, systems and staff which "consistently" tell them they are "not bad" and they are "not mad."

"Twelve sessions of counselling is nothing, the recovery journeys take longer due to the effects of trauma. And it may not be recent trauma but traumatised childhoods linked back to childhood. Or their parents had experienced SMD themselves – so how are they supposed to be good role models for their children? We talk about breaking the spiral. For some people it's the families they're born into, they've just never been given the opportunities. But yes some people do get out of it."

– VCSE Frontline Worker

Additional Key Feedback:

"We normalise day drinking, bottomless brunches, doing loads of coke at the weekend – what's okay for rich or affluent people, it's totally different for what's considered okay for low income and marginalised people." **– A Frontline Worker**

"Intergenerational trauma is quite prevailing in our service users. For the ones where it isn't prevailing we can meet their needs quite quickly and I would say it can be more straightforward, as they may have more of a functional support system around them." **– VCSE Support Worker**

"Hull is a poor city, I was bred here. Education is bottom of the list for many, they are learning off their peers instead. There's entrenched poverty, hopes and aspirations of people is to win the lottery, rather than use education to get themselves out of there. There's no ambition, no hope, just following in the footsteps of family members and peers. There's high rates of teenage pregnancy, high rates of dyslexia. They're not interested in education because their parents weren't, it's not passed down. They need to be given some hope. The people of Hull need some hope. There's no investment. Covid killed off the city centre. People are great, and generous, but it's sad. It's learnt behaviour, people are growing up with this as the norm." **– Probation Services Worker**

"Smith & Nephew is relocating to outside of the city, so the Council is looking to redevelop this area. They have done this with Humber Street too, but there aren't enough people coming into Hull to keep that going. It's exactly what happened to Prospect Centre, and then Princes Quay, and then St Stephens. It's a pattern that the Council does, keeps redeveloping areas." **– VCSE Frontline Worker**

"I'd say the WW2 bombings are too long ago to blame I think, it's a bit of a stretch, but many people went to sea. Anlaby, Hessle Road, Spring Bank, they were all bustling roads during the fishing days, they're all run down now." ***– A Frontline Worker***

"Our geography is against us, we have issues with recruitment. Hull is a standalone, it's not like Leeds which can draw from a wider pool for recruitment. We are here, we are on a limb. Young people go to university and don't come back." **– VCSE Frontline Worker**

“People understand that lasting change takes time, trust, courage and consistency” – Long Term and Clear Commitment to Services, Funding and Innovation

“Hull could be brave and pioneer some of this stuff. It’s a unique city, unique positioning and background, its geography, it’s out of the way. Deep heritage with the fishing industry, the gritty working class stuff. There’s a solidarity about it. Hull has something about it which could be quite pioneering and have a go at these things.”

– A Frontline Worker with Lived Experience

People with multiple unmet needs want to have more faith, trust and reassurance that the services they are accessing will be there when they need them, even if they need to keep coming back over time.

This should be central to the relationship-building at play between staff and their clients, and between commissioners and providers. Both staff and clients agreed that long-term funding is needed to create lasting change and sustainability.

To get clear on what this would mean, and to meet this need for our clients, long-term and courageous commitment is needed to services, funding and innovation. This may mean getting clearer on what our aims and ambitions are, such as how motivated we are to end multiple disadvantage in Hull. Do we believe it is possible? How is morale across the health and care system? Staff also wondered whether it is possible we can develop a “theory of change” or an outcomes framework that all sectors work towards.

These were a few of the suggestions that staff made when discussing lasting change. Some people also argued that Hull is in a unique position to pilot brave, new, change-making ideas.

The consequences of not taking action are significant. What is in the realm of possibility, and how far are we willing to stretch it?

“What are we actually trying to achieve? Do we have a theory of change? What are our outcomes and long term vision? The Crisis charity has a strapline, it’s “end homelessness.” Is ours “end SMD?” or isn’t it? If it isn’t, then what is it? The aim should be to stop SMD, not just make it a little bit better. Not just reduce it, end it. It’s not an overnight fix, but yes we can end it, but you’ve got to have that goal, and everyone’s got to be bought into it.”

– A Manager of Services

Additional Key Feedback:

“Long term support is crucial – one lady her kids have now left home and she’s isolated again, she’s come back to us, that’s the value of us being here so many years, that people know we are still here to come back to even if it’s been years since they came to see us.” ***– VCSE Frontline Worker***

“Longer term funding would enable us to rent a property. Our funding at the moment isn’t long enough for getting a lease. Funders like the sexy stuff, like Fred turned his life around. But they don’t want to pay our gas and leccy.”
– VCSE Frontline Worker

*“Longer term funding is needed. Two years doesn’t scratch the surface. We cling onto small wins when funders want to see massive changes. These people may have 20, 30, 40 years of disadvantage. Two years funding won’t scratch the surface. We need long term commitment. 5 years minimum. It takes time for word to spread in these communities, 2 years isn’t enough. We are just adding to people’s traumas and disappointments when services are taken away because the funding has come to an end. I do get that money has to come from somewhere. From a probation point of view, if they’re not offending as much or we’re doing less recalls, it may improve our working with people. So we could give people more time and attention, so it will help us to do less recalls [having longer term funding].” **– Probation Services Worker***

“This artificial distinction between children and adults is working against young people. As soon as they turn 18, they’re seen as perpetrators. This needs to change. All the time up to 18 it’s “victim, victim” but the paradigm shifts when they come of age and the system recategorises them as perpetrator. The 18-year-old is immediately seen as a perpetrator, not a victim anymore. We do lots of court advocacy, we say here that we don’t excuse what they’ve done, but we explain why it’s happened….Yes, I do think young people would continue coming here into adulthood and beyond 25 and for a long time. We have ‘exit plans’ for young people as they’re about to turn 25. We are currently looking at how to keep engaging a young person for whom we know the Exit Plan won’t be enough, thinking about how they can still use our service, still come to us.” **– VCSE Frontline Worker**

“Big conversations are needed, big grown-up conversations if we are serious about this. We need to have much braver strategies.”
– A Frontline Worker with Lived Experience

“The standard you walk past (as the Mayor, or as a worker) is the standard you accept. This applies to the Council Leader. And if the police walk past it, everyone’s going to walk past it, because they see the police walking past it. Unless we all buy into this, it won’t change.” **– A Manager of Services**

“It doesn’t matter where I come from, how I got here or what language I speak” – EU Nationals, Migrants, Refugees, Asylum Seekers and People from Minoritised Groups

“There is so much hidden homelessness. They may be sleeping on friends’ floors, or exchanging a sofa for exploitative labour. They have no right to work and no right to benefits. They are left destitute.”

– A Specialist Worker with Asylum Seekers

People with multiple unmet needs in Hull includes people from minoritised groups and different racialised backgrounds, including people who may have recently arrived in Hull from overseas.

This includes Asylum Seekers and those who have been Refused Asylum, Unauthorised Migrants (sometimes referred to as ‘illegal immigrants’), refugees, migrant workers, EU nationals and non-EU nationals.

Staff noted that these individuals are already facing high levels of hypermarginalisation from society and face the additional complications of ***prejudice, racism, and discrimination.***

Upon arrival in Britain, staff told us they are more at risk of experiencing the impact and effects of multiple layers of disadvantage, especially Asylum Seekers. It was noted they may face long periods of detention, poor mental health, domestic abuse, extreme isolation, homelessness and stressful and repeated contact with the Home Office – or even the criminal justice system – to ascertain settlement status.

During the writing of our report, frontline workers told us that Asylum Seekers now make up one-third of rough sleepers in Hull.

Feedback we received during our research made it clear that there is no current city-wide strategy for meeting the needs of minoritised groups in Hull, though some work has previously been commissioned around Social Inclusion.

The most recent Destitution Report for Hull is dated 2009 ('After Wilberforce – An Independent Enquiry')[12] and this did not include EU Migrants. Frontline workers felt that the destitution report should be updated for Hull.

Hull has a large population of EU Nationals and the frontline workers we spoke to identified their needs as being different to native and British-born people with multiple unmet needs. Not only are there translation, access and language barriers, but there are cultural sensitivities to be aware of such as differences in usage of drugs and alcohol. For example, frontline workers informed us that the culture of amphetamine and alcohol use is much higher than opioid use for EU Nationals, and different approaches and interventions are required.

In order to understand the scale of need across the city, and the responsibilities, capacities and capabilities of the health, care and public health system to respond, additional strategic work is felt to be needed across statutory services.

As a City of Sanctuary with a proud anti-slavery heritage in the legacy of William Wilberforce, Hull may wish to give credible voice and visibility to people with multiple unmet needs who are in racially minoritised groups.

Owing to the charged political environment, the sensitive social issues facing people from minoritised groups, and the upsetting and traumatic experiences they have endured, this work would benefit from trauma-informed leadership and a long-term, systems transformational approach.

Although we are not able to do justice for people from minoritised groups in this Needs Assessment, we hope this short section contributes to movement in the health and care system towards thinking about these issues.

"If they've gone through Libya, they've been subjected to trauma and horrendous conditions. It's a very common route if coming from Africa. It's much worse than coming through Tunisia. We know they've been trafficked if they come through Libya.

"There they will be forced to work without pay, beaten if they ask for their wages, contained at gunpoint and forced into warehouses, or tortured on the phone to extort money from family members who can hear their screams down the phone.

[12] Campion, Peter; Brown, Sally and Thornton-Jones, Helen, Migration Yorkshire (2009)

“Women and girls are raped, young men and boys we often find they have been raped too, but they won’t admit it for a while. All Asylum Seekers need counselling. There is a common attitude among them to dismiss what has happened to them – ‘but we all went through it and that’s what happened’ – they don’t want to admit what they’ve been through.”

– Specialist Support and Legal Worker with Asylum Seekers

Additional Key Feedback:

“It’s amazing to them to get benefits. To keep body and soul together they will work for £5 or £1 per hour. Exploitation is very high. But the modern slavery definition has to have the element of coercion, so it doesn’t meet the criteria. But it is exploitative labour.” ***– Frontline Worker***

“People find themselves being trafficked, when they believed they were going to be smuggled. Smuggling is a breach of a country’s law. Trafficking is a breach of individual’s law. No trafficker says ‘I’m going to traffick you.’ They paint a picture for you instead.” **– Specialist Legal Worker**

“Immigration advice and status is the only way out of the situation. It’s illegal in this country to provide immigration advice if you’re not qualified and regulated, it’s an imprisonable offence. You can give someone a temporary room over their heads, or a food parcel, but you will have to do that for years, because the only way to get them out of that situation is immigration status. Some people have no way of resolving their immigration status and have been there for 10 or 20 years in temporary accommodation. I ask people ‘would you have come to the UK if you knew it would take 20 years?’ They say ‘no, because I have lost my life.’ They lose the chances for a family life, for a career, getting married.” ***– Specialist Legal Worker***

“The Home Office is in chaos. It’s taking a year or longer for decisions to come through, that’s just for settlement. Asylum has 5-year backlogs, with 170,000 people in it. All this talk of hotels and barges, if people were just given a decision, they could claim benefits and wouldn’t be costing the Home Office anything.” **– VCSE Frontline Worker**

“Ukraine is devastated even if the war ends. A few people will go back there. Relationships are now beginning to breakdown because temporary accommodation is coming to an end, people are having to find permanent housing, some are now claiming homelessness.” ***– Frontline Worker***

“We haven’t got any accommodation for Unauthorised Migrants. We need this, and English language provision, and access to counselling, and immigration advice and status. Those are the needs of this group.” **– Specialist Legal Worker**

“We have an increase in modern slavery cases and short-term visas. The visa is tied to an employer, if you leave that employer you’re expected to leave the country. It’s slavery in another form.” ***– VCSE Frontline Worker***

In-Hospital, Acute and Secondary Care findings:

"Somewhere I can call home" – Safe and Reliable Housing

"People in hostels are stuck. They often don't end up in their own place. The hostel environment, some are drug dens. People's chances of recovery are so slim. [They] don't have the solid foundation to help with improvement." **– A Hospital Frontline Worker**

The staff we interviewed mentioned all types of accommodation and housing as being the single biggest gap within the current system for people experiencing multiple unmet needs. Staff working with people in hospital, acute, outpatients and secondary care settings described housing as being "at a crisis point" and "a nightmare" that they have to deal with every day.

There is an "overwhelming need" for additional accommodation of all types: social, supported and direct access – especially for people who need mobility-accessible and adapted housing. The lack of available and suitable places for people to live has a knock-on effect within hospital settings, as it results in delayed discharges of patients.

One frontline worker told us: "We've got a complex needs hostel that is full with people with complex needs. So once it's full, you don't have any scope to put anybody else with complex needs anywhere because there's only the one [place], and then there's no move-on plans for the people [in the hostel] because they're not really sure what's next.

"Long-term accommodation is needed and it should be 'what's next.'"

When discussing housing and social care options, staff we spoke to felt that access depended on social status. They felt that people with multiple unmet needs were not getting referred at the same rates compared to other groups of people. Patients are also often placed in hostels with other vulnerable people and surrounded by harmful use of substances and "they can't

rest because they don't have the right support around them. Can't progress because the right support isn't surrounding them and it is so costly."

In considering accommodation options, it's also important to consider a person's living environment outside of the hospital, for example being independent on the ward is not the same as living in a hostel or independently in a flat. Ongoing support is felt to be needed; people want their own place but often they are not able to "keep up with it" or they miss appointments relating to the property.

A need for housing which people can make and call a home, and settle down to rest – moving out of "survival mode" and having that foundation from which to begin to heal – was found across all of our qualitative research.

"Someone's got my back" – Advocacy, 'Hand-Holding' and Floating Support

Across hospital, acute, secondary care and discharge settings it was found that people with multiple unmet needs would benefit from advocacy of some kind.

Advocates in hospital settings should have this role "to fight for their right to access care" and speak up on behalf of patients, ensuring that their voice is heard and their health and care needs properly understood by clinicians.

Emergency Department waiting areas may be a good environment to trial the use of frontline advocates, making use of this waiting time to be "proactive" for patients, to sit and talk to people, and allow other services (such as voluntary services and charities) to come in and identify people who may have additional needs.

Where there is also a language barrier or different cultural needs, this presents further barriers to getting the right care and intervention, and is another area where advocacy is felt to be of support.

In terms of the effectiveness of advocacy-type roles, staff we spoke to said they have seen a "major improvement" since the Homeless Health and Inclusion Team started work within Hull University Teaching Hospital. Part of their role is ensuring the needs of people with multiple unmet needs are appropriately seen, heard and met.

The need for effective and accessible advocacy for people with multiple unmet needs was found across all of our qualitative research.

"Somewhere I can go to at odd hours" – Walk-In Centres with Open Access

"When it's the end of the day and it's cold outside and there isn't anywhere for somebody to go, there ends up being a bit of a Mexican standoff..." **– A Hospital Frontline Worker**

People with multiple unmet needs need to be able to access health services "after hours" and outside of usual opening and visiting times.

Many services are not available after hours. Often, when a patient attends the Emergency Department, they are given leaflets or maybe someone leaves a voicemail on their phone about a service, and the onus is on the patient to follow it up. An example was given about frustration when it is the end of the day and it is cold outside and "there isn't anywhere for

somebody to go, there ends up being a bit of a Mexican standoff" over whether or not to keep the patient in the hospital for the night.

The staff member said: "That's actually quite difficult as it is as heartless as that sounds. It's really hard to keep somebody who doesn't have an acute medical need in an acute trust. Because I've got 25 other people in the back of ambulances that can't even get into the department at that time, and that is, you know, it's a difficult balance."

Another example of the need for after hours access is in speciality services such as drugs and alcohol, mainly because "there are no weekend provisions now."

A staff member explained to us: "So if we saw patients on a Saturday morning in need of methadone, we can, you know, we can try and advocate, try and get them to keep them till Sunday morning so they can have a dose of methadone and then on the way and we can get scripts sorted out for Monday. So there's no break in there in the methadone. We need weekend coverage. Studies show alcohol withdrawal is not properly managed on weekends. Maybe it's due to limited staff." After hours and weekend provision of services is either limited or not available and is a need. This might also go towards improving equity of care and improving patient and client outcomes. In particular, needs around opiate use are often not being met effectively in the Emergency Department, and are contributing to rates of self-discharge. Support for stabilisation when a person needs admission is needed.

"People want to hear what I've got to say and learn from me" – Lived Experience Input and Co-Design is meaningfully valued by Services and Staff

Across hospital settings, the patient's voice can sometimes get lost and can sometimes not be sought at all during their care.

Some staff also felt that, at the same time, "boundaries sort of get blurred" sometimes. Boundaries getting blurred can occur even when the staff member is advocating for the person, but what they are saying or doing isn't necessarily what the person wants. In those situations it can be more about the staff putting "their own values on that situation."

One hospital worker we spoke to said that listening to the patient, letting them be heard, and coming up with a plan together gives the patient some control and can be a turning point for patients.

More effective and dedicated efforts to the inclusion of lived experience voices and co-design was found across our qualitative findings, both in-community settings and in-hospital environments. This might be something to look at culturally, systemically or collectively across services.

"Please give me back my dignity" – Authentic Dignity and Respect from Staff and Services

"They've got a little old lady there that's maybe had a stroke or something. She's going to be treated better than our person that we've got in there. And I can categorically tell you that I've witnessed it so many times." **– A Hospital Frontline Worker**

People with multiple unmet needs face "inequity" when they are accessing health and care settings or have poor experiences as patients. Furthermore, too often their care is dependent upon which staff member they get to see during that particular visit or interaction.

When accessing care, some staff explained that people have had poor interactions with health and social care in the past, plus many people have a history of trauma, and these experiences have left them mistrusting services and professionals. This goes on to directly impact their access to care.

Most staff we spoke to felt that, overall, people are having poor experiences as patients both in the Emergency Department and as inpatients. One staff member said the experience is “very variable… and the outcomes they receive depend on the attitudes of the staff looking after them.”

People with multiple unmet needs will often either leave without treatment or have long lengths of stay and delayed discharge. One staff member said: “current safeguarding and discharge practice is inadequate.” At least some of this appears to be attributable to clinical and professional attitudes and culture.

Some staff members noted that often, people facing layers of multiple disadvantage are coming through the Emergency Department (ED) and are “attending with non-ED problems” and that “clinicians are not identifying or even exploring reasons for frequent attendance.”

This is reinforced by a story told to us during our research by a client with lived experience, who is now supporting Yorkshire Ambulance Service with patients who are frequent attenders at hospital or frequently dial 999 for an ambulance. She told us about a current patient who has called out an ambulance numerous times over a period of several months and how the Ambulance Service would like to better understand what is happening for this patient. She has encouraged the emergency staff not to focus exclusively on the frequent attendance issue, but instead to holistically consider “what it is the patient is receiving from contact with paramedics that they are not receiving elsewhere in their life.” For example, is loneliness an issue for this patient, is it mental health or anxiety, is it human contact? This suggests that it is only by properly affording a patient the time to be considered respectfully and holistically that we can more accurately understand what that person is going through.

Some of the issues around this are challenges due to time pressures and major turnover of staff. We were told that the services are also different depending on where a patient lives, and the limitations of the services such as not being available after hours.

An example is when patients who are using substances are "left in withdrawals, waiting time up to 8-24 hours, so they [patients] just leave without being treated."

Poor experiences of care are directly related to stigma and bias and the lack of knowledge and understanding about people experiencing multiple unmet needs, which we highlight further below: *"Hospitals and staff feel safe and welcoming for me"* – **Ending Stigma and Unconscious Bias, Creating Psychologically-Informed Environments**.

"Everybody needs a Pam" – Trauma-Informed Key Workers and/or Single Points of Contact

"It is always a sick joke we don't share the same system. I can't see why."
– A Hospital Frontline Worker

There is a need for people with multiple unmet needs to have clearly coordinated care which is also joined-up and recorded well by the staff who are supporting its delivery.

There is currently no system for routine identification of people with multiple unmet needs across hospital settings, nor coding for this information across databases and IT systems. It was difficult to extract quantitative data for this report for these reasons **(see page 54)**. In addition, access to information and data sharing between services, especially between hospitals and the community sector, is considered slow at best and at worst does not happen. Some staff said the system does work sometimes e.g. via emails, phone calls, handovers etc and "if you know they are there [in hospital] it is usually not difficult." However, sometimes staff and services are unaware when one of their clients is in hospital.

Our research noted that safeguarding has an "easy to see" alert in the system, but not all people with multiple unmet needs need safeguarding or they are not referred for it even when it is appropriate.

With different services working from different documentation systems, it can become "really difficult" for staff navigating services and their patient's care. One staff member said: "it is always a sick joke we don't share the same system. I can't see why."

Sometimes, vital information is missing from the community sector's notes or vice versa, from the hospital sector's notes. Within the hospital, referrals are often delayed without identification and access to information, requiring "lots of chasing" and a neglect to inform staff of potential risks when interacting with a patient. An example of this was given about a patient with a history of violence towards staff members, but nothing was highlighted on his record. No one had informed the nurse working with him that she was at risk and needed to use caution. However, it is not clear if historic risk is viewed as "live risk" across the hospital setting and whether this may risk people being refused care when they need it.

It was also noted that although there are some Data Sharing Agreements in place across the local health and care system, it can take a long time to obtain consent.

Our research findings found additional gaps that more coordinated care or 'care navigators' such as key workers might be able to support with. We were told about gaps in services for women, inconsistency in care, access issues to mental health treatment, and issues with referrals to Adult Social Care or hospital staff not completing Duty to Refers. Another considerable gap is the lack of planning for prison release, which impacts on health, addictions and housing. In addition, staff mentioned that "deaths of people who are homeless are not taken seriously" and called for more frequent reviews where learning could prevent future deaths. Overall, across hospital settings, staff felt there was a lack of services available to meet identified needs.

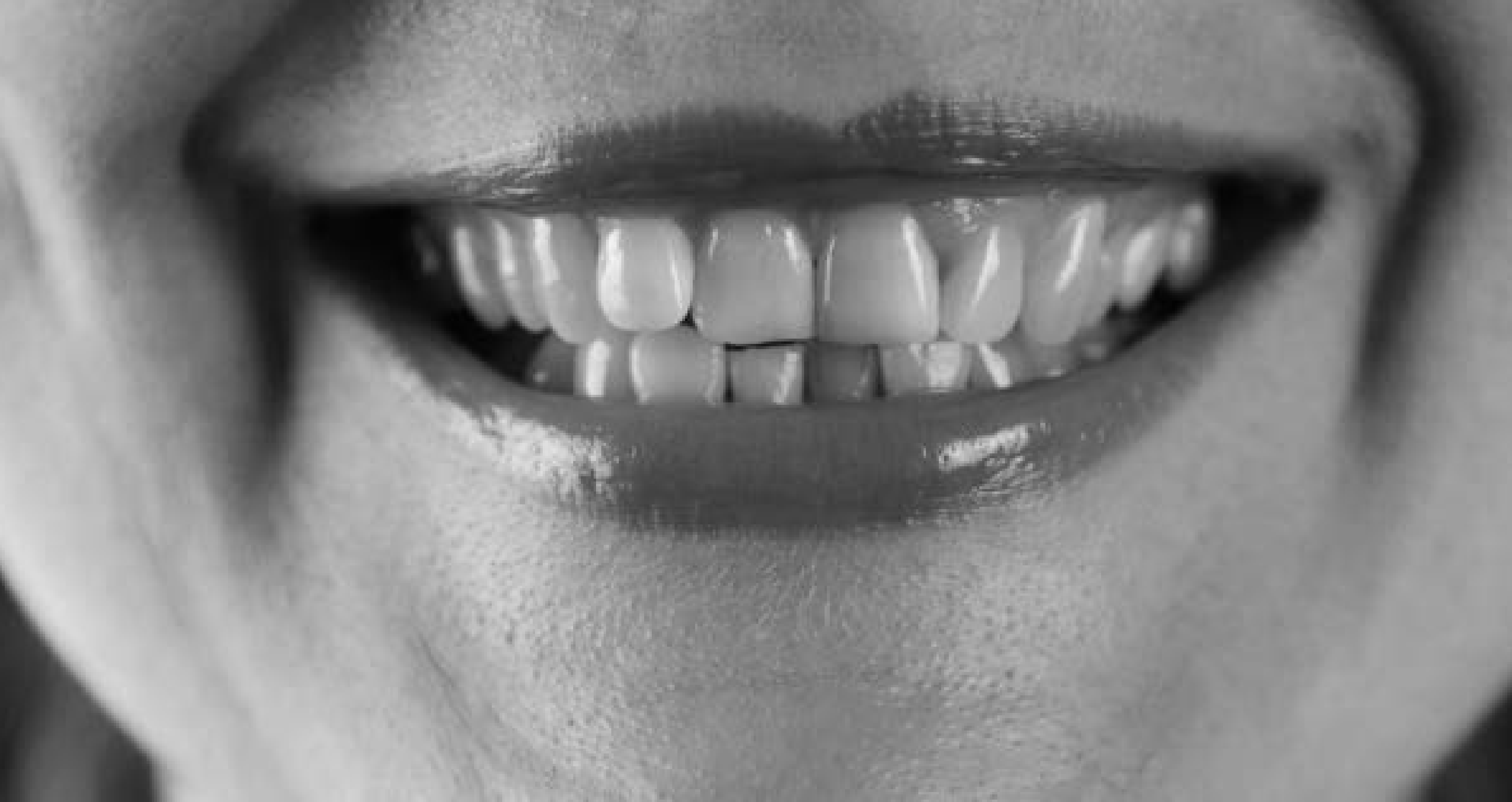
Our research also noted the views of staff who told us that the current system does not meet patients' needs. People with multiple unmet needs "fall through the cracks" and this directly impacts on health outcomes. Many argued that the system simply doesn't meet needs, or as one staff member said: "if a patient doesn't fit into 'the way it is' the patient doesn't get seen."

Many staff voiced frustrations and told us that "the system is broken" and the majority agreed that "the reality is, there are lots of improvements needed in inclusion health."

A 'single point of contact' such as a shared information system or shared care record and database might support this need to be met, but further research and engagement is needed with people who have lived experience in order to better understand the extent of this need and whether there is consent among patients for shared care records and record-keeping of this type.

Care navigators and key workers who have responsibility for coordinating all services around a client/patient may also present solutions to these challenges. A directory of services might be required to support with successful navigation and coordination of support around an individual. Where there are difficulties in accessing a service once it has been identified for a patient, advocacy (or having trained advocates within hospital settings) may also be an option for exploration.

Staff indicated that they support the provision of key workers and care coordinators because they can build relationships with people and establish trust. It was also noted that it helps when the voluntary sector steps in or there is somebody available to advocate for a patient.



“I know where to go to get my teeth seen” – Dental and Physical Healthcare

“[Being homeless] changes the way you look after yourself physically, so the point people turn up to hospital is a point of desperation at times.” **– A Hospital Frontline Worker**

People with multiple unmet needs have a need for accessible general healthcare, particularly when acute medical issues are not present and there is not really a need to use hospital provision.

A discussion point for the staff we spoke to was that often people are not making use of primary care and that we need to look at how community services are provided to see if they are truly meeting people’s needs. For example, dental and oral healthcare matters are unable to be met by primary care so something else is required.

Being homeless “changes the way you look after yourself physically, so the point people turn up to hospital is a point of desperation at times” and there was a plea from staff to intervene much earlier. Some staff argued that patients are turning up at the hospital when they could have care in a calmer environment that would suit their needs better in the community.

In addition to avoiding hospitalisation, it was also suggested that the system should have robust community care to “make sure they’ve got the support they need” once someone with multiple unmet needs is discharged from hospital.

One staff member said: “people don’t attend appointments or [are] around when professionals go [to visit], but maybe that’s more about the services being more flexible to meet those needs.” This report further covers accessibility of services under *“Somewhere I can go to at odd hours”* **– Walk-In Centres with Open Access.**

In addition, sometimes when people are admitted to hospital they are then “medicalised” but staff told us this “doesn’t really uncover the main issues to really change the direction of overall outcomes for a patient.” There is an argument that the system is creating “dependency” and patients are being “institutionalised.” One staff member gave the example of receiving a phone call about an old patient she had because the patient had listed her as next of kin.

We have discussed loneliness, isolation and the holistic needs of clients earlier on in this report, please see *"All I want is a friend"* – **Loneliness and Isolation** in particular.

A few generalist staff we interviewed said that they felt people with multiple unmet needs did get their reason for admission addressed and cared for when they came to hospital, but that overall physical healthcare needs should be met through primary care rather than secondary care. This still leaves a gap around dental care.

Some staff felt the system for physical healthcare was working well. One staff member said: "you don't realise what people go through" and viewed the hospital as a safe place for people to come to. She gave an example of someone in the hospital every other week until he moved to a different accommodation where he now receives more support. She said: "before everyone took his money, beat him up" and with the hospital team involved in getting him moved, she said "it does make a difference to his life, definitely." Therefore, it's important not to underestimate the importance of hospitals as a safe place where care is there when you need it the most.

Generally, more clarity is needed around the meeting of physical and dental healthcare needs and what is best practice for people with multiple unmet needs – whether that is a community-first approach that utilises primary care and community settings, a hospital-inclusive approach, a combination, or something else.

What is clear is that there is a strong and consistent, sometimes frequent, need for accessible physical healthcare for people with multiple unmet needs.

"The physical pain I'm in is taken seriously" – Efficient, Equitable and Trauma-Informed Pain Relief and Prescribing

"They'll be given pain treatment up until leaving hospital. Then, when they've gone, that's it. And then they'll go and self-medicate." **– A Hospital Frontline Worker**

People who are experiencing the impact and effects of multiple unmet needs require fair and equitable access to pain relief medication.

There is a current barrier of care around pain relief within the health and care system, and possible stigma is at play which is exacerbating this issue.

In some instances, staff told us that patients do not receive the same pain relief as other patients do, particularly when they are discharged and their pain relief is completely stopped (unlike for other patients who take prescriptions home with them and are offered support around pain management). This is an example of significant inequity in the system, driving health inequalities, poor patient outcomes, and unhelpful stigma.

Patients are also more likely to self-medicate with harmful amounts of drugs and alcohol in order to cope with the physical pain they are experiencing – such as pain from open wounds, ulcers that have formed around needle injection sites, or injuries sustained whilst living on the streets.

During the research for this report, we saw someone in so much physical pain from leg ulcers that they could not answer questions or talk to us because they had to go and lie down.

Being left with no option but to self-medicate because clinicians will not prescribe pain relief is not trauma-informed in its approach to patient care and is unhelpful for patients who are trying to recover from substance use, as it could lead to relapse.

A staff member described the issue to us: "If they're in hospital, they've clearly got something wrong with them, and usually, they're in quite a lot of pain. They [hospital staff] don't like to give them pain relief. Sometimes they will give them pain relief and then it's kind of 'OK, we're going to give this to you while you're in here and although you're not fully recovered, you're well enough to be discharged, but we're not giving you anything when you leave.' So you know they'll be given pain treatment up until leaving hospital. Then, when they've gone, that's it. And then they'll go and self-medicate."

Withdrawal is another prescribing area that staff told us is not treated appropriately and we talk more about this below: *"Hospitals and staff feel safe and welcoming to me"* **– Ending Stigma and Unconscious Bias, Creating Psychologically-Informed Environments.**

A doctor with experience of street medicine also informed us that mental and emotional pain can manifest as severe physical pain, due to the same impact on pain receptors.

In order to break the cycle of care inequity, self-medication and patient relapse, a more trauma-informed approach to pain relief and prescribing might be considered.

"I won't be discharged to the streets" – Options for Intermediate and Step-Down Care following Hospital Discharge

"Step-down care gives you time to work with the clients and make an impact."
– A Hospital Frontline Worker

People with multiple unmet needs in hospital settings need access to options for intermediate and step-down care, particularly coming up to and following discharge.

Various frontline workers we spoke to highlighted a big gap in providing step-down care, with one saying that the "underlying issue is lack of all types of accommodation particularly step-down and intemediate care to aid hospital discharge." This gap in step-down from hospital provision leads to people who "still have needs not met" and "nowhere appropriate to go." In worst case scenarios this means some patients are being discharged to the streets.

Those working directly with people with multiple unmet needs said: "When you are a patient, you're worried, anxious" and therefore we, as workers, need "a different provision to work with people."

Outside of the hospital, step-down gives you "time to work with the clients and make an impact" and provides a safe place to further recovery without being stuck in a hospital bed. It allows time to establish a "multi-agency approach" which many staff members said is more effective in supporting people experiencing the impact and effects of multiple unmet needs.

Another staff member explained: "what we really have is a gap in provision of step-down beds to give us breathing space." Staff felt they needed more time to get services into place for the individuals they are supporting or caring for across hospital settings.

“Hospitals and staff feel safe and welcoming to me” – Ending Stigma and Unconscious Bias, Creating Psychologically-Informed Environments

“I’ve witnessed them been treated differently. I’ve heard comments from my guys saying ‘they just think I’m a junkie.’ ” **– A Hospital Frontline Worker**

People with multiple unmet needs need to feel that hospitals and hospital staff are safe environments for them to access. At present there is evidence that this is not always the case and that hospitals and staff can feel unsafe and contribute unknowingly to health inequalities. There is additional evidence that hospitals do not provide psychologically-informed environments for patients who are traumatised or have history of trauma.

When accessing care, staff explained that patients experience stigma, discrimination, unconscious bias and prejudice from staff and from the hospital environment. This is usually due to what is seen as their “chaotic lifestyles” and “complex needs” meaning they often get dismissed by clinicians. Reportedly, due to this stigma and unconscious bias towards people with multiple unmet needs, staff are acting as gatekeepers to care. Staff told us that these “gatekeepers” are not always aware of the barriers they are causing.

Due to the extremely busy environment, these gatekeepers can feel that the patient is causing a barrier to others. For example, in the Emergency Department, staff try to “get rid of them because it’s one problem solved” when there are so many patients waiting to be seen. Some staff members said that some security staff are also acting as a barrier to care because they sometimes turn people away or do not have training on how to de-escalate a situation. This causes patients to have negative experiences of care which perpetuates the cycle of distrust and inequity.

One staff member said that the barriers to access were “purely the patients themselves” due to their lifestyle. This seems like a problematic statement given the full range of evidence and findings throughout this report. It suggests that unconscious bias may be going unrecognised in hospital settings or that conscious bias across hospital cultures is considered acceptable.

Patients can be “labelled and dismissed” we were told, and “find it very difficult to access hospital services.” They are misunderstood, discriminated against, and “not treated with the respect they would like to be.”

Staff said that often, labels such as “substance misuse, criminality, they are the first things that are spoken about [by hospital staff], not the needs. There is lots of eye-rolling. They view them differently, and there is not a lot of understanding about why people behave the way they do.”

Another staff member explained to us: “I think [patients] experience a lot of prejudice and misconceived ideas about what it means to be homeless, why someone may have issues with alcohol… This idea from hospital staff that these patients are time-wasters. Some [staff] think [they] are a waste of time or are not using the help appropriately or not making good decisions.”

Staff interviewed described stigma and bias as something other hospital staff have about patients, that they assume patients brought their situation on themselves, or that it is a “life choice” **(see page 26 for our discussion on language around ‘choice-based’ behaviours).** These assumptions are causing staff to become “desensitised” and result in patients not receiving due care and attention, or as one worker said, receiving only “a bit of TLC.”

An example of this was when a patient was being discharged and was not going to be provided with the medications he was receiving while in hospital. As a result, he was “still actively withdrawing” and the staff member interviewed had to intervene and advocate for the patient. She said: “he is a constant repeat attender with withdrawal symptoms, control seizures… So even when they’re in hospital, under the care of medics, they’re dismissed and that is frustrating as hell.”

Staff told us that “basic empathy” is missing. Showing an interest in the person, just having a chat, showing empathy and basic kindness can make a big difference to someone.

However, many staff noted that there is a lack of understanding between staff and their patients as to how someone comes to being in a position where they have multiple unmet needs. Staff said “a lot of them, when you talk to people, they go ‘God, I never realised that. God, I never knew that’ ” when you tell them about the patient’s circumstances. There is a team in the hospital currently trying to educate hospital staff on the trauma that people have gone through, “providing some information and helping patients to tell their stories and highlighting what they have gone through.”

There was one staff member interviewed who felt that there was judgement in society but that it does not happen in the hospital, and described hospital as a “safe haven” for people with multiple unmet needs, and that this is why they attend even when they do not need acute medical treatment. It is worth considering this, and what hospital provides to an individual that is not met elsewhere in their life, whether that is safety, human contact, or anything else.

That said, the majority of staff agreed that education and training are needed to bring awareness and “get rid of the stigma attitude” that many hospital workers have. Staff felt that culturally there is a lack of awareness and as a result, the public are “less tolerant and less forgiving.” Staff stated that we intervene well, as a society, in children’s lives when they are facing multiple disadvantages, but felt that we don’t do this for adults. An example given was for a patient with a criminal history: “If you are looking at offended versus not offended, the not offended would be funded, even if the one who offended has more needs.” It is a perception issue. They made a call for cultural change.

We have talked about poor access to pain relief medication already, and another example area of barriers to care across hospital settings is in the management of withdrawal symptoms. When someone is alcohol dependent, their withdrawal is often "not picked up on" or "doesn't get managed properly, or there's no urgency about it." Withdrawals often lead patients to leave the hospital or self-discharge in order to self-medicate. This also continues to perpetuate the cycle of inequity.

Staff told us that trauma-informed workers, and awareness, education and training especially focused on changing attitudes to reduce stigma and bias would help with these issues.

"The people helping me aren't tired and burnt out" – Compassionate Workplaces and Trauma-Informed Organisational Development

"How can staff support us if they're not supported themselves or they have their own trauma?"
– A Person with Lived Experience

People with multiple unmet needs require staff and key workers who are in turn well-supported by their workplaces and their employers. It is also important that staff themselves do not have unprocessed trauma and that they are receiving support for any trauma in their own lives. Lived experience amongst staff and volunteers is much welcomed by the clients we talked to, but they also said the staff need to be in a good place to be able to provide care and support.

A dominant theme from the interviews was that, overall, staff in hospital settings are under a great deal of stress on the job. This was for both general hospital staff and specialist staff working with people with multiple unmet needs.

Those interviewed felt that people were trying their best, but with staff shortages and having to look after more patients, staff are "feeling stretched" and "overrun," "run off their feet" and "underpaid." In general, there was a feeling of dissatisfaction with the job.

For staff working directly with patients in this category, many reported the work to be extremely challenging. One staff member explained it was a "privilege to understand and know why someone acts the way she or he does." Although they enjoyed working with their patients and being able to advocate for them, many felt let down most of the time and frustrated, feeling that sometimes they "feel helpless to help others" and that this is leading to staff burnout.

Learning about people's pasts and what they are up against, one staff member said it is "hard to witness what they witness… it's really hard to see the most vulnerable" not getting the care they need.

Another staff member told us: "We're trying our best, but we feel like we are drowning."

Some staff recognised that they need more emotional support because the work can be "really emotionally soul-destroying." One person said: "The job is more frustrating than rewarding." Some roles are also hard-to-recruit-for and because they are seen by job candidates to be challenging, can leave openings for a long time and lead to chronic under-staffing or difficulties in staff retention.

The lack of available services and the current great hospital pressures create more barriers for people experiencing multiple unmet needs. As one worker explained, when a patient does not

show up or self-discharges without being seen by a clinician, it is felt as a relief to overworked staff, even though it leaves a widening gap for those patients who need interventions the most and are not getting them.

Staff specifically working in the Emergency Department stressed that they know there is a perception that they are "not caring" but they do in fact care and want to help, but they feel very stretched working in an overcrowded and "stressful working environment."

Another staff member said: "it's just hard at the moment. How do you get to that point to deliver the needs?" She added that it is a priority to deliver support that meets the patient's needs, but finding balance is challenging in the current working conditions and staff "just can't provide for needs as much as we want to."

This brings into spotlight issues of moral injury or moreover, instances of where needs have not been met effectively or to the standard that staff are accustomed to seeing and for which they trained for. This can present further difficulties and pressures within the job across hospital settings.

One staff member explained to us how interventions to protect and safeguard children work well across the system but that "you don't culturally do that with your adults who are…at risk of being disadvantaged." It is a binary opposition felt by staff when they come into their role to help but find they are only able to do so with patients who present for care "in the standard way." This might indicate that greater parity of esteem is needed between children's and adults' needs.

Standardisation can often discount people, as was explained to us by staff: "People's needs, you know, that's the entire premise that we're all employed and have all signed up to, a vocation, all for, and nobody will disagree with that. But we can't square away in our heads something happening non-standard. When our organisation is driving to standardise everything if you see what I mean."

Examples of non-standard practices include not allowing patients to step outside of the Emergency Department to have a smoke break, or a patient showing up dishevelled or inconsistent in the way staff think a person should present. If someone starts to shout or "act out" they will be asked to leave. Another example is digital exclusion, where follow-up appointments are now phone calls, yet some people do not have access to a phone or do not have enough money to have minutes and data available to take the call. For staff, that can be a relief, as it is one less patient to see. For the patient, it can impede their care, contribute to inequity, and encourage distrust of staff and services.

Some staff said that they felt culture changes are needed to address these issues, which would probably need to be met through organisational development and staff training, and as discussed earlier in *"Hospitals and staff feel safe and welcoming to me"* **– Ending Stigma and Unconscious Bias, Creating Psychologically-Informed Environments.**

Crucially, psychologically-informed environments may benefit not only patients, but the staff working in them too. It was noted that a new "cooling off" space has been created in the hospital which is a newly-started mental health hub taking people out of the Emergency Department environment. It was not clear if this was solely for patients or for staff to utilise and benefit from too.

Further research is needed to understand the extent of exhaustion and burnout across the workforce, how it came about, how it is affecting care and support for people with multiple unmet needs, and what the solutions might be.

Case Study: Duncan's Story

**Please note all names have been changed in this report in order to protect people's privacy and identities*

Duncan, 50, is formerly homeless and is in recovery from addiction to drugs and alcohol. He has his own council-let flat where he has been for about a year and is starting to feel settled, and the neighbours are beginning to say hello to him:

"I'm starting to feel like it's my home. I see some dog-walkers about and say hello to them. I've got good neighbours. The pharmacist really cares too, tells me I'm looking well."

He's slowly making connections to the community and his peer support worker has helped him to join the local Men In Sheds group: "I'm the youngest there, but I look up to them, they're quite fathering. It is different for me being there because one way or another I've been exploited all my life."

Duncan is worried about losing his floating support from key workers and the relationships he has built up with his support team. This is because it is the first time he has trusted a service and its staff:

"If I didn't have this support I would have relapsed. I would have fallen backwards, but I've had support with benefits, with sorting bills so they're on a direct debit and I don't have to think about them…"

"The thought of losing [my key workers] scares me to death. They get me, they know how I think. You can't help but build a friendship up. It helps me get out. I find excuses not to go places I do, it helps me to get to places when I've got help to get there."

Duncan is a keen advocate of ongoing floating support and its significance, particularly during what he calls 'transition stages' such as from homeless to hostel, and then hostel to house. During transition stages is when Duncan needed his key workers the most. He was picked up from his hostel to move into his new flat with just two bin liner bags and a small TV, but the support he's had means it has been a sustainable change:

"This time it has worked. Without the support of [my key workers] I wouldn't be sat where I am right now. Getting out of Miranda House to a hostel to independent living. I've got a flat now, first one I've had in years, I've been sober for over a year. I haven't touched drugs for 3 years. Without my workers I wouldn't have the standard of life I have today.

"The transaction from hostel to flat is the most important. It's when I needed you the most," Duncan says to his peer support worker during our visit.

Duncan has had a particularly good experience of trauma therapy with his NHS psychologist before it came to an end a few months ago. Before this support he says he had never realised the level of grief and sadness in his life.

As a way of honouring the parting of this therapeutic relationship, Duncan's psychologist accompanied him to York on the train to buy a guitar together. Duncan plays guitar and loves a variety of music, and he is now picking this hobby up again. His likes New Order and his favourite genre is indie rock.

He also likes Muay Thai and martial arts (spectator only, he says he feels too old to learn) and watching biographical documentaries about famous sportspeople:

"I like hearing about people's lives and how they got into it. They have strong family values but they're ruthless in the ring. I really like the discipline, they start training at 4 years old."

Consistency in his key workers and building confidence is important to Duncan. He views his support workers as having got him to where he is now, living independently, and in charge of his medication, his bills, and his finances:

"Now I have the option if I want to go in that shop and get myself something I can. I've never had that before.

"It's always in the back of my mind knowing I've got the full support of the team. Seeing the same people helps. How can you put your trust in somebody if you're not seeing the same person?"

Duncan is excited about building a table at the Men In Sheds group he goes to, where the other men are teaching him some basic woodworking skills:

"I'd like to make a coffee table for my flat. A pine standard table with thick legs."

"A mental health residential placement was the turning point for this man and his care."

Finding ways of "holding people"

Some of the feedback we received around the needs of people with multiple unmet needs related to the ways that we, as systems and services, need to change our outlook and perspectives on recovery:

- "How do you hold someone, still hold them somehow, who doesn't want to go to rehab or change. How do we hold people? We hear 'they're just not ready yet, so off they go, back to the streets…' That's valid, but there's something around services having provision for people who aren't ready yet."

Case Study: Russell Street Hostel

This story from **Russell Street Complex Needs Hostel in Hull** demonstrates strong joined-up working – while continuing to emphasise the idea that services and systems need to find more ways of "holding people" for whom recovery may be a long way off, or who may not 'recover' in the conventional ways that society often expects:

"We had a [man in his 50s] who was in Russell Street, the complex needs hostel, and he was causing everybody difficulty. He'd been sleeping rough for a long time, he wouldn't wash or clean, he was defecating and urinating….

"We didn't know what to do, everyone was looking to the Mental Health team for a solution. Eventually Changing Futures involved a legal solicitor who steered us in the direction of residential care. A mental health residential placement was the turning point for this man and his care. He was just a different person. We'd been stuck thinking it was psychological, or a physical problem, or even that he was doing it on purpose to keep people away from him.

"But we found he wasn't incontinent and we couldn't find a psychological issue, talking to him you would come away thinking he's doing really well and why has he been referred. He wasn't your typical homeless person, he had been in the military, he had been a working man for many years. Eventually we found some of his stories were fictitious and the people in them did not exist, but I remember my first assessment with him, I found him so believable and I thought he was doing great.

"We followed the Court of Protection route and he is still defecating, but the turning point was realising there was nothing we could do. Everyone was looking to Mental Health to make this guy better. But we got this guy off the street and into appropriate accommodation. Mental health support wasn't enough, the relationship-building wasn't enough. We think it's likely to be some sort of cognitive impairment down the line, whether it's early onset dementia we don't know.

"Something distressing must have happened to him at some point though. We don't know."

- **With thanks to the clinical staff who shared this story with us.**

An ideal trauma-informed and compassionate culture can "carry people" when they can no longer carry themselves – as staff interviewed pointed out and summarised:

- "One man sleeps in a graveyard, you don't even notice he's there, he blends in with the mud. How can he be happy? You think. But he is. Another one sleeps outside shops, he's well-known, people bring him food. It's the norm for them, I don't know what it would take to bring them indoors."

- "We need a more nurturing approach. Warmth, kindness, holding people in an environment where they feel cared for, so people begin to feel better about themselves. Not the 'all or nothing' stuff. The middle ground. People do recover, yes, but how do you get people to believe they're not a failure? How do we carry people better?"

- "We need more openness and honesty about us all having troubles, celebrities have helped with some of this. But we need it in politics too, more higher profile people saying they're alcoholics. It's not just exclusive to people on Council Estates. Abuse and trauma is not unique to people in prisons."

Many of the people we spoke to, both staff and people with lived experience, emphasised that we must see the bigger picture of a person. They argued that instead of focusing on presenting emotions, behaviours and symptoms, we could see the wholeness of the individuals we are supporting: "their joys," their dreams, their gifts, their worthiness etc.

When we keep looking for complexity in people, or assuming it is there, we will keep finding it. We were encouraged to think about systems as complex, rather than people.

"It's the system which is complex, not the person."

- A Person with Lived Experience

"Slow-burn suicide" in clients

Related to this theme of holding and carrying people with multiple unmet needs is the hidden issue around what one Voluntary Sector leader described as ***"slow-burn suicide."***

We have included this feedback in our report to raise awareness of this issue in Hull.

The idea of **slow-burn suicide** means when someone has given up on life and no longer cares about what happens to them:

People told us it's time to stop trying to get traumatised people to navigate complex systems.

- "We have women who are in slow-burn suicide. They don't actively take their own life, but they give up on life. They won't reach old age, we'll lose them in their 40s. We lose about 5 women per year."
- "They've given up – they don't care if they caught, don't care if they go to prison, carry on mixing in the same circles, no material possessions, no emotional attachment, kids have been removed, domestic abuse relationships are present, we lose those women."
- "Why do they give up? – Services haven't responded at the right time for them, with the right support. You won't get a 2nd or 3rd chance to help that woman."
- "If someone is in front of you, just start working with them – do not try to get people to navigate a system, don't try to get traumatised people to navigate a system. "
- "We have to recognise that intervention may not work the 1st, 2nd or 3rd time, there will be hiccups in the journey setting them back, but we have a chance to make a significant difference… and have to take those chances."

For people in this position who have given up and do not feel hope, and do not feel motivation to seek help, we might think about how services and systems might be organised to meet this degree of despair and desperation.

To reframe this as "slow-burn suicide" helps to bring urgency and highlight this hidden aspect of people's lives where we can think about how to hold and "carry people" in this situation.

We may think about where the points are in the system that could pick up and respond to this need, and if they are not there yet, we might think about how to create them.

Complex health and care systems

Another common theme worth a mention from our research came through around ***complex systems,*** which people feel to be unreasonable and unrealistic for clients with multiple unmet needs and multiple layers of disadvantage to use:

- "We need to stop mystifying it all, remove the mystifying, they keep it mystified so nobody can understand any part of the system or how to access help."
- "If someone is in front of you, just start working with them – do not try to get people to navigate a system. Don't try to get traumatised people to navigate a system."
- "People's anxiety automatically rises when they know they've got to deal with Statutory Services or engage with the system."

Conclusions & Recommendations

Our findings suggest that breaking the cycle of multiple unmet needs is a holistic task for systems.

Conclusions

In this report we have holistically explored the needs of people who are experiencing the impact and effects of multiple unmet needs. We have used a range of quantitative data sources available to us alongside qualitative approaches including interviews and case studies.

In the main, based on **quantitative analysis** work, we have been able to make a strong case for the following conclusions:

- We have estimated that there are almost **16,000 people across Hull who are experiencing the impact and effects of multiple unmet needs,** about 8% of the total adult population, and that this figure is most likely an underestimate when data for domestic abuse, mental health and children is included;
- This is a **baseline estimation** and one which has no comparable equivalent locally from which to further understand its significance or how it may have changed in recent times;
- This estimated and likely minimum of 8% is similar to known rates of coronary heart disease and diabetes in Hull;
- There is unfortunately **no single data source** that can quantify multiple unmet needs in Hull, it is problematic and at times challenging to do so due to data variance and incongruence, and going forward this may be something which systems and services wish to plan for;
- Based on the sources of local quantitative data available to us (for example from local substance treatment, probation services and hospital settings), the prevalent additional need areas that people are experiencing most frequently are: ***housing and accommodation, support for substance use and dependence, support around domestic abusive relationships, physical healthcare needs, mental health treatment, disability and long-term illness support, contact with the criminal justice system or policing, and support around children;***
- We found that hospital settings in particular might not be meeting the needs of patients in this category due to significant rates of self-discharge, readmission and Did Not Attends (DNAs), but limited monitoring and recording practices in general mean that data is currently unable to tell us more;
- People come from a range of ages and can be affected by multiple unmet needs at any stage in their lives, and those affected are more likely to live in the most deprived areas of Hull;
- We found that women have more ‘combination of need areas’ than men, and that it is possible to conclude that the majority or all of women who are sex working have additional needs relating to substance use and dependence.

Based on our **qualitative research findings**, we have been able to complement and expand upon the above discovery of people’s needs with a wealth of additional evidence and stories.

In our qualitative analysis, we found **25 areas of evidenced need** for people who are experiencing the impact and effects of multiple unmet needs and multiple layers of disadvantage. This research made use of interviews with staff, clients, patients and Experts-by-Experience, case studies and field research visits.

These needs were found across our two qualitative research strands of **In-Community and Outreach** settings and **In-Hospital, Acute and Secondary Care** settings.

We have started the work of further refining these 25 identified qualitative needs by breaking them down into categories of ***practical and physical needs, emotional needs,*** and ***cultural/strategic/systemic needs,*** however – as you will see below – in some instances the needs we have identified can quite possibly sit across multiple categories and may be practical or emotional in nature at the same time as cultural and systemic. This is possibly the inevitable nature of a holistic needs analysis and therefore it may benefit well from holistic responses.

The issues and inequalities that people are facing have been found to be wide-ranging, multifacted and overlapping. Our findings suggest that **breaking the cycle and patterns** of having multiple unmet needs is indeed a holistic task for services and systems.

We don't presume to have all of the answers, and these 'grey areas' around defining the types of needs identified might be considered when thinking about recommendations and next steps.

Practical and Physical Needs:

Practical/Physical Need Statement	Practical/Physical Need Description
"Somewhere I can call home"	Safe and Reliable Housing
"Someone's got my back"	Advocacy, 'Hand-Holding' and Floating Support
"Somewhere I can go to at odd hours"	Walk-In Centres with Open Access
"Someone helps me with my bills and my benefits"	Long-Term Financial Support
"I've got something to do"	Non-Clinical and Holistic Approaches and Interventions
"I know where to go to get my teeth seen"	Dental and Physical Healthcare
"When I'm ready, support for my addiction is available"	Accessible Treatment for Substance Use and Dependence
"The physical pain I'm in is taken seriously"	Efficient, Equitable and Trauma-Informed Pain Relief and Prescribing
"I won't be discharged to the streets"	Options for Intermediate and Step-Down Care following Hospital Discharge

Emotional Needs:

Emotional Need Statement	Emotional Need Description
"People show me I have worth and value"	Confidence, Self-Worth and 'Unconditional Positive Regard'
"Why has nobody told me this before?"	Tools, Skills and Psycho-Education
"There's time and space for me to grieve"	Safe Spaces for Grief and Loss
"All I want is a friend"	Loneliness and Isolation
"I know what 'Good Love' looks like"	Attachment, Boundaries, Trust and Trauma
"Everybody needs a Pam"	Trauma-Informed Key Workers and/or Single Points of Contact

Cultural, Strategic and Systemic Needs:

Cultural/Strategic/Systemic Need Statement	Cultural/Strategic/Systemic Need Description
"People want to hear what I've got to say and learn from me"	**Lived Experience Input and Co-Design is meaningfully valued by Services and Staff**
"Please give me back my dignity"	**Authentic Dignity and Respect from Services and Staff**
"I don't have to fit in and people embrace my differences"	**Neurodiversity, Speech, Language and Communication Styles**
"I can feel safe as a woman"	**Women's Specific Support**
"I can feel safe as a man"	**Men's Specific Support**
"People understand that lasting change takes time, trust, courage and consistency"	**Long-Term and Clear Commitment to Services, Funding and Innovation**
"It doesn't matter where I come from, how I got here or what language I speak"	**EU Nationals, Migrants, Refugees, Asylum Seekers and People from Minoritised Groups**
"I am shown that this isn't my fault"	**Intergenerational Trauma, Health Inequalities and Breaking the Cycle**
"Hospitals and staff feel safe and welcoming to me"	**Ending Stigma and Unconscious Bias, Creating Psychologically-Informed Environments**
"The people helping me aren't tired and burnt out"	**Compassionate Workplaces and Trauma-Informed Organisational Development**

We worked with the above summaries of the 25 identified qualitative needs in order to come up with our report's **Recommendations** and you can read more about this process on **page 129.**

Comparisons between the data

In general, there is good symmetry and consistency between the quantitative assessment and the qualitative assessment of needs. From the various strands of research, the most commonly cited needs we discovered were:

(In no particular order)

- *"Somewhere I can call home"* – **Safe and Reliable Housing**
- *"Someone's got my back"* – **Advocacy, 'Hand-Holding' and Floating Support**
- *"Somewhere I can go to at odd hours"* – **Walk-In Centres with Open Access**
- *"When I'm ready, support for my addiction is available"* – **Accessible Treatment for Substance Use and Dependence**

- *"People want to hear what I've got to say and learn from me"* **– Lived Experience Input and Co-Design is meaningfully valued by Services and Staff**
- *"Please give me back my dignity"* **– Authentic Dignity and Respect from Staff and Services**
- *"Everybody needs a Pam"* **– Trauma-Informed Key Workers and/or Single Points of Contact**
- *"I know where to go to get my teeth seen"* **– Dental and Physical Healthcare**

This was true and consistent regardless of the domain marker of primary unmet need being examined e.g. homelessness, harmful use of drugs and alcohol, contact with the criminal justice system, domestic abuse or the removal of children.

As a reminder, the most cited needs from our quantitative research were: *housing and accommodation, support for substance use and dependence, support around domestic abusive relationships, physical healthcare needs, mental health treatment, disability and long-term illness support, contact with the criminal justice system or policing, and support around children.*

We were surprised at the high levels of consistency and similarity in themes that we heard across services and individuals, no matter what the presenting need or issue was at hand.

This was perhaps to be anticipated, as both our quantitative and qualitative analysis strongly suggested that many people are believed to be experiencing at least two of the domain markers for multiple unmet needs **(as per Our Definitions, see page 19),** that needs are interrelational by nature, and therefore there is likely to be symmetry across them. This is why a holistic assessment of needs is important when planning system responses for this population.

To echo one of the clients we met during the compilation of this report: ***"it's the system which is complex, not the person,"*** then it is perhaps also no surprise to discover that the majority (if not all) of the needs we have identified are deeply grounded in common themes of vulnerability, trauma and basic humanity. When considering solutions, it might be worthwhile for systems and services to keep this theme of raw, shared humanity in mind along the way.

Next steps

Moving forwards, and owing to the array of multifacted needs identified for people who are experiencing multiple layers of disadvantage, a holistic approach is arguably needed which can combine in its thinking the findings of the quantitative and qualitative data.

As the analysis has taught us, it will be important to include people who have lived experience when considering these next steps and understanding how we can learn from what they have to teach us, and then implementing their valuable insights across services and pathways.

Having trauma-informed environments, staff and approaches were also much-cited and championed in our research, and Hull may wish to consider how the findings of this report link into wider strategic work around this agenda.

We would also like to draw attention to ***"People understand that lasting change takes time, trust, courage and consistency"*** and some of the comments we received from staff which asked us to look at our theory of change around multiple unmet needs in the city, and the appetite for meaningful and lasting change. We have offered some more detailed **Recommendations,** based on the outputs of two collaborative workshops that ran in November 2023, on the following pages.

Recommendations

In order to reach the following **Recommendations,** we ran two all-comer workshops inviting people who were interested in this report and its research (including people with lived experience and frontline staff) to come together.

At these workshops we provided delegates with high-level summaries of the Needs Assessment report findings and key themes. Table-top exercises were facilitated in small groups so that we could begin to collaboratively explore potential recommendations or ways of taking our research forwards into transformation and change initiatives.

We have aimed for this process to be as co-owned and co-designed as possible within the timeframes, with input along the way from Experts-by-Experience.

We also sought to capture the journey to our recommendations with the support of a graphic illustrative artist and you can see the output from this on the following page.

Following the workshops, we worked with the steering group for this project to organise the workshop outputs into draft recommendations which were then further refined.

We hope that the final recommendations may support services and system leaders to reflect on and implement actions around the findings of this report on behalf of people who are facing multiple unmet needs in Hull.

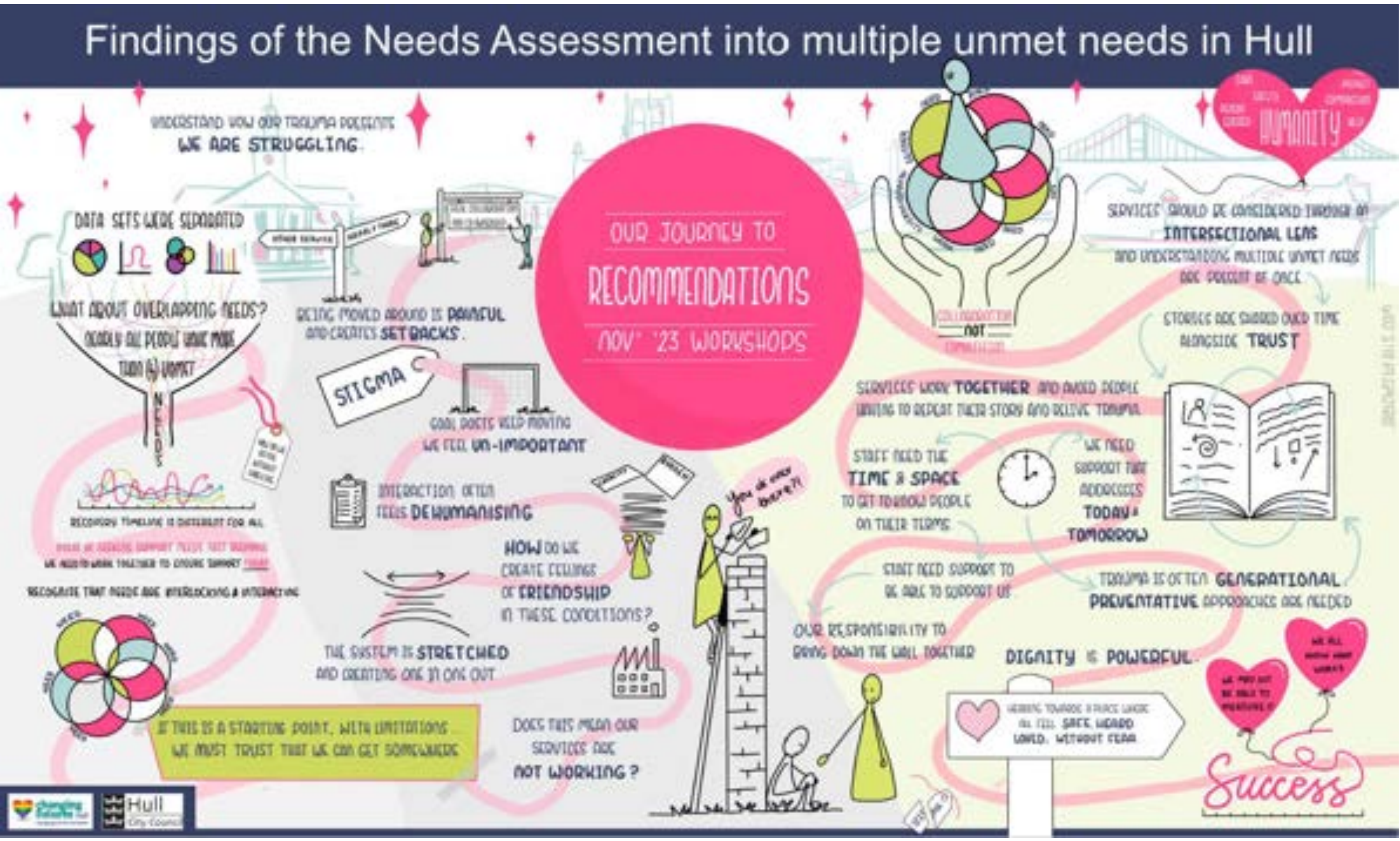
To use the learning from this report to continually improve our understanding and enable us to better prevent and address multiple unmet needs in Hull, we offer these 12 Recommendations:

1) **Including People with Lived Experience**
   We recommend that the views and experiences of people with lived experience of multiple unmet needs are consistently embedded and included across all levels of service design, decision-making and delivery.

2) **Continuity of Care**
   We recommend committing to a model of continuity of care for clients and patients who are experiencing (or are at risk of) multiple unmet needs, which offers a single point of contact for individuals and frontline workers, and care navigation of an individual's co-designed care plan.

3) **Safe Homes and Housing**
   We recommend that this report contributes to ongoing discussions and summits taking place as a response to the current housing crisis in Hull. Our research found safe, reliable and secure housing to be a foundational need for people who are experiencing the impact and effects of multiple unmet needs, and that without this, many of the other needs of individuals cannot be met.

4) **Holistic and Non-Clinical Care**
   We recommend increasing the access to holistic and non-clinical interventions in the city, including peer support, coaching, mentoring, and activities designed to tackle boredom, loneliness and isolation.



5) Inclusion Healthcare

We recommend:

- **a.** bespoke long-term, holistic and personalised inclusion health primary care to meet the needs of people facing multiple unmet needs, utilising trauma-informed approaches and created in co-design with people who have lived experience and professionals who have expertise in this need area;
- **b.** instilling best practice around access, experience and outcomes for people with multiple unmet needs across primary care in collaboration with people who have lived experience;
- **c.** ensuring that pain relief prescribing in all health settings is person-centred, equitable and trauma-informed;
- **d.** access to trauma-informed step-down (intermediate) care following hospital discharge, and improved care and attention to discharge processes for people who are experiencing multiple unmet needs.

6) Trauma Prevention Public Health

We recommend the development of a long-term and ambitious public health approach to trauma prevention which incorporates an all-age population-level lens to identify, mitigate, resolve and prevent trauma in the city.

7) Trauma-Informed Training, Education and Awareness

We recommend ongoing availability and access in Hull to trauma-informed training for people who live and work here, considering the existing provision and working to improve coverage and accessibility where needed.

8) Trauma-Informed Approaches to Data

We recommend services review how they collect, use and share information about their clients, to ensure people's needs are holistically understood and supported, and that we have more trauma-informed approaches to asking for and using this data.

9) Caring for our Workforce

We recommend improving support for staff around caseloads, recognising the impact of ongoing reduction in resources, and giving more attention to the currently high rates of workplace burnout, chronic stress, and compassion fatigue.

10) Transitions

We recommend greater consideration of the transitions across people's life courses – in particular those of childhood to adulthood, or prison to release – both furthering our understanding of and taking any action towards disconnect between services and the impact this may have on prevention or health inequalities.

11) Recognising and Celebrating Good Practice

We recommend more frequent recognition, celebration and sharing of good practice in the city, in particular that which enables improved responsiveness to the needs of people who are experiencing exclusion or risk of exclusion based upon a) speech and language skills, b) reading and comprehension / literacy, c) individual communication styles that may be linked to a trauma history, mental health or disability, and d) neurodiversity.

12) Acting Now with What We Do Know

We recommend acting now with the information we already have to reduce the inequalities faced by the following groups who are experiencing (or are at higher risk of) multiple unmet needs:

- **a.** people with protected characteristics as per Equality Act 2010 (where the protected characteristic e.g. disability, religion, belief, gender, age, sex, marital status, sexual orientation, pregnancy or maternal status, etc. may increase the risk of or existence of systemic exclusion);
- **b.** racially and ethnically minoritised groups, including (but not limited to) EU Nationals, Migrant Communities, Asylum Seekers, Refugees, unauthorised migrants or people who have been refused asylum, Gypsy, Roma and Traveller communities;
- **c.** people who are currently sex working or who have previously sex worked;
- **d.** Children who are currently Looked After, and those who have been in the children's social care system at any point in their lives.

We once again wish to thank everyone who was involved with and contributed to this report. So many people gave their time and energy generously and freely.

Without the input of the staff, leaders, current clients, former clients, and Experts-by-Experience that we spoke to and spent time with on this journey, we could not have reached this point.

Thank you for reading.

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Further Information

Appendices and further information, for example in relation to our quantitative data and baseline estimates of people who are experiencing multiple unmet needs, can be accessed on request from Hull City Council Public Health.

To request more information about this report in general, please contact: PublicHealthAdmin@hullcc.gov.uk.

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